Implementing an Aboriginal & Torres Strait Islander Health Curriculum Framework

*Findings from National Consultation*

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Aboriginal and Torres Strait Islander Health Curriculum Framework – Findings from National Consultation Workshops
Introduction

About the Aboriginal and Torres Strait Islander Health Curriculum Framework Project
Enhancing the cultural capabilities of the health professional workforce to better care for Aboriginal and Torres Strait Islander patients is a critical step in improving the health of Aboriginal and Torres Strait Islander people.

Health professionals need to be both clinically and culturally competent to genuinely affect positive outcomes. This is true for the whole population but is particularly important for Aboriginal and Torres Strait Islander peoples whose health outcomes are unacceptably poor. Ensuring all health professionals develop cultural capability before graduating from higher education is one way of improving the delivery of healthcare for Aboriginal and Torres Strait Islander peoples.

It is recognised that a necessary step to guide and assist Higher Education Providers (HEP) in developing the cultural capabilities of health graduates is a national Aboriginal and Torres Strait Islander Health Curriculum Framework. The introduction of a Framework across higher education has the potential to encourage consistency in outcomes, while providing a benchmark of the minimum level of cultural capabilities required to work effectively with Aboriginal and Torres Strait Islander peoples.

Health Workforce Australia, with the assistance of Curtin University, have undertaken the Implementing an Aboriginal and Torres Strait Islander Health Curriculum Project to develop a national Framework to support HEP to improve the knowledge and capabilities of health professionals to work more effectively with Aboriginal and Torres Strait Islander people and their communities. It will also provide health graduates with the skills to contribute to transforming health service organisations to be more inclusive and culturally safe.

Purpose of this Report
This report presents findings from a 4-staged consultation process undertaken with key stakeholder groups around Australia from October 2013 to May 2014. These consultations aimed to gather the views and input of different stakeholders pertaining to a number of key aspects in the conceptual design and implementation of the Framework. The 4 stages were:

STAGE 1: Key Informant Interviews (Oct-Dec 2013)
STAGE 2: Six face-to-face workshops with higher education and health professional stakeholders (Jan-March 2014)
STAGE 3: One face-to-face workshop with Accreditation authorities and professional body representatives (March 2014)
STAGE 4: On-line consultation (March 1 - April 30 2014)
This report presents findings from data collected and analysed through each of these different consultation processes. The findings across the different consultations were also collated, to identify the implications from the consultations on the conceptual design, development and implementation of the Framework.

Whilst there were slight differences in the emphases of the findings between each of the types of consultation processes, there were themes that continually reoccurred across the consultations, indicating consensus in a wide range of key areas.

The key findings across all of the consultation processes are highlighted in the table below.
Implications of Consultation Findings for the Framework

1. Diversity, local context, partnerships and lifelong learning are core themes that must be threaded throughout the Framework.
2. As terminology is contested, the Framework must consider how terms and definitions are used with respect to consultation feedback.
3. There is general agreement for the proposed theories, principles, content and strategies for effective implementation (as outlined in the Consultation paper), with slight modifications.
4. The Framework must be developed in partnership with Accreditation and professional standards bodies, and in turn, support provided to explore how professional standards can be revised to reflect Aboriginal and Torres Strait Islander cultural capabilities.
5. The Framework should be incorporated into accreditation processes, with cultural capability and responsiveness training occurring across accreditation and professional bodies.
6. The design of the Framework to include foundational capability development followed by vertical and horizontal integration of learning outcomes across a health professional degree.
7. The Framework must have significant emphasis on the process of curriculum implementation (almost more than content), including support resources, tools and guidelines for staff and HEP in order to create authentic and transformational learning experiences.
8. The implementation guidelines must include (amongst other elements):
   - Importance of leadership across key aspects of higher education.
   - Active partnerships between accreditation and professional bodies and HEP.
   - Development of staff capabilities to support effective curriculum implementation.
   - Importance of organisational cultural competency to drive effective implementation.
9. The Framework needs to identify the capabilities of HEP and the extent to which it engages its local community.
10. The Framework must build on evidence of best practice and promote resource sharing throughout the sector.
11. Student capabilities mapped within the Framework must build on existing work in higher education whilst reflecting developments in the health sector in relation to cultural capabilities, and assessed.
12. Innovations in assessment processes are required.
## Summary of Consultation Findings

### Stage 1 – Key Informant Interviews – Key Findings

<table>
<thead>
<tr>
<th>Considerations in the development of the Curriculum Framework</th>
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<tbody>
<tr>
<td><strong>Principles of the Framework</strong></td>
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<tr>
<td><strong>Key informants strongly discussed:</strong></td>
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<tr>
<td>• Principles must be overarching (clinical expertise, cultural competence, research ethics, and involvement in Aboriginal and Torres Strait Islander communities) rather than being overly prescriptive, to allow for local innovation</td>
</tr>
<tr>
<td>• Aboriginal and Torres Strait Islander diversity and local context of learning</td>
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<tr>
<td>• Learning is lifelong</td>
</tr>
<tr>
<td>• Partnerships and collaboration with Aboriginal and Torres Strait Islander stakeholders and across sector</td>
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<tr>
<td>• Reciprocity of engagement</td>
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<td>• Leadership and university wide commitment and engagement</td>
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<table>
<thead>
<tr>
<th><strong>Framework Design</strong></th>
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<tbody>
<tr>
<td><strong>Key informants strongly discussed:</strong></td>
</tr>
<tr>
<td>• Integration of Aboriginal and Torres Strait Islander health curricula horizontally and vertically</td>
</tr>
<tr>
<td>• Build on what has worked – use case studies</td>
</tr>
<tr>
<td>• Flexibility in design – to allow adaption to different contexts and innovation in education</td>
</tr>
<tr>
<td>• Requirement for non-Aboriginal and Torres Strait Islander and Aboriginal and Torres Strait Islander teaching skills to deliver Framework, and guidelines for professional development activities to develop these attributes</td>
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<tr>
<td>• Identify strategies so learning is not an exercise in guilt and berating; yet challenging, transformational and emotion-based</td>
</tr>
<tr>
<td>• Stipulate requirements across multiple levels for a partnership approach to design and delivery</td>
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<tr>
<td>• Outline mechanisms for bringing Aboriginal and Torres Strait Islander people to the classroom, and the classroom to the community</td>
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<table>
<thead>
<tr>
<th><strong>Key informants also discussed:</strong></th>
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<tbody>
<tr>
<td>• Minimum requirements for Faculty and HEP development to support implementation of Framework</td>
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<tr>
<td>• Avoid generalisations and tick box approaches; emphasis on developing understanding and skills to respond to diversity</td>
</tr>
<tr>
<td>• Stipulate how cultural safety is embedded in Framework design</td>
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<tr>
<td>• Clarity of terminology, without being reductionist</td>
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<tr>
<td>• Realistic and achievable expectations/learning outcomes/implementation guidelines</td>
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<tr>
<td>Curriculum content</td>
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<table>
<thead>
<tr>
<th>Enablers supporting cultural capability of Framework</th>
<th>Key informants strongly discussed:</th>
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<tbody>
<tr>
<td></td>
<td>• Ethical role of educators in responding to racism tactfully but responsively. Moving away from blaming and shaming</td>
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<td></td>
<td>• Skilled facilitators in the context of racially charged settings</td>
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<td></td>
<td>• Teaching and learning environments that are inter-culturally safe that is for both Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander people</td>
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<tr>
<td></td>
<td>• Mechanisms for ongoing input from Aboriginal and Torres Strait Islander representatives at staff, student and community levels</td>
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<tr>
<td></td>
<td>• Partnership approaches, audit and assessments that are inclusive of Aboriginal and Torres Strait Islander input</td>
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<td></td>
<td>• Outlining of minimum resourcing (staff, funds etcetera) to ensure transformational and effective delivery is not compromised</td>
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<table>
<thead>
<tr>
<th>Key informants also discussed:</th>
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<tbody>
<tr>
<td>• Cyclical curricula evaluation process</td>
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<td>• HEP commitment to cultural self-assessment</td>
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<td>• Increasing the presence of Aboriginal and Torres Strait Islander staff and students</td>
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<td>• Focus on small group work, ground rules and safe spaces</td>
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<tr>
<td>• HEP response to institutional white privilege/ racism/ self-assessments/ executive commitment and engagement in cultural safety training and practice</td>
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<tr>
<td>• HEP supporting and promoting communities of practice/ inter-culturally safe spaces</td>
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<tr>
<td>• Aim for long term investment and change - rather than short term results</td>
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<tr>
<th>Sector collaboration</th>
<th>Key informants strongly discussed</th>
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<tr>
<td></td>
<td>• Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander leadership required – both ‘top down and bottom-up’</td>
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</tbody>
</table>
- Criteria for linking to higher level HEP strategies, Aboriginal and Torres Strait Islander employment strategies, policies and executive commitment
- Linking of curricula to broader sector and defining in Accreditation standards is crucial
- Accreditors need to be upskilled to be able to effectively assess cultural competency of curricula
- National HEP network/ collaboration/ sharing of resources

**Considerations in the development of Graduate Capabilities and Learning outcomes for the Curriculum Framework**

<table>
<thead>
<tr>
<th>Students are able to</th>
<th>Skills &amp; Attributes</th>
<th>Knowledge &amp; Understanding</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Deliver evidence based care in a culturally competent way</td>
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<td></td>
<td>Adapt and respond to the local Aboriginal and Torres Strait Islander experience</td>
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<td></td>
<td>Be reflexive in practice; understanding biases and conditioning</td>
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<td></td>
<td>Remain humble in practice</td>
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<td></td>
<td>Interact in a meaningful way</td>
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<td></td>
<td>Have confidence and ability to take on multiple roles: health worker, friend, advocate for Aboriginal and Torres Strait Islander people</td>
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<tr>
<td></td>
<td>Integrate cultural competence, understanding, and reflection within the professional experience</td>
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<tr>
<td></td>
<td>Be confident and adept to collaborate and engage in partnership with Aboriginal and Torres Strait Islander professionals, organisations, community members, colleagues</td>
<td></td>
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<td></td>
<td>Culture as central within professional practice</td>
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<td></td>
<td>Whiteness and privilege in the personal and professional context</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complexity of the Aboriginal and Torres Strait Islander patient experience</td>
<td></td>
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<tr>
<td></td>
<td>Critical reflection on own culture</td>
<td></td>
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<td></td>
<td>Impact of power relations and imbalances</td>
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<td></td>
<td>Knowledge of Aboriginal and Torres Strait Islander history; shared Aboriginal and Torres Strait Islander / non-Indigenous history</td>
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<td></td>
<td>Contextualise history within the contemporary Aboriginal and Torres Strait Islander experience (understand trauma is not culture)</td>
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<td></td>
<td>Lifelong cultural learning - understands commitment</td>
<td></td>
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<tr>
<td></td>
<td>Reciprocity of Aboriginal and Torres Strait Islander engagement in principle and in practice</td>
<td></td>
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<tr>
<td></td>
<td>Non- Aboriginal and Torres Strait Islander health graduates acknowledge they are not the experts, and to listen to Aboriginal and Torres Strait Islander colleagues and patients.</td>
<td></td>
</tr>
</tbody>
</table>
• Knowledge of history of health care for Aboriginal and Torres Strait Islander people, as well as distinct health challenges that are faced.
Stage 2 – Higher Education & Health Professional Stakeholder Workshops - Key Findings

Eleven key themes emerged from the HEP and health professional stakeholder workshops. These themes are outlined below, as well as other significant points that were raised.

**Need to build on respected existing Frameworks (such as):**

- **National Aboriginal and Torres Strait Islander Health Plan 2013** – incorporating the elements of health equality and a human rights approach; Aboriginal and Torres Strait Islander community control and engagement; working in partnership; and accountability for outcomes
- **National Cultural Respect Framework 2004-2009** – although the end date for this has passed, the underpinning philosophy is still relevant. Of particular importance is the notion that there is a need to focus on the process of learning that is how material is taught/facilitated, as much as the content itself
- **NACCHO Cultural Safety Training Standards (2011)** – recognises cultural competence is a journey and one moves back and forth along a continuum depending upon the community in which one is working
- **CDAMS Framework and AIDA Review (2012)** – importance of Aboriginal and Torres Strait Islander health being vertically and horizontally integrated; curriculum mandated with assessable content; power of partnership agreements with Medical Deans; and the importance of clinical placements
- **2007 United Nations Declaration of Rights of Indigenous Peoples**

**Leadership is crucial**

- Institutional leadership across all levels of HEP is critical
- Aboriginal and Torres Strait Islander health and its inclusion in curricula is regulated and embedded at a strategic level
- Aboriginal and Torres Strait Islander representation on governing bodies including accreditation is important
- There is commitment of funds to support implementation
- The importance of **ALL** staff taking responsibility and demonstrating cultural capability is critical

**Accreditation bodies MUST be engaged**

- Accreditation must incorporate explicit standards which relate to Aboriginal and Torres Strait Islander curricula, staff and their capabilities, students, and community engagement
- Accreditors must also be trained to assess for Aboriginal and Torres Strait Islander content and quality of delivery

**Health Sector/ Community/ higher education partnerships need to be enhanced**

- Strong linkages between workplace- higher education crucial
- Support from clinical professionals – so capabilities are given the same priority as clinical skills
Partnerships between Aboriginal and Torres Strait Islander and non-Indigenous people in design, assessment and delivery

Identify a foundational ‘baseline’ for minimum requirements nationally across Australia

**Terminology / Definitions are contested**

Cultural Competency contested - Cultural Safety often preferred due to focus on self-reflexivity and recognition of power differentials. Cultural Capability, Responsiveness and Humility also considered

At the same time, recognise there will always be limitations so need to articulate the definitions being used

Broad agreement that whatever term is used needs to capture
- That learning is lifelong
- Graduates need to be able to take actionv- not just have knowledge and skills
- Recognise Diversity/ Uniqueness
- Enveloped within Aboriginal and Torres Strait Islander Terms of Reference

**General support for proposed Curriculum Principles**

Principles need to also capture:
- That care is client-centred and there is a strong link with primary health care principles (which is consistent with interprofessional practice models)
- Learning is graduated and context dependent
- Development of self-reflection, humility and respect are important components

Deeper embedding of the notion of RESPECT, shared responsibility and working in partnership

Focus on learning ‘from’ and ‘with’ rather than ‘about’ Aboriginal and Torres Strait Islander peoples (similar to interprofessional education principles)

No abbreviations- full Aboriginal and Torres Strait Islander terms

**Strong agreement for Framework design to include a foundational first year unit followed by vertical and horizontal integration**

Aboriginal and Torres Strait Islander Health curricula needs to be mandated within HEP and assessed

Needs to be broad and flexible - not prescriptive – to enable local innovation

Racism – a zero tolerance policy should be articulated throughout Framework

Curriculum should be grounded within the local context whilst recognising the importance of diversity

**Strong support for proposed content, while also considering**…

Greater theoretical understanding to explain pedagogical principles

Differentiate between teaching of culture and teaching how to engage with culture
Whiteness, white privilege and racism – these concepts all play a critical role in learning – however the teaching strategy for implementation is key so that students aren’t polarized but the issues are addressed and managed effectively to promote transformational learning.

Emphasis on strengths-based learning/ good news statistics/ positive stories of shared history and programs which have positive outcomes etcetera.

Understanding Diversity – needs to be a key student learning outcome and also impacts on Aboriginal and Torres Strait Islander educators and students.

Link between individual capabilities and system/ organizational cultural competence.

Assessment and evaluation of content and outcomes - must be rigorous.

Aboriginal and Torres Strait Islander people are the ultimate consumers, therefore need to be included in curriculum design and assessment.

Process of Curriculum Implementation is almost (if not more) important as content/ design

Workforce development - capabilities required for both Aboriginal and Torres Strait Islander and non-Indigenous educators’ requirements and HEP strategies to develop their capacity.

Importance of clinical placements – including strategies around cultural training in the context of clinical supervision, and impact of student placement on receiving organizations.

Strong support for simulated learning.

Strategies to bring community voices into HEP curricula through lived experience of Aboriginal and Torres Strait Islander peoples.

Complexities of assessing capabilities – needs an innovative strategy

Ideal assessment practice would include Aboriginal and Torres Strait Islander people in determining whether or not a student could provide culturally safe care.

Capabilities of assessors and what is assessed needs consideration.

Community engagement as the consumer.

Simulation is a powerful way to assess as confounders can be controlled.

Framework needs to consider capabilities of students, staff, the organisational unit, and the extent to which it engages its local community.
Stage 3 – Accreditation Workshops - Key Findings

Three key themes were established through the Accreditation and Professional Bodies Workshop.

**Unanimous agreement that Framework should be incorporated into accreditation processes**
- Involving Aboriginal and Torres Strait Islander people in accreditation is imperative
- There needs to be cultural safety training for assessors and staff within accreditation
- Need to align accreditation and higher education providers in terms of describing necessary professional standards and graduate outcomes

**Cultural capability and responsiveness training needs to occur across accreditation and professional bodies**
- This development needs to happen at ALL levels - not just the assessors
- Required attributes include reflexive thinking and practice and collaboration and involvement of local Aboriginal and Torres Strait Islander people to guide the context of required capabilities
- Interprofessional sharing of resources across accreditation and registration bodies through on-line forums to assist information sharing (some disciplines have undertaken considerable work)

**Strong recognition of the need for partnership approaches between HEP and Accreditation bodies in developing evidence statements and evaluation tools**
- Key assessment criteria not only how curriculum is developing cultural safety capacity in students; but how time and resources are being allocated by the HEP to implement curriculum
- Multiple sources of evidence need to be reviewed including: student based; elements of the curriculum; community experiences; and HEP planning documents
- Importance of positive reinforcement and constructive responses from assessors to inspire HEPs to develop further in this space

Stage 4 – Online Consultation – Key Findings

Eight key findings emerged from the online consultation process.

**Definitions are complex**
- Support for most definitions, with many suggested amendments
- While definitions are important, the Framework needs to ensure definitions used do not become overly reductionist/ simplistic, or evoke dualistic approaches
Caution regarding the delicate nature and potentially offensive associations that may occur by using contentious or ‘coloured’ words such as ‘white’ and ‘black’

Definitions must recognise Aboriginal and Torres Strait Islander diversity, and meaning made within the local context

Definitions must be realistic and achievable

**Strong agreement for the proposed theoretical perspectives whilst including –**

- An emphasis on sharing cultural spaces
- Care around the notion of learning as a continuum - can imply an unrealistic investment by health services/ education
- Contention around use, abuse and colourisation that happens by using the notion of ‘whiteness’
- Cultural capability education must be critically examined to ensure dominant power relations do not remain unchanged

**Effective pedagogy of this content is key**

- Strong agreement of the proposed teaching principles and content
- A strengths-based approach was favoured, whilst also recognising that genuine learning in this context can at times be uncomfortable
- Effective and safe teaching and learning strategies required
- Focus on innovative, experiential and practice based examples
- Focus on transformational teaching and learning approaches that favour adult learning principles
- Identifying how content provided by Aboriginal and Torres Strait educators is supported is a key aspect to effectively embed curriculum
- Contention whether ‘whiteness/ white privilege/ power’ should be a specific topic, or integrated within a reflective process

**Assessment**

- Critical importance of involving Aboriginal and Torres Strait Islander people in developing assessment criteria and assessment process
- Developing capabilities is an ongoing journey, with ‘achievements’ determined by the recipient of care
- Assessors must themselves have cultural capabilities

**Partnerships between accreditation, health sector and higher education critical**

- Overwhelming agreement that Accreditation and professional bodies’ involvement is absolutely crucial to implement curriculum.
- Involving Aboriginal and Torres Strait Islander stakeholders in developing and assessing standards
- Accreditation authorities to ensure all registrations of health professional is inclusive of Aboriginal and Torres Strait Islander criteria and formalised, with minimum standards across health professions
**HEP action on Graduate Attributes and Reconciliation Action Plans**

- HEP must have specific Graduate Attributes related to Aboriginal and Torres Strait Islander people
- Recognise that evidencing attributes is complex, and experience may be ‘more powerful’ than assessed outcomes
- RAPs are important for HEP as they unify community, build relationships, provide a focal point and support translation to practice
- Caution around the potential for RAPs to stay as simply a document that is not translated into action

**Developing culturally competent organisations**

- Unanimous agreement for Universities Australia culturally competent organisational requirements
- HEP policies need to be built from relationships in the local Aboriginal and Torres Strait Islander context, with accountability embedded
- Suggestions for resource allocation to support organisational cultural competency must be feasible and innovative
- Importance of Aboriginal and Torres Strait representation at the senior leadership level

*Proposed factors critical for implementation success unanimously supported*
Stage 1 – Key Informant Interviews

Method
Between October and December 2013, telephone and face-to-face interviews were conducted with Key Informants (KI) who were purposively selected for their expertise and known engagement in the area of Aboriginal and Torres Strait Islander health and/or education.

Participants were approached via email and telephone to invite them to participate in interviews at a time that was suitable to them. To provide some triangulation to the interview process, some interviews were conducted with two interviewers.

Interview questions were developed within the Project Team, then reviewed and endorsed by the Project Advisory Group. Interview questions were used as prompts to elicit open-ended responses in a yarning style from interviewees. Interview responses were recorded by the interviewers in point form (not verbatim). Data was then collated and synthesized to draw out key themes arising from interviews. Analysis of interview data is broadly organized into themes that had a strong response, to indicate issues that KIs repeatedly discussed, and ‘other’ key points that were raised. Due to the open-ended nature of the interviews, while some themes were repeatedly discussed, in synthesizing of data the Project Team have been cautious in applying quantitative measures to interview responses. The summary section provides an overview of the main themes as linking back to elements of the on-line consultation paper that is, Principles of Curricula, Content & Design, and considerations for tertiary and health sectors.

A total of 21 KI participated in interviews, with their professional roles falling into three broad categories (Table 1). It is important to note that many KIs occupied dual categories either in their current positions, or occupy one of those roles previously. Participant types were identified based on the primary role they represented for the interview process.

Table 1. Number of participants per interview category

<table>
<thead>
<tr>
<th>Professional category</th>
<th>Number of participants</th>
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<tbody>
<tr>
<td>Interface of education delivery (Course coordinators, tutors, lecturers etcetera)</td>
<td>9</td>
</tr>
<tr>
<td>Management/ executive in higher education (Pro Vice Chancellors, Deans, Directors etcetera)</td>
<td>7</td>
</tr>
<tr>
<td>Government</td>
<td>1</td>
</tr>
<tr>
<td>Representatives from professional organisations</td>
<td>4</td>
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Findings

Regardless of their professional position, KIs generally often shared views on the direction, content and implementation process required for the developing Aboriginal and Torres Strait Islander Health Curriculum Framework. The similarity of views indicates possibly not only the broad thinking and experience of the KIs (for example as an educator, and as a contributor to curricula design), but also an emerging collective consensus in regards to what has been learnt- and what is needed- to effectively move forward in developing the cultural capabilities of health science graduates within the tertiary setting.

1. What knowledge, skills and capabilities do KIs expect health students to graduate with?

Broadly, KIs described students need to develop an equal combination of professional competencies distinct to their field with knowledge and experience in the Aboriginal and Torres Strait Islander health and cultural domain. Graduates need to be able to understand the ‘space and place’ of Aboriginal and Torres Strait Islander people; a skill that KIs described should not compromise professional skills; but rather broaden them to understand culture as central within their profession. KIs strongly reiterated the importance that knowledge must translate to flexibility in practice, equipping graduates to be adaptive and responsive to the local Aboriginal and Torres Strait Islander experience.

KIs outlined that understanding the complex context facing many of their Aboriginal and Torres Strait Islander patients are should be key graduate learning outcomes, particularly:
- Historical context and impact of past policies
- Social determinants of health and impacts on conditions and symptom presentation
- Kinship and health care requirements
- Communication
- Impacts of rural/ remoteness and health access, and the fact that it is often not possible to ‘refer on’ (requiring a depth of experience) and also the isolation of remote work

A strong theme coming through the interviews was that while graduates need to understand culture in the historical context, the dialogue needs to change from the ‘historically polluting’ to one that contextualises history based on the contemporary Aboriginal and Torres Strait Islander experience. While knowing Aboriginal history is very important when working with Aboriginal people, KIs discussed the importance of recognizing – and celebrating- history as a shared experience between Aboriginal and Torres Strait Islander and non- Aboriginal and Torres Strait Islander people as critical.

This is not about feeling guilty- but about moving forward. Some KIs also referred to the importance of graduates understanding their potential contribution as a health provider, in bettering Aboriginal and Torres Strait Islander health outcomes as important in empowering the future graduate.

There was considerable reference amongst KIs regarding the importance of graduates understanding the cultural diversity of Aboriginal and Torres Strait Islander Australians, with an ability to place diversity within the local context. Graduates must also have a deep understanding of diversity more broadly- that the Aboriginal and Torres Strait Islander
experience is not just culturally diverse, but diverse in a host of elements (for example geography, social, economic).

KIs strongly felt having a deep and authentic appreciation of culture and other elements of diversity should subsequently instil in graduates the ability to interact with their Aboriginal and Torres Strait Islander clients in a way that is responsive to context and avoids stereotypes. While graduates need to understand the intersection of the bio-medical model of health and the Aboriginal and Torres Strait Islander model of health, some KIs highlighted that not ‘boxing’ individual Aboriginal and Torres Strait Islander patients in to these models of health is extremely important. Also emphasized was the need to ‘shift thinking away from the exoticization of Indignity’ so graduates are able to engage productively with the contemporary Aboriginal and Torres Strait Islander experience.

**Reflexivity in practice** was strongly highlighted as a crucial graduate capability by KIs, whereby the effect of one’s own socialisation and culture on perceptions and language, and ultimately interactions with Aboriginal and Torres Strait Islander peoples, is explored. Reflexivity was described as enacted in graduates who are considerate, respectful and caring, and able to acknowledge and learn from their mistakes. While knowledge and experience creates confidence, health professionals must not become arrogant; with some KIs commenting reflexivity skills must foster humility in a graduate. Further, being critically reflexive, challenging paradigms and world views including those of their chosen health profession, was also emphasized. Understanding the role of key terms such as whiteness, white privilege and endemic power imbalances throughout Australian society was also referred to by some KIs as critical in graduate learning. KIs also highlighted the skills (and thus effectiveness) of the educator/lecturer in assisting students to make sense and use of that experience, reflecting on their cultural, social and professional positioning *in action* as key to transforming student knowledge from ‘armchair’ reflexivity, to reflexive practice. It was also noted that there must be many simulated opportunities to ‘perform’ their professional role and reflect on the consequences of that to inform their future experience.

KIs unanimously highlighted that **learning in this space is lifelong**; and therefore graduates should demonstrate commitment to ongoing Aboriginal and Torres Strait Islander’s professional development beyond their tertiary studies. It was also discussed that graduates who are open and willing to engage with difference, and understand this learning as lifelong, highlights capabilities that develop through education and learning experiences that inspire and transform.

Some KIs discussed the importance of graduates who are equipped with the capability to build ongoing learning opportunities through regular encounters with Aboriginal and Torres Strait Islander people; as it is only through having ongoing engagement and relationships with Aboriginal and Torres Strait Islander people, mentors, friends and guides, that non-Aboriginal and Torres Strait Islander people become more adept. KIs referred to the importance of **partnerships approaches**, with graduates having deep understanding of the role of specialised Aboriginal and Torres Strait Islander health professionals as not only cultural brokers but also health professionals (such as Aboriginal health and liaison officers) and how to work collaboratively with these professionals.

The ability to partner, engage and follow-up at a community level was also highlighted as an expected graduate outcome, with graduates understanding there are longer term needs of the patient and the community that the patient comes from, underpinned by the **reciprocity**
of engagement. Capacity to develop relationships within communities, understanding how communities function, and the role of empowering individual and communities in ownership of their own health outcomes (rather than being the expert, educated professional) were important learner capabilities that emerged through interviews. Some KIs highlighted that ultimately, *cultural competency is a level of practice achieved if experienced by the Aboriginal and Torres Strait Islander patients themselves.* Graduates must be confident and skilled in developing relationships and partnerships with Aboriginal and Torres Strait Islander organisations to be able to mentor their achievements in this space.
2. What has been learnt in the development and implementation of specific Aboriginal and Torres Strait Islander health curricula?

What doesn't work

KI educators working at the interface felt a common problem in the delivery of Aboriginal and Torres Strait Islander health curricula is that it is delivered in a way that suggests (often indirectly) an expectation of students, that in their health professions they must be ‘agents of reconciliation’ and hold ‘political contingencies in their heads’. One educator felt the student experience- and their professional role - can subsequently be compromised in this ‘highly charged, highly visible space’. Also discussed was a sense of the issues that have ensued as politics meets education; with some KIs feeling education has at times has had a negative effect as political views and personal biases from the educator have been an agenda in the classroom. It was also strongly noted that working with this content is challenging and at times exhausting for educators.

Educators identified that HEP have clearly learnt that educating students in this space is inherently complex, particularly heightened by the ignorance and resistance that they will meet in the classroom. Many educators will be working with a minority percentage of students who are ‘ready’ to engage maturely and respectfully, requiring extremely well developed skills in the educator. Lectures clearly don’t work; it is small group and process driven learning (rather then prescriptive content) that is required. It was also commented that in the often-used process of reflexive journaling as an assessment, exploration of material can be stifled if the student is not compatible with this mode of learning, or they write and reflect what they know the tutor wants them to hear. KIs strongly highlighted that without the right skills in the educator; implementing Aboriginal and Torres Strait Islander health curricula can do potentially more harm than good.

At a management level, KIs felt it is not enough to have single, standalone Aboriginal and Torres Strait Islander health units; that to genuinely develop, students need to interact with Aboriginal and Torres Strait Islander health curricula over time and across their program of study. If material is not embedded and built on, it does not get integrated at a deeper level, in the students learning paradigm. In many HEP, it was felt single Aboriginal and Torres Strait Islander unit delivery has driven the siloing of Aboriginal and Torres Strait Islander material in higher education; contributing to its ongoing ‘othering’ and left students asking, ‘why is there not a standalone unit on other cultural groups? What’s so special about Aboriginal and Torres Strait Islander Australians?’ KIs also felt that contributing to this has been the significant shortfall in ‘broader faculty development’. While graduate attributes and capabilities may be espousing cultural capacity, a shortfall here at either a faculty or university level, has hindered progress and contributed to the siloing of Aboriginal and Torres Strait Islander health curricula and development.

KIs also voiced concern that in many Aboriginal and Torres Strait Islander health curricula, there is a generalisation and far too broad a use of the terms ‘Aboriginal and Torres Strait Islander health and culture’, resulting in the proliferation of stereotypes and attempt to manage the Aboriginal and Torres Strait Islander patient with a ‘one size fits all’ approach. Diversity is poorly explored and understood, and the introduction of generalised Aboriginal and Torres Strait Islander perspectives that are counter to the western medical model-particularly when
delivered in a didactic fashion- have ‘watered down’ Aboriginal and Torres Strait Islander diversity and content into a broad brush cultural model. This has been further antagonised by the ‘tick box approach’ to learning outcomes, feeding generalisations and stereotyping, rather then instilling skills in students to effectively engage with diversity and the individual Aboriginal and Torres Strait Islander context. Some KIs discussed the over emphasis on achieving skills that demonstrate terms such as ‘cultural competence or safety’, combined with a saturation of too many facts and figures where ‘white people are seen as evil and Aboriginal people as fragile’ has lead too often to students feeling defensive and the Aboriginal and Torres Strait Islander space is too hard with no solutions. Students feel helpless and guilty, with many fearful about engaging with Aboriginal and Torres Strait Islander patients in their future health practice and ‘doing it wrong’. The Aboriginal and Torres Strait Islander patient has become almost the ‘mythical client’; curricula in places, has lost its humanness. Students get scared there is a whole new set of skills that need to be learnt. It was also cautioned that there has been an ‘over-emphasis on culture’, and only looking at the culture difference at the cost of the patient with their individual needs as they intersect with their health care.

Curricula have also not, it was felt, been effectively evaluated, and the inherent complexity of evaluating the impact of this material was also mentioned. One KI noted that often material is touted as being an exemplar, but HEP ‘just see it as Aboriginal and Torres Strait Islander business’. The **lacking of effective evaluation**, identified at a national level, was seen as key to developing a more authentic understanding of what elements of Aboriginal and Torres Strait Islander health curricula really is effective. It was also felt that without a framework to embed Aboriginal and Torres Strait Islander health curricula there has been a scattergun approach with no quality assurance as to whether information delivered is appropriate, correct, or having desired learning outcomes and impact.

The failings in partnerships with community and organisations, and the **misunderstanding of what reciprocity means in practice** also emerged in some interviews. With an over emphasis of learning about Aboriginal and Torres Strait Islander people as ‘other’, some KIs felt material has become voyeuristic, particularly due to a chronic lack of an Aboriginal and Torres Strait Islander workforce or engagement of Aboriginal and Torres Strait Islander staff in Aboriginal and Torres Strait Islander health curricula delivery. The lack of space in the tertiary setting for Aboriginal and Torres Strait Islander pedagogy to break down the ‘ivory tower’ and transform teaching and learning in mainstream health contexts is unsatisfactory not only in curricula, but in affecting change within the tertiary space more broadly. The well-known yet serious issue of chronic burn out of the minority of Aboriginal and Torres Strait Islander staff due to constant demands to lead learning experiences and share stories, highlights overworking a handful of Aboriginal and Torres Strait Islander educators and leaders is not working well. For some KIs, this includes widely experienced issues in recruiting and retaining Aboriginal and Torres Strait Islander staff in the academic setting and the failings in ensuring the cultural safety for staff and students- is institutionalised.

The significant shortage of non- Aboriginal and Torres Strait Islander staff who have had sufficient training/ exposure/ experience with Aboriginal and Torres Strait Islander people and health to deliver Aboriginal and Torres Strait Islander material (or strategies of HEP to build staff skills in this space) has shown that **without a suitable workforce, curricula delivery can possibly have a detrimental impact on the student experience.** Educators also commented on the lack of committed and progressional professional development for staff to enhance their skills, with the reactive nature of HEP – and **lack of committed funds- to ensure Aboriginal and Torres**
Strait Islander health curricula is being implemented in a safe, effective and ultimately transformative way. To effectively deliver Aboriginal and Torres Strait Islander health curricula is human and financially resource intensive- a major challenge facing HEP in the current climate.
What is working

KIs agreed that experience clearly shows that Aboriginal and Torres Strait Islander material works best when it is integrated across subjects and delivered through a range of innovative learning approaches, notably immersion, simulated learning, case studies, lectures, online work etc. Small group work and ‘facilitated discussion in the tutorial environment as opposed to content specific didactic lecture delivery was identified as a far more powerful and transformative learning strategy.

KIs praised developments to date in curricula, providing students with basic facts and history of disease, colonisation and social justice, assisting the broadening of knowledge across the student body in recent years. The more recent and widespread understanding that the fundamental learning that cultural competency/safety/security is an ongoing life-long journey- rather then something that is a ‘one-off’ training- is also an important positive learning within the sector. Curricula that help students ‘learn to learn’ – where students learn about other cultures is a life-long process, about their own culture, whiteness, risk taking, willingness to make mistakes and openness to difference, as a crucial positive learning in Aboriginal and Torres Strait Islander curricula.

Some educators noted the different professional spaces that the students come from, and the effect on their engagement and learning. Allied health students were described as more likely to be ‘respectful and ‘get it”; suggesting a future Aboriginal and Torres Strait Islander Health Curriculum Framework whilst being broad enough to be applicable across the different disciplines, must also have capacity to work with the inherent differences in the discipline specific ‘culture’ from which students are coming.

The more engagement a university has with the health profession, and particularly those who are ‘clinical champions’ in the Aboriginal and Torres Strait Islander space also contextualises and grounds Aboriginal and Torres Strait Islander learning to both the local Aboriginal and Torres Strait Islander experience and the professional culture of the students’ chosen discipline. Similarly, the bringing of local Aboriginal and Torres Strait Islander community to the classroom, and the classroom out in to the community, is an extremely powerful learning process. Also, the more learning is personalised, the more effective it becomes:

I call it the Nanna test- engage one of your family, someone who you care very deeply for, and ask what are their health care needs? How would you want them to be treated? If you don’t do this, it remains at the awareness level- it needs to shift to application. Bottom line skill is developing ability to communicate and have good bed side manner- its easy to learn where to stick a needle, but FAR HARDER to learn and possess the human skills to be a good relator. It’s about developing skills to be able to interact in a meaningful way.

The increase in Aboriginal and Torres Strait Islander staff within HEP is assisting the re-imagining of mainstream environments and slowly, assisting the increase in Aboriginal and Torres Strait Islander student numbers. In terms of content delivery, experience suggests the partnership approach of Aboriginal and Torres Strait Islander and non- Aboriginal and Torres Strait Islander teaching teams is extremely successful.

Experience has demonstrated that implementing a curriculum with standards, and accreditation standards, is achievable. There are some really good examples of how students
are meeting the minimum standard of working with Aboriginal and Torres Strait Islander people, and some are going above and beyond. Recognition of the value of being skilled to work with Aboriginal and Torres Strait Islander clients also highlights the positive achievements in this space over the recent years.

**Case Study Examples**

KIs reflected on a number of exemplars in Aboriginal and Torres Strait Islander health curricula delivery. While the information below is clearly not exhaustive, it does provide the Project crucial references for adopting elements into the Framework that have been shown to work exceptionally in tertiary spaces across Australia.

There were many references in interviews to the CDAMS (Council of Deans of Australian Medical Schools) Framework, with its strong focus on Aboriginal and Torres Strait Islander pedagogical principles and well-developed practice case studies. It was felt one of the key ingredients to the success of the CDAMS model is that although it is not mandated curricula, is an integrated curricula with strong ‘behind the scenes’ leadership in Aboriginal and Torres Strait Islander medical education and strong Aboriginal and Torres Strait Islander leaders within some of the implementing HEP. The focus on collaboration and coalitions to facilitate change has given traction to this model in an area that is notoriously difficult. Importantly, teaching is from a positive strengths based perspective.

At Charles Sturt University (CSU), the adoption of a ‘top-down, bottom-up approach’ to Aboriginal and Torres Strait Islander curricula, underpinned by sound executive support at the **Vice Chancellor and executive level**, which is written into governance structures, and KPIs has resulted in the university shifting towards Aboriginal and Torres Strait Islander curricula being embedded as core business. This approach is facilitating a long term commitment and approach to Aboriginal and Torres Strait Islander curricula at CSU: while champions are needed to lead, it was highlighted that this is not sustainable long-term, particularly as these are contested spaces where ‘champions can get worn down by peers’. Sustainability is deeply dependent on institutional commitment. The impact of similar executive support has been seen at Sydney University, where there has been a directive from Deputy Vice-Chancellor (Indigenous) that all staff across the university need to undergo cultural safety training – even if they only teach one lecture a year (as is the case in medicine). This has been a strategy aiming to address the issue of logistics of implementation and suitability of experience. Other forms of higher level direction and support has also been demonstrated through the **impact of having an Aboriginal and Torres Strait Islander Board of Studies** or the like (such as that which exists at CSU) to oversee the development and implementation of teaching and learning activities, while providing an accountability mechanism for how the university is developing in the Aboriginal and Torres Strait Islander space more broadly.

At Flinders University, the **integration of Aboriginal and Torres Strait Islander content** into each year of the student’s medical and nursing course is a stand out success. This has been facilitated through a number of modes of delivery and case studies and broadening of position outcomes. The use of an ‘anti-racist’ approach through curricula was also reported as a successful element to the Flinders approach.

In terms of specific program delivery, at CSU – the Aboriginal and Torres Strait Islander Dirrawany program for Aboriginal and Torres Strait Islander students was praised for its process of not only teaching culture, but **how culture is upheld in the context of their lived experiences**, and how individuals view their health. For non-Aboriginal and Torres Strait Islander students, the
Aboriginal and Torres Strait Islander Culture and Health 130 Unit at Curtin University was also discussed, with reference to its focus on Aboriginal and Torres Strait Islander /non-Aboriginal and Torres Strait Islander partnership delivery; bringing a diversity of Aboriginal and Torres Strait Islander voices into the learning environment through vodcasts; and the focus on workshop/tutorial facilitated reflective discussions as the core element driving the learning experience delivered to large numbers of students (>2300 per annum). It is the emphasis and inclusion of a large body of Aboriginal and Torres Strait Islander educators in both of these programs that is absolutely crucial to their success, as the lived experience of culture in the modern context is discussed, explored, and engaged with through the sharing of personal stories.

At Queensland University of Technology, the adoption of an Aboriginal and Torres Strait Islander pedagogies online forum to contextualise Aboriginal and Torres Strait Islander ways of engaging has been very powerful and effective. It involves developing a yarning circle, which the designer reported resonated very well with students and offered a powerful learning experience. The graphics were appropriate (nomenclature), and the yarning circle offered different emersion yarning experiences. The circle worked off the principle that learning is much more than a cognitive experience, that feelings must be engaged to move students more authentically towards Aboriginal and Torres Strait Islander curricula. A number of other examples were also referred to for their successful work in Aboriginal and Torres Strait Islander curricula, including James Cook University, Newcastle University, The University of South Australia, Bendigo University, Western Sydney University, Physiotherapy’s integrated curriculum at Monash University and the University of Otago in New Zealand. The University of Western Australia as a leader in the field at the Centre for Aboriginal Medical and Dental Health was highlighted, particularly its experience integrating, assessing and evaluating curricula horizontally and vertically.

The strong Aboriginal and Torres Strait Islander academic leadership at the University of Melbourne has clearly been an instrumental factor supporting much development, including the adoption of the CDAM curriculum model and a strong focus within the university on community engagement and experience for students. Dr Louisa Remedios (Physiotherapy) from the university was also referred to for her innovative work trying different approaches to deliver these curricula more effectively.

In terms of the process of developing cultural awareness and competencies, it was suggested there are many examples from New Zealand in cultural training that are particularly ‘transformational’. However in potentially adopting elements of these models, it was again reiterated that the context needs to be ‘right’ and the training well resourced to be effective.

3. Developing cultural safety in education for staff and students: what is required?

Creating culturally safe teaching and learning environments for both Aboriginal and Torres Strait Islander AND non-Aboriginal and Torres Strait Islander staff and students was a major priority and concern for KI educators. Developing ‘two-way spaces’ and working towards environments that are ‘interculturally competent’ were terms used by some KIs to describe culturally safe spaces for all.

Educators strongly felt that it is extremely important that there is a movement away from models of teaching that ‘strip away non-Aboriginal and Torres Strait Islander students defences by being negative or berating them in relation to colonisation’. The ethical role of the educator
was discussed in relation to replacing student defensiveness with a more productive and forward moving quality. One Aboriginal and Torres Strait Islander KI described a culturally safe teaching and learning environment for students as a ‘site for uncertain travellers; where non-Aboriginal and Torres Strait Islander people are permitted to be uncertain’. These spaces need to ‘non-essentialised, so people can speak outside expectations of themselves, ask silly questions but be responded to respectfully. You are at your most vulnerable – it can be both comforting and confronting’.

To create this space, some educators described the need for **ground rules and for educators to be reflexive and mature enough to know they are both facilitators and also members of an inter-cultural learning space**. One KI discussed how the educator models this experiential process for the student by taking risks and moving into the uncertain space with the students, demonstrating coping and self-support strategies. It was also discussed how the **educator also needs to be a facilitator, skilled and trained in group process learning and dynamics, particularly in the context of racially charged settings**. Managing tension, defensiveness and racial fraction were all specialised skills that were referred to by KIs as required by an educator to facilitate an effective learning environment. The link between creating culturally safe learning environments and HEP providing enough funds to train and support facilitators was also highlighted.

**Developing cultural safety in staff requires that the executive level lead by example.** A strong theme coming through many of the interviews was that HEP executives and management need to have a commitment to the development of cultural safety throughout the HEP setting, and demonstrate it by leading by example, undertaking their own training that continue to develop cultural safety. The point being made was that executives must champion to the broader HEP why developing cultural safety is so important.

A strong theme at management levels was **creating culturally safe learning environment driven by authentic partnerships between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander staff, students and communities**. The need to reach a ‘critical mass’ of Aboriginal and Torres Strait Islander staff and students was also identified, and in staff, there was description of the racial division of academic labour with assumptions about Aboriginal and Torres Strait Islander academics underpinned by white privilege - that Indignity may be the criteria for education and that expectations of scholarly achievements/ capacity in Aboriginal and Torres Strait Islander staff is lower than non- Aboriginal and Torres Strait Islander staff. Some KIs referred to understanding concepts of institutional white privilege and racism – and importantly, addressing it is the precursor to developing cultural safety within the teaching and learning experience. HEP need to address their own institutional and systemic racism in order to ‘genuinely’ educate students Interviews also discussed in terms of staff professional development, broadening knowledge includes not just exposure to Aboriginal and Torres Strait Islander culture and health content, but understanding institutional racism/ white privilege impacts at recruitment and retention stages, organisational ‘culture’ and barriers, and developing, supporting and **promoting spaces where Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander staff can come together (communities of practice) to practice culturally safe spaces**.

There was considerable discussion in interviews around **how the university demonstrates their commitment to Aboriginal and Torres Strait Islander health and culture is a key indicator** driving cultural safety. Particularly meaningful pathways and employment through long term fractional appointment was highlighted. These pathways need to be obvious to both staff and
students, and valued strongly within the organisation. There was strong agreement that initiatives and the momentum of Aboriginal and Torres Strait Islander curricula must be formally ratified in university policies, ensuring that it is not dependent on key people to continue, with the importance of resource commitment.

Some KIs felt developing **cultural safety requires a multi-layered approach** – where a curriculum is implemented by genuine and authentic support by top levels in the HEP, peak professional bodies including accreditation bodies. It was also discussed how important it is for the assumption of educators to be checked and examined: educators – and the programs they teach- need to be **audited and accredited, with requirements for ongoing professional development built into expectations of staff** (e.g. performance indexing etcetera). Assessment for students, staff and HEP, was identified as a key element of ensuring ongoing culturally safe environments are being worked towards.

While Aboriginal and Torres Strait Islander staff leading this agenda and influencing change and action is crucial, a very strong theme across all interviews was the need for **demonstrated partnerships and collaborations between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander staff**, showcasing a shared understanding to the broader university. It was also discussed that HEP need to work better together with other HEP to recognize institutional qualities and exemplars of where this is done well would assist this process, as well as the importance of partnerships with accreditation bodies in developing and implementing cultural safety standards as well as “professional regulation” to ensure culturally safe teaching and learning settings are not just an ideal, but a requirement.

KIs who currently working at level of Policy development felt a major challenge in this space currently is the **complexity of terminology**; and HEP being unclear on what key terms such as cultural safety or competency mean in practice. What has tended to occur is a fixation on ‘tick box achievements’, rather than sustained ongoing commitments. One KI prefers the terms ‘cultural responsiveness’ because it suggests keeping the process alive and forward thinking; ‘it’s about every person is different and your responsiveness and practice is different every time…you remain alert’. Perhaps HEP should be aiming to develop cultural responsiveness in staff and students as a conceptual and practical term.

4. What approaches are required from a higher education and accreditation perspective to facilitate change?

**Higher Education**

A strong theme coming through the interviews in relation to facilitating change within the higher education sector is the need for a **rigorous, committed and ongoing assessment of organisational conduct and teaching and learning delivery**. KI’s referred to the need for authentic organisational self-assessment in terms of progress and development in Aboriginal and Torres Strait Islander curricula and cultural conduct more broadly, as well as high level support and institutionalised commitment through supportive policies and ongoing resource allocation.

**Leadership and resource commitment** was identified as one of the most important agents of change within higher education and a very strong theme through KI interviews. Leadership was discussed at many levels of higher education; from executive and management requiring
high-level championing by Deans and Pro Vice-Chancellors of Health (supported by policies school accountability) to those at the ‘coalface’, with one KI arguing it is essential to invest in lecturers and educators as leaders of change facilitation, providing support for non-Aboriginal and Torres Strait Islander lecturers to spend time having experiential encounters with community members, and supporting Aboriginal and Torres Strait Islander lecturers by valuing their knowledge and how it comes in to the learning setting. Exploring pathways for Aboriginal and Torres Strait Islander community members to play a leadership role in curriculum delivery was also suggested to support change within the higher education setting.

Connecting Aboriginal and Torres Strait Islander health curricula to a whole framework within the university such as within Reconciliation Action Plans and health workforce agendas were described in some interviews as important drivers of change. To address risks of sustaining Aboriginal and Torres Strait Islander content in the curriculum over time, it was suggested that a Faculty Aboriginal and Torres Strait Islander Curriculum Committee is employed to audit the curricula every 2-3 years, monitoring that Aboriginal and Torres Strait Islander curricula remains up-to-date, active and relevant. The crucial role of engaging Aboriginal and Torres Strait Islander expertise in an appropriate and rigorous way was also emphasized in some interviews, alongside the cautioning of tokenistic involvement.

Again, a strong theme through interviews was that change will be facilitated through ongoing evaluation of how effectively Aboriginal and Torres Strait Islander health and culture is taught, assessed and integrated in to the learning experience. Some KIs identified evaluation areas as including attitudes, empathy, understanding whiteness, ‘colour blindness’, stereotypes. Some KIs also linked curricula assessment to looking multiple knowledge systems and multiple ways of learning. Suggestions included pre and post course qualitative evaluation methods such as focus groups and also longitudinal to capture long-term effects of learning.

To keep the enthusiasm for change, some KIs described the importance of promoting successes and achievements - that the broader university is able to see and reflect on progress in this area. One KI felt a good motivation for HEP is to instil a connection and sense of responsibility for ‘what is going on in their backyard’, giving involvement in Aboriginal and Torres Strait Islander health curricula a personal face for the university. Again, this reiterates the strongly felt perspective for the need for higher education to develop and sustain real and active relationships with local Aboriginal and Torres Strait Islander communities.

Accreditation

To facilitate change within the accreditation space, KIs described the need to consolidate and find common ground and agreed priorities, transforming the current accreditation context which is characterised by many different, often competing perspectives and priorities across health professions. Ensuring accreditation board members have sufficient knowledge to be able to engage effectively with issues around tertiary curricula was also suggested as a necessary development. Some KIs felt while accreditation board members are clinically experienced, sometimes they do not have background knowledge in curricula design or teaching and learning environments, making collaborations with higher education bodies’ complex.

The power of accreditation guidelines was acknowledged and subsequently, some KIs felt accreditation bodies hold a potentially crucial role in changing not just education- but health professional attitudes and practice. It was felt that within higher education, the specifics as
outlined by accreditation bodies can sometimes be given as ‘excuses’ to not include Aboriginal and Torres Strait Islander material in a curriculum that is ‘too full’. The role of accreditation programs in defining competency in cultural responsiveness and the need for students to be capable and accredited in that domain will hold HEP accountable for what they are teaching and be extremely powerful in facilitating change. Reviewing and enhancing the relationship between the higher education sector and accreditation bodies, and supporting the higher education sector to be better informed around accreditation bodies to promote ongoing dialogue in the Aboriginal and Torres Strait Islander space, was strongly iterated.

5. Visioning the Aboriginal and Torres Strait Islander Health Curriculum Framework

When asked what their vision was for how an Aboriginal and Torres Strait Islander Health Curriculum Framework could be brought to life, KIs strongly reiterated the importance of many previously discussed key elements, as well as offering some innovative and inspiring suggestions in developing the Framework.

The Framework needs to be developed around long term learning, with strategies that continue to build engagement and commitment in the learners. Some students have the best of intentions but when they are ‘in situ’ they are deeply confronted by the complexity – and reality that there are no ‘quick answers’. The Framework must be developing in students early, the understanding of the complexity of this space- and lifelong engagement that is required. The Framework needs to instil knowledge in the learner that cultural competency is not a destination, but a constant quest for learning.

Framework flexibility and a broad approach, articulated by general overarching principles- rather than a specific prescriptive approach was also highlighted, to give the different disciplines capacity to contextualise material to their context. HEP need to have autonomy with the Framework; the Framework should not be an exercise of dictating to HEP what must be done, but rather an inspirational and motivational guide. Framework flexibility is also important so that implementation can be specific to the local Aboriginal and Torres Strait Islander context. One KI suggested if each university ‘anchors itself into local knowledge’ there could be a knowledge network established nationally. Combined with evaluation, this could contribute to a growing evidence base that implementing an Aboriginal and Torres Strait Islander Health Curriculum Framework can- and does- lead to positive outcomes (for example more non-Aboriginal and Torres Strait Islander students studying Aboriginal and Torres Strait Islander curriculum; more Aboriginal and Torres Strait Islander students and academics at university; changes in health service practice and Aboriginal and Torres Strait Islander engagement etcetera).

The importance of sufficient resourcing – funds and staff- to implement the Framework was reiterated, highlighting that for many HEP, their previous experience working in this space has been chronically underfunded and reliant on the passion and goodwill of committed individuals. While it was argued the Framework should be mandated and part of the accreditation process, it was acknowledged this is contested. If not mandated, the Framework definitely needs to be an agreed strategic priority throughout the university to signify its importance. The Framework must be embedded, so as not to be vulnerable to losing traction through changing staff and management.
Embedding cultural safety through the design of the Framework was also discussed, with the need for the principles of the curriculum to mirror the same values as the content. Incorporating Aboriginal and Torres Strait Islander pedagogies into what is an inherently western curriculum model needs to be explored. It was also suggested incorporating Aboriginal and Torres Strait Islander pedagogies within the Framework design best be developed by consulting with Aboriginal and Torres Strait Islander students who will have real pride in other people taking an interest in their culture, while fostering acceptance of the planned education process.

The Framework content must be challenging—this is important material and should be challenging thinking and practice. The university also has to be prepared to stand by those teaching it, meaning that it will not 'cave in to complaints' by students who don’t like to have their privilege challenged as they engage with the material. The Framework also needs to be demanding (in a sense) institutions are engaging in a more philosophical exploration around how HEP regard and respond to difference – in values, world view etcetera- difference that speaks not only to the Aboriginal and Torres Strait Islander experience, but also to difference more broadly-the ‘intercultural space’. KIs discussed the need for the Framework to identify how it relates to the local Aboriginal and Torres Strait Islander Terms of Reference, to avoid superficiality in design and delivery.
The following aspects were given as suggested Framework content:

- Shared history, colonisation, racism, contemporary issues including barriers and facilitators accessing the health system
- Building knowledge about Aboriginal and Torres Strait Islander health organisations and understanding how to collaborate
- Aboriginal and Torres Strait Islander health and culture on the global stage
- Clinical skills congruent to enacting cultural responsiveness
- Understanding the current context the differences in metropolitan, rural and remote health and culture
- Working with Aboriginal and Torres Strait Islander communities & understanding community dynamics
- Collaborating with Aboriginal and Torres Strait Islander people in prioritising needs and formulating solutions
- Components of successful health programs in Aboriginal and Torres Strait Islander settings
- Influences of diverse cultural behaviours- ‘intercultural interaction’
- Understanding current political climate in Aboriginal and Torres Strait Islander affairs and health matters
- Power relationships both historically and currently
- Shifting to a strengths based approach: ‘Good news’ stories in Aboriginal and Torres Strait Islander health (instead of re-iterating the negatives); developing a positive position based on strength of Aboriginal and Torres Strait Islander people
- Courage to address- racism & privilege in the workplace
- Knowledge and immersion in local Aboriginal and Torres Strait Islander context (to university/ place) and own (student) self in that cultural and spatial context
- Multi sectorial health promotion and action
- Ensure Framework is teaching both Aboriginal and Torres Strait Islander material

These content elements were not listed in priority of order, nor expanded on in terms of where they would sit in terms of vertical integration. What was emphasized across interviews it is also not what so much is in the Framework, but how it is done, that KIs emphasized as understanding how to ensure learning and delivery is transformative. Process based learning includes how partnerships with Aboriginal and Torres Strait Islander professionals, organisations and communities are enacted, as well as keeping learning ‘modern’ – so that Aboriginal and Torres Strait Islander culture doesn’t become something that is projected as time passed, was also highlighted.

Educators highlighted the importance of the framework prioritising simulation, fieldwork and clinical placements, visioning a Framework built around the emotional response—with considerable work unpacking and reflecting—that best develops cultural capacity of students. The Framework needs to guide, as much interaction between students and a diversity of Aboriginal and Torres Strait Islander people as possible. Students need to develop understanding and skills that relationships are central to any engagement in the Aboriginal and Torres Strait Islander space.

A strongly discussed theme was the importance of the Framework identifying the kind of skills required to deliver content. KIs discussed the detrimental impacts of educators who are not suitably skilled in this space and the importance of the Framework clearly outlining what pedagogical skills are required to deliver this material- for both non-Aboriginal and Torres Strait
Islander and Aboriginal and Torres Strait Islander educators. One KI argued that it is an ‘ethical issue’ if there isn’t workforce faculty development to implement the framework. Suitable staffing to support the implementation of the Framework must include guidelines and provisions for recruiting and retaining Aboriginal and Torres Strait Islander health professionals and educators. It was also felt that this issue needs consideration from a macro-policy perspective- HEP find it hard to compete with the salaries that Aboriginal and Torres Strait Islander health professionals can get elsewhere.

Lessons from across the sector highlight the powerful impact – and need- for partnerships to curriculum planning and delivery. Informants referred to this both in the classroom (ie Aboriginal and Torres Strait Islander / non-Aboriginal and Torres Strait Islander staff to partner in content delivery and learning activities) and at an institutional level (ie collaboration with Aboriginal and Torres Strait Islander Education Centres on the university campus to design and implement). Again KIs strongly reiterated how the Framework needs to demonstrate both principally and also in its elements- Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander collaboration. Partnerships with peak bodies and health organisations, as well as national collaboration to support resource sharing and dissemination of best practice was important beyond the life of this Project. One KI felt a significant change required here is that HEP become ‘more willing to share’; that the competition between HEP to get funds is one of the biggest road blocks to collaborative approaches. Institutions must move beyond the competiveness to recognise the kind of investment and relationship building that’s required to create meaningful cross-institutional collaborations.

One KI also discussed how as this Framework would not be enforced by policy; the Project is likely to expect approximately half of the 40 or so Australian HEP to adopt changes to their health curricula. The suggestion was that perhaps if 10 of these HEP implement the Framework fully, the Project needs to consider how to support these piloting HEP whilst stimulating the others into action. Once the Aboriginal and Torres Strait Islander Health Curriculum implementation was underway, it was also suggested a list of engaged HEP should be made public. This would pressure on HEP that have not adopted this approach and prompt them into action.

A final point was that teaching and learning – and the higher education sector- is undergoing significant change due to the development of online courses. Thus, education models will change dramatically over the next 5-10 years and its important the Framework is responsive, adaptable and suited to future changes.
Stage 2 Higher Education & Health Professions Stakeholder Workshops

Overview
HWA held preliminary pilot workshops at the HWA conference, the Indigenous Allied Health Australia conference and at the Future Health Leaders meeting during November and December 2013.

The national multidisciplinary consultation workshops formally began in Perth on the 29th January and were completed in Darwin on March 6th 2014. Stakeholders were invited to participate following email communication from HWA A/CEO to the higher education sector, governments, health services including the Aboriginal community controlled sector, the HWA Board, internal Standing Advisory Committees, and the Future Health Leaders. An online registration process was launched on HWA’s website for participants to register their interest in Perth, Melbourne, Adelaide, Brisbane and Sydney. A separate invitation was emailed to key organisations in the Northern Territory for the consultation workshop held in Darwin.

Overall there was good participation in each state at the workshops, although actual attendance numbers were fewer than registration numbers (Table 2).

| Table 2. State by state workshop delivery date, registration and attendance numbers |
|---------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Date held | Perth | Melbourne | Adelaide | Brisbane | Sydney | Darwin | TOTAL |
| 29th Jan | 29th Jan | 3rd Feb | 6th Feb | 10th Feb | 11th Feb | 6th Mar | 184 |
| 3rd Feb | 17 | 43 | 38 | 35 | 35 | 16 | 184 |
| 6th Feb | 10 | 28 | 28 | 27 | 29 | 12 | 134 |
| 10th Feb | 10 | 28 | 28 | 27 | 29 | 12 | 134 |
| 11th Feb | 10 | 28 | 28 | 27 | 29 | 12 | 134 |
| 6th Mar | 10 | 28 | 28 | 27 | 29 | 12 | 134 |

In terms of the professional categories of participants, Table 3 illustrates this was varied across the different states. Overall the greatest representation was from the educational sector, followed by representatives from professional organisations. Representation varied in each state; for example, at the Sydney workshop the greatest representation was from the professional sector followed by health service administration and management, yet in Brisbane there was overwhelming representation from the education sector and no health service administration and management.
Table 3. Attendance based on participant category

<table>
<thead>
<tr>
<th>Category</th>
<th>Perth</th>
<th>Melbourne</th>
<th>Adelaide</th>
<th>Brisbane</th>
<th>Sydney</th>
<th>Darwin</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Educator/Trainer</td>
<td>4</td>
<td>16</td>
<td>11</td>
<td>19</td>
<td>5</td>
<td>5</td>
<td>60</td>
</tr>
<tr>
<td>Health Service Admin/Manager</td>
<td>3</td>
<td>3</td>
<td>8</td>
<td>0</td>
<td>8</td>
<td>5</td>
<td>27</td>
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<tr>
<td>Health workforce Researcher</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Professional representative</td>
<td>1</td>
<td>7</td>
<td>4</td>
<td>6</td>
<td>13</td>
<td>1</td>
<td>32</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>

Each workshop ran over a five-hour period, giving background information for participants on the curriculum project followed by small group discussion and a workshop facilitated by an intercultural team. A total of four worksheets were used to provide a stimulus to participants and elicit their feedback and input to the development of the Framework.

- Worksheet 1 - survey of proposed Framework teaching principles
- Worksheet 2 – qualitative feedback on suggestions re: Framework curriculum design
- Worksheet 3 - survey of proposed Framework curriculum content
- Worksheet 4 - qualitative feedback on suggestions re: sector collaboration

Findings

Aggregation and analysis of data from worksheets was completed using Microsoft excel. Worksheets 1 and 3 had response rates calculated for each listed principle (13 possible answers in worksheet 3 and 14 possible answers to worksheet 4) across the different states (Table 4 & 5). For each principle in the two worksheets, the number of participants across all workshops combined who agreed, disagreed or were unsure of the stated principle was also calculated. Worksheets 2 and 4 were qualitative, with a few prompt questions to stimulate discussion. Comments were collated under key themes that emerged.

One of the Project team also took notes during whole group discussions under the different worksheet headings, adding content to commentary findings.

Worksheet 1. Proposed Teaching Principles

This Worksheet asked whether participants ‘agreed’ ‘disagreed’ or were ‘not sure’ whether the 13 proposed Teaching Principles\(^1\) were appropriate for the Framework.

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\(^1\) See Appendix A for Worksheet and Proposed Teaching principles
The response rate to this worksheet was variable across the different workshops, with the highest response rate occurring in the Darwin workshop (86%) and the lowest in Perth (47%) (Table 4).

Table 4. Possible and actual response rates to worksheet 3 based on participant attendance

<table>
<thead>
<tr>
<th>Worksheet 1 Response</th>
<th>Perth</th>
<th>Brisbane</th>
<th>Melbourne</th>
<th>Sydney</th>
<th>Adelaide</th>
<th>Darwin</th>
<th>TOTALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>10</td>
<td>26</td>
<td>25</td>
<td>27</td>
<td>27</td>
<td>13</td>
<td>1085</td>
</tr>
<tr>
<td>Actual</td>
<td>61</td>
<td>169</td>
<td>257</td>
<td>182</td>
<td>270</td>
<td>146</td>
<td>1085</td>
</tr>
<tr>
<td>Possible</td>
<td>130</td>
<td>338</td>
<td>325</td>
<td>351</td>
<td>351</td>
<td>169</td>
<td>1664</td>
</tr>
<tr>
<td>Ratio</td>
<td>47%</td>
<td>50%</td>
<td>79%</td>
<td>52%</td>
<td>77%</td>
<td>87%</td>
<td>65%</td>
</tr>
</tbody>
</table>

Overall, participants agreed with most Principles, providing feedback on the need to fine-tune wording in some of the principles and clarify specific terms. There was unanimous support for Principles 6, 9 and 11 which describe the involvement of Aboriginal and Torres Strait Islander peoples in curriculum design and development; the focus on self-reflection and critical analysis and the need for strategies around supporting both Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander educators due to the emotional load that teaching this content can endure. Principles 1-4 were the most contentious; with participants commenting on the similarities between 2 and 4 and the need to condense them, and the need to clarify terminology such as ‘holistic’ and ‘foundational’ whilst watching for deficit terminology.

Extra elements that were discussed included
- Condensing of principles – both in breadth and verbosity
- Need overarching principles followed by implementation/ action
- Statements need to be strong language
- Concern over ‘white’ privilege, consider ‘mainstream’ privilege
- Role of simulation in education
- Mentorship required in clinical placements
- Assessment of curriculum/student learning – by whom and how to challenge dominant paradigm of assessment
- Need for culturally appropriate research
- Methods of delivery are important
- One-sided – what do Aboriginal and Torres Strait Islander students get out of it?
- Local adaptation/ engagement is important
- Change management framework (organisationally)
- Focus on decolonising health- rather than just differences
- Speak to how learning content holistically deepens understanding of holistic health (vertical and horizontal integration, interprofessional)
- Role of educators/ capabilities – and their commitment
- Racism needs to be identified more prominently within the principles

Worksheet 2. Curriculum Model and Assessment

This worksheet asked participants to give feedback on their preferred model of curriculum design and what should be assessed.

In terms of the model of the curriculum, there was overwhelming support for:
- A combined approach- which includes a foundation standalone unit followed by vertical and horizontal integration with beginner, intermediate and advanced levels, with optional pathways for further student development
- Support for life-long learning
- Local /contextualised learning
- Focus on practice – simulation, case studies, clinical placements
- Flexibility to allow cross disciplinary adaptation
- A client centred approach which incorporates primary health care
- Focus on self-awareness, and building relationships
- Displaying pedagogical innovation and Aboriginal and Torres Strait Islander pedagogical approaches (non-linear, land links, relationship etcetera)
- Council of Elders/ Aboriginal and Torres Strait Islander input

Whilst clinical placements were seen as an excellent opportunity for students to demonstrate their application of knowledge and skills and whilst highly desirable, the majority of participants did not see a role for compulsory clinical placements given the burden that this would place on many organisations. Simulation was widely considered as an opportunity to be explored where students would be able to demonstrate whether or not they were able to apply their knowledge and skills in a ‘safe’ environment.

In terms of assessable components of the curriculum, there was considerable discussion of the complexities of assessing given the specialised nature of this content. There was broad agreement that assessment should focus on application of knowledge and skills in practice, observation, hands-on learning. Participants also highlighted the crucial role of Accreditation bodies in evaluating the efficacy of assessment.

Key assessable aspects discussed include:
- Attitude, knowledge, skill, behaviour, reflexivity
- Clinical placement
- Cross-cultural communication/ relational skills/ engagement
- Extent to which students demonstrate a positive ‘shift’ in their thinking
- Cross-disciplinary work and the interprofessional setting

Assessment methods suggested included self-reflection; case study/role play/simulation feedback; Client/ community feedback; ongoing learning; Use of holistic assessment-meet outcomes across many subject areas; Peer assessment and Summative – with written, theoretical assessment. There was widespread agreement that ongoing feedback loops leads
to continuous improvement. The role of community members as the ultimate consumers of the Framework in the design- and potentially- implementation of assessment (ie client feedback on clinical placements etcetera) was strongly supported. The crucial role of Aboriginal and Torres Strait Islander people in assessing whether cultural capability levels have been ‘achieved’ was highlighted.
Worksheet 3. Proposed Curriculum content

This worksheet asked for participant feedback on the proposed content of the Aboriginal and Torres Strait Islander curriculum. The response rate was over 50% across all states, with the highest response rate occurring in the Darwin workshop (76%) and the lowest in Brisbane (42%) (Table 5).

Table 5. Possible and actual response rates to worksheet 3 based on participant attendance

<table>
<thead>
<tr>
<th></th>
<th>Perth</th>
<th>Brisbane</th>
<th>Melbourne</th>
<th>Sydney</th>
<th>Adelaide</th>
<th>Darwin</th>
<th>TOTALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>10</td>
<td>26</td>
<td>25</td>
<td>27</td>
<td>27</td>
<td>13</td>
<td>1077</td>
</tr>
<tr>
<td>Worksheet 3</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Response</td>
<td>Actual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>94</td>
<td>154</td>
<td>224</td>
<td>225</td>
<td>241</td>
<td>139</td>
<td>1077</td>
</tr>
<tr>
<td></td>
<td>Possible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>140</td>
<td>364</td>
<td>350</td>
<td>378</td>
<td>378</td>
<td>182</td>
<td>1792</td>
</tr>
<tr>
<td></td>
<td>Ratio</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>67%</td>
<td>42%</td>
<td>64%</td>
<td>60%</td>
<td>64%</td>
<td>76%</td>
<td>60%</td>
</tr>
</tbody>
</table>

This Worksheet asked whether participants ‘agreed’ ‘disagreed’ or were ‘not sure’ with the 14 proposed curriculum content. Overall, participants broadly agreed with most of the proposed content, providing feedback on the need to fine-tune wording in some of the principles and clarify specific terms. While the majority agreed on inclusion and implementation of most of the proposed principles, there was notable concern regarding Principles 10, 11 and 12, which refer to stereotypes, whiteness (and privileges) and racism. Feedback highlighted the negative; deficit and generalised nature of the content statements needed further consideration and potential revision to develop their appropriateness for inclusion in the Framework.

Extra elements for consideration
- Clinical placement considerations – community protocols for effective engagement, preparation, etcetera
- Focus on strength based delivery – resilience, connectedness
- Capacity building, community development, community engagement
- Link curriculum to practice
- Practice, simulation, case studies etcetera
- Examination of policies (government, workplace, health, education)
- ‘Teaching the teachers’, teaching tools, teaching in contested spaces
- Exemplars - Models of care, health services, organisations, research etcetera

See Appendix B for Proposed Curriculum Content
Addressing institutional racism/ critiquing workplace culture

Worksheet 4. Health and Educational Sector Collaboration

This Worksheet asked participants to comment on how they thought health sectors and tertiary institutions should collaborate to embed the Framework.

There was overwhelming agreement that collaboration across health and tertiary sectors needs to be improved interprofessionally. The journey between the learning experience of students in HEP and the ongoing learning in the clinical setting needs to be articulated.

The need for Accreditation bodies to ensure there are standards which relate to Aboriginal and Torres Strait Islander health and that these are effectively assessed by accreditors was very strongly identified. Accreditation bodies recognising progressive development in cultural capabilities in a professional setting was also suggested. Leveraging the success of disciplines that have had significant experience and achievements in delivering Aboriginal and Torres Strait Islander content (such as nursing and medicine) was also highlighted.

Participants also discussed:
- Committed collaboration and joint agreements between HEP/health services/Aboriginal and Torres Strait Islander Community
- Joint agreements, Memoranda of Understanding (MoU) and policies from those sectors involved, to strengthen the impetus to collaborate
- Partnerships with Aboriginal and Torres Strait Islander people in curriculum design and delivery
- Collaboration and synergy around effective alignment of clinical practice with curriculum learning components and outcomes
- Framework needs considerable flexibility for greater buy-in from the health sector
- The need for shared, and generalised, resources, to encourage collaboration. Suggestions for a national website and dedicated resources to coordinate and centralise
- Create stakeholder engagement opportunities, particularly for leadership groups in each sector.

Participants also discussed greater collaboration between HEP, to encourage shared language, aims and goals and generic curriculum with platforms for shared tools and teaching and learning resources. Participants widely agreed top down strategies, at a government level, would encourage and enable greater collaboration. Particularly compliance by Accreditation bodies as directed by Ministerial directives.

In terms of health services and institutions partnering for clinical placements, participants discussed joint aims and shared outcomes, identified through Memorandum of Understandings. There needs to be time spent building relationships to ensure there is joint understanding of the intended achievements of a quality placement and what is required from all angles to achieve it (student, service and institution). People did realise that partnerships, while desired by many stakeholders, requires sustained commitment of aims and resources to make meaningful practice.

Finally, participants gave feedback on what they felt were key enablers to facilitate the development of cultural capability within health and education sectors. Key themes included:
- Champions/ leaders who embody and demonstrate cultural capability
- Increasing Aboriginal and Torres Strait Islander staff/ student numbers
- Building on existing successful practice
- Mutual benefits for stakeholders and buy ins
- Repository of cultural learning materials and sharing broadly
- Resources to support partnerships and genuine collaboration
- Case studies and the use of simulation preceding clinical placements
- Flexibility and multiple pathways, exploring opportunities for Aboriginal and Torres Strait Islander Terms of Reference in practice
- Safe learning and exploring environments to make mistakes, to learn
Stage 3 – Accreditation Workshop

Overview
A consultation workshop was held with Accreditation authorities and professional stakeholders to gather their views and input in the design and implementation of the Aboriginal and Torres Strait Islander Health Curriculum Framework. Participants from registered and non-registered health professions were invited by email to join the workshop, which was held on March 31st 2014 in Melbourne. A total of 31 people attended the workshop, representing a broad range of health professions (Table 6).

Table 6. Accreditation Workshop participation by professional category

<table>
<thead>
<tr>
<th>PROFESSION</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing/midwifery</td>
<td>5</td>
</tr>
<tr>
<td>Medicine</td>
<td>7</td>
</tr>
<tr>
<td>Dentistry</td>
<td>1</td>
</tr>
<tr>
<td>Health science</td>
<td>1</td>
</tr>
<tr>
<td>Allied health</td>
<td>2</td>
</tr>
<tr>
<td>A&amp;TSI health workers</td>
<td>1</td>
</tr>
<tr>
<td>Speech pathology</td>
<td>1</td>
</tr>
<tr>
<td>Exercise/sports science</td>
<td>1</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>1</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>2</td>
</tr>
<tr>
<td>Radiology</td>
<td>1</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>1</td>
</tr>
<tr>
<td>Australian Health practitioner</td>
<td>3</td>
</tr>
</tbody>
</table>
The workshop had the following desired outcomes:

- **Utilise the expertise, feedback and input** of participants in the design, development and implementation of The Framework
- **Obtain agreement** from the majority of participants of the need for the inclusion of professional cultural capability in Aboriginal and Torres Strait Islander health care to be explicitly included in all health profession accreditation standards
- Participants recognise the importance of collaborative partnerships in Aboriginal and Torres Strait Islander care
- **Generate commitment** from the majority of representatives to work within their Accreditation domains to revise Accreditation Standards and processes

The workshop ran over a five hour period, giving background information for participants on the project followed by small group discussion and a workshop facilitated by Karen Cook (HWA Consultant) and Professor Dawn Bessarab (Curtin Project Team member) who were an experienced intercultural team. Three worksheets were used to provide a stimulus to participants and elicit their feedback and input to considerations in relation to accreditation. Key themes and findings emerging during this workshop in response to the worksheet questions are provided below.

**Findings**

**Worksheet 1: Should an Aboriginal and Torres Strait Islander Health Curriculum Framework be incorporated within the accreditation process?**

There was unanimous agreement from workshop participants the **Framework should be incorporated into accreditation processes.** Participants highlighted the **involvement of Aboriginal and Torres Strait Islander people as imperative**, particularly in the domains of governance; assessment; consultation and education of accreditors. **Cultural safety training and ongoing professional development of assessors and staff within accreditation bodies** was also identified as critical with the incorporation of this content. Participants strongly stated that developing cultural capabilities is not just a graduate outcome, but requires development across the health and education sectors. Sharing of resources and continuous quality improvement mechanisms were viewed as important strategies in committing to the ongoing cultural development of accreditation and professional standards.
Participants identified the importance of alignment across accreditation and education bodies in terms of the necessary professional standards and graduate outcomes, and the need to develop explicit statements articulating capabilities required in students. The importance of looking at case studies and accreditation exemplars, as well as positively affirming the pockets of development that have been occurring in this space, was also highlighted.

Participants also had recommendations for the developing Framework which re-iterated components raised in previous workshops, such as the need for flexibility in the design of the Framework to allow for local innovation; horizontal and vertical integration; leadership, governance and commitment to on-going engagement with communities at a local level; and organisational critical reflection tools to support continuous improvement.

**Worksheet 2: Attributes and Professional Development required by Accreditors**

There was unanimous agreement that cultural capability and responsiveness training needs to occur across accreditation teams and professional bodies. Professional development needs to be ongoing, with a focus on breadth or ubiquity of learning outcomes, and a uniformity across disciplines and assessors nationally. Importantly, participants highlighted development of cultural capabilities needs to happen at all levels; from decision makers to committee members and assessors, to enable a shift in attitudes and a focus on Aboriginal and Torres Strait Islander issues and content.

In terms of the attributes required by accreditors to evaluate the extent to which standards are met, participants strongly reiterated the need to be critically reflexive and to demonstrate culturally safe skills. The involvement of Aboriginal and Torres Strait Islander peoples in assessment processes and at a committee level was recognised as an important mechanism in defining the required skills, and also those which are relative to the local context.

The availability of online resource tools to support cultural capability development for accreditation assessors across disciplines was also discussed. It was recognized that some accreditation bodies have much greater expertise in the development of resources and support than others, and that their experience could potentially support those disciplines new to the area. The positive impact of resource sharing online and adaptation of existing tools (such as the LIME critical reflection tool) was highlighted.

An important topic discussed by participants was that accreditation is a process that has the capacity to strongly influence quality enhancement. Accreditation needs to be an informative, productive experience, and shifting attitudes to use a strengths based approach through the accreditation process itself- was an important element discussed.

**Worksheet 3: Evidence and Evaluation Tools**

Participants were asked to consider what aspects accreditors should look for when evaluating whether HEPs and their clinical/fieldwork partners are developing the capabilities required in graduates to work effectively with Aboriginal and Torres Strait Islander people. A partnership approach with HEP was highlighted in order to build on existing processes and working with
HEP to find better ways of undertaking assessments. Participants strongly identified the *key assessment criteria was whether curricula is able to provide evidence that it is enabling students to be culturally safe in practice*. Identifying the HEP allocation of staff time and university resources to enable effective teaching and learning was also highlighted.

In terms of sources of evidence for assessors, participants identified the following:

- **Student based**
  - Students feedback & reflective practice
  - Clinical placement observation/analysis
- **Community based**
  - Aboriginal and Torres Strait Islander community controlled organisations and direct community feedback
  - Clinical placement observations/ feedback
  - Simulated feedback etcetera
- **Indirect**
  - University planning documents
  - Curriculum content and nature

Participants had a number of suggestions in terms of what would assist accreditation authorities to undertake assessments. These included:

- Benchmarking tools
- Progress reports
- A summary of clinical assessments outcomes where graduate cultural capabilities were evaluated
- Aboriginal and Torres Strait Islander health evidence
- Resources from
  - Royal Australian College of General Practitioners
  - NACCHO
  - Australian College of Remote and Rural Medicine
  - LIIME (self-assessment tool adapted appropriately)
- Case studies/ best practice/ show case exemplars

When asked how Accreditation Authorities should respond if they find HEPs are not delivering on the Framework, participants discussed the *importance of positive reinforcement and a constructive developmental response*. Accreditation conditions can (and when appropriate should) be applied to institutions if they are not complying with the standards. However, it was suggested that support for those HEPs whose performance needed improvement through the use of recommendations, suggestions for cultural training and access to exemplars were highlighted as a strengths based approach to assessment.
Stage 4 Online Consultation Process

Overview
An online consultation paper was developed by the project team and made available for public consultation on the HWA website for five weeks, closing on April 30th, 2014. Key stakeholder groups from the health and education sector were invited via email to complete the online consultation.

The paper addressed similar areas that were explored in the face-to-face workshops, such as perspectives on terminology theories; key elements, principles and content of the curriculum framework; and perspectives on health and education sector collaboration.

A total of 29 respondents from across Australia completed the on-line submission, representing a wide range of sectors (Table 7 & 8).

Table 7. Respondent state demographics

<table>
<thead>
<tr>
<th>ACT</th>
<th>WA</th>
<th>NT</th>
<th>NSW</th>
<th>VIC</th>
<th>QLD</th>
<th>SA</th>
<th>TAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
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Table 8. Respondent sector demographics
(NB: some participants identified they represented more than one sector)

<table>
<thead>
<tr>
<th>Sector demographics</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
<td>Health Unit Executive</td>
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<tr>
<td>General Practice Service</td>
<td>1</td>
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<tr>
<td>Health Workforce Planner</td>
<td>2</td>
</tr>
<tr>
<td>Health Worker</td>
<td>2</td>
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<tr>
<td>Rural and remote health service planners or providers</td>
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</tr>
<tr>
<td>Non-government (private)</td>
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</tr>
<tr>
<td>Medical College</td>
<td>1</td>
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<tr>
<td>Education providers to the health workforce</td>
<td>6</td>
</tr>
<tr>
<td>Medical Student</td>
<td>1</td>
</tr>
</tbody>
</table>
Findings

Definitions

Respondents were provided with a list of 14 definitions proposed for use in the framework and asked whether the agreed or disagreed with the definition with room for comments on how it should change.

Appendix C presents feedback of participants on each of these definitions. In summary, Nakata’s definition of the intercultural space was widely supported at a 94% agreement response rate. The Australian Health Ministers Advisory Council’s (2004) definition of cultural respect, Tervalon and Murray-Garcia’s (1998) definition of cultural humility and Universities Australia’s definition of Indigenous cultural competence were also very strongly supported, with 92%, 88% and 86% agreement respectively.

Feedback on some of the definitions - notably ‘whiteness’ and ‘intercultural space’, highlight the delicate nature and potentially offensive associations that may occur by using the words ‘white’ and ‘black’ as definition descriptors. One respondent indicated it can ‘promote colourism’. Feedback suggests how colour is referred to (or inferred), must be scrutinized in the Framework’s definitions, to avoid the promotion of binary or reductionist thinking.

Feedback also highlighted the importance of definitions that recognise Aboriginal and Torres Strait Islander diversity, and meaning made within the local context. The movement away from

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4 Australian Health Ministers Advisory Council’s Standing Committee on Aboriginal and Torres Strait Islander Health Working Party (AHMAC-SCATSIH), 2004, Cultural respect framework for Aboriginal and Torres Strait Islander health: 2004-2009, Department of Health, South Australia.


6 Universities Australia 2011, National best practice framework for Indigenous cultural competency in Australian universities, Department of Education, Employment and Workplace Relations (DEEWR), Canberra, ACT
Definitions that identify a finite set of skills or abilities (such as in the idea that someone may be ‘culturally competent’) towards concepts that capture more realistic and simplistic elements was a strong theme from participants in their feedback.

Definitions with the lowest support were the Victorian Government’s description of Cultural Responsiveness at 61%, Terry Cross’ et al’s definition of cultural competence and notions of whiteness, with the narrow scope described in what respondents articulated as complex contexts, the major shortfalls in the proposed definitions.

Feedback from respondents highlight that while defining aspects of cultural development as applied to the Framework is challenging due to the complexity of the area, ensuring definitions do not become overly reductionist and simplistic, or evoke dualistic thinking or an idea of finite attributes and/or achievable outcomes, is crucial when considering which definitions are used within the Framework.

**Theoretical Perspectives**

The theoretical perspectives proposed for inclusion in the curriculum were:

- Exploring one’s own positioning including whiteness, power, privilege
- Critical reflexivity
- Process of learning versus content/outcomes based
- Sequential, lifelong learning
- Link between personal and organisational knowledge, action and accountability
- Diversity

81% of respondents felt the theoretical perspectives outlined above were appropriate for the development of, and inclusion within, the Aboriginal and Torres Strait Islander Health Curriculum Framework.

Additional comments provided for consideration were:

- Avoid using misleading terms (notably European Australian)
- Need to emphasise sharing cultural spaces (cultural interface) and capabilities required
- The continuum of capability development is a panacea and too costly for health services to invest in long term
- Contention around use, abuse and colourisation that happens by using the notion of ‘whiteness’
- Without a critical perspective on cultural capability education, how it’s being conceptualised (achievements or ongoing leaning journey) and ongoing focus on reflexivity on self, Aboriginal and Torres Strait Islander peoples risk being stereotyped, resulting in current power relations and the associated racism in health service delivery remaining unquestioned and unchanged

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8 Cross, T Bazron, B Dennis, K & Isaac, M 1989, Toward a culturally competent system of care, Georgetown University Child Development Center, Washington, DC.
Key elements of the health curriculum framework

Respondents were presented with Universities Australia’s five teaching and learning recommendations to effectively embed Indigenous curriculum. Most respondents strongly agreed that these recommendations were crucial to supporting effective implementation.

Key additional comments included:

- Adding linking with each registration of health professional within any organisation with annual updates applied across jurisdictions
- Adding how Aboriginal and Torres Strait Islander content provided by Aboriginal and Torres Strait Islander educators must be supported and included
- Adding cultural competency as a Graduate Attribute to embed HEP commitment and contribute to graduates employment opportunities
- Evaluation of teaching and learning processes must include Aboriginal and Torres Strait Islander people

All respondents also agreed that the provided contextual factors that Universities Australia identified as leading to the success of curriculum approaches were relevant.

In terms of other key elements to be included in the Framework, responses included:

- Strengths based good news stories rather than a deficit curriculum model
- Major focus on opportunities for immersion/socialisation/interaction between Aboriginal and Torres Strait Islander people and non-Indigenous learners
- Linking curriculum to employment strategies of Aboriginal and Torres Strait Islander people
- Dedicating resources to support cross-institutional information/resource sharing

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9 Universities Australia Five Teaching and Learning Principles (2011, p.9)
1. Embedding discrete Indigenous knowledge and perspectives in all university curricula to provide students with the knowledge, skills and understandings which form the foundations of Indigenous cultural competency.
2. Inclusion of Indigenous cultural competency as a formal graduate attribute or quality.
3. Incorporation of Indigenous Australian knowledge and perspectives into programs according to a culturally competent pedagogical framework.
4. Training teaching staff in Indigenous pedagogy for teaching Indigenous studies and students effectively, including developing appropriate content and learning resources, teaching strategies and assessment methods.
5. Creating reporting mechanisms and standards which provide quality assurance and accountability of Indigenous Studies curricula

10 Universities Australia identified success factors (2011)
1. leadership
2. staff professional development
3. curriculum taught by staff who are adequately prepared for teaching in an intercultural space
4. institutional support and valuing of Aboriginal and Torres Strait Islander perspectives
5. Aboriginal and Torres Strait Islander community engagement and partnerships
6. financial and human resources to ensure the sustainability of the program
Proposed Teaching and Learning Principles

Respondents were asked whether they agree, disagree or were unsure of the proposed 13 Teaching Principles for the Framework. Appendix D presents the full results of respondents’ feedback.

In summary, there was unanimous agreement for the inclusion of Teaching and Learning principles 4, 6, 8, 9, 11, 12, and 13, highlighting the importance of innovative, experiential and transformational teaching and learning approaches that favour adult learning principles, recognising that genuine learning in this context can at times, be uncomfortable for both learner and educator, and effective and safe teaching and learning strategies are required.

Respondents mostly agreed with the other proposed teaching principles, providing feedback on the need to fine-tune wording (such as holistic and social determinants) in some of the principles and clarify specific terms. Caution was also indicated towards teaching contentious terms, such as ‘white privilege’, as one respondent commented “not all privileged students are white, and not all whites are privileged”.

Proposed Curriculum Content

Seventy one percent (71%) of respondents agreed that the proposed content adequately described the requirements (as listed in Appendix B) for an effective Aboriginal and Torres Strait Islander Health Curriculum Framework, and 29% disagreed.

Respondents gave many suggested amendments and points to consider in the proposed content. The key issues/suggestions raised were:

- Contention whether ‘whiteness/ white privilege/ power’ should be a specific topic, or integrated within a reflective process
- Importance of focusing on strengths base and moving forward ‘together’
- Focus on practice based examples wherever possible - the ‘how to’

In terms of suggested additional content, the following was given:

- How historical issues influence contemporary ones (for example the contemporary issue of Aboriginal identity and identification, which has resulted from mixed-descent and assimilation policies)
- Elements informing stereotyping and negative policy language
- Working with Aboriginal and Torres Strait Islander health professionals and community controlled services across all streams/inter professionally
- Advanced Aboriginal and Torres Strait Islander health professional achievements
- State level policies (historical) and state cultural awareness policies (contemporary)
- Using discipline specific population health approaches
- Relating cultural diversity to Principle 14 and evidence of why care is non-linear
- Impact of past, current and future research practices of the health status of Aboriginal and Torres Strait Islander people.

Assessment

Respondents also gave suggestions of how assessments should be undertaken for cultural capabilities. Key points were:
• Critical importance of involving Aboriginal and Torres Strait Islander people in developing assessment criteria and standards and actual assessment process
• Need for more evidence on assessment effectiveness
• Effectiveness of peer to peer assessment, with students being ‘great moderators’ of each other’s behaviour
• Issues of ‘achievement’ and contestation around ‘competence’ – developing capabilities is an ongoing journey and can only be achieved with ongoing Aboriginal and Torres Strait Islander supervision within the actual workplace so that it is situational and based on the local context
• Strengths based approach to assessment and assessment by application of skills and evidence through practice
• Examiners must themselves have cultural capabilities
• Cultural safety is determined by the recipient of care not the deliverer; as such, wherever possible, assessment be based on this

Suggested methods for assessment were:
• Mixed methodology
• Peer group discussions and student led symposiums
• Layered approach to assessment through student reflection for foundational material; intermediate learning incorporates feedback/ assessment by Aboriginal and Torres Strait Islander community member; and final year builds on this by assessing through documented hours of engagement with Aboriginal and Torres Strait Islander community and feedback
• Including both regional and metropolitan fieldwork experiences
• Case studies, simulation, practical role play

Role of Accreditation Authorities

Respondents gave views on what they thought the role of Accreditation Authorities should be in specifying the requirements for teaching and learning, research, human resources and community engagement in relation to Aboriginal and Torres Strait Islander health within Accreditation Standards.

There was overwhelming agreement that Accreditation authority involvement is absolutely crucial to implement curriculum.

Other responses highlighted:
• Critical role of accreditation authorities in auditing classroom based practice
• Critical importance of involving Aboriginal and Torres Strait Islander people/ stakeholders in developing and assessing standards
• Accreditation authorities to ensure all registrations of health professional is inclusive of Aboriginal and Torres Strait Islander criteria and formalised, and the need for further assessment within their current professional development requiring annual audit of their skill sets
• Accountability mechanisms for authorities, and workplaces, in implementing standards
• Minimum standards across health professions
• Have a costed program for addressing existing gaps and deficiencies

Role of Higher Education Providers
Respondents were asked whether they thought HEP should have specific attributes or capabilities for graduates related to Aboriginal and Torres Strait Islander people. Almost all respondents (94%) agreed there should be specific attributes.

There were a number of valuable comments around the complexities of implementing attributes or capabilities such as:

- Complexities of evidencing capabilities
- HEP context- i.e. should HEP in areas with high Aboriginal and Torres Strait Islander population be expected to have a higher level of accountability with capabilities
- Experience is more powerful than assessed outcomes

Respondents were also asked whether they thought HEP should have a Reconciliation Action Plan. Most respondents (81%) agreed that this was important, giving a number of reasons including:

1. RAPs unify community with HEP and create accountability and responsibility pathways
2. RAPs build relationships, partnerships and trust with community by demonstrating HEP commitment
3. RAPs should not be the responsibility of Aboriginal and Torres Strait Islander staff
4. RAPs support intentions and rhetoric to be translated into practice and action
   The development of action items and timelines creates a more active way rather than simply symbolic gesture
5. RAPs create a focal point for staff and students around Aboriginal and Torres Strait Islander issues

A small proportion (19%) of respondents were not convinced about the usefulness of RAPs. The main reason given was the potential for RAPs to stay as simply a document that is not translated into action.

**Organisational Cultural Competence**

Appendix E presents a list of proposed Organisational Cultural Competency requirements that drew on the Universities Australia report (2011 p109) and key informant interviews that took place for the project.

Respondents were asked whether they agreed/disagreed with these requirements, providing comments where relevant. **All respondents agreed with the list of proposed organisational cultural requirements.**

While respondents agreed with the above requirements, they also highlighted the need for HEP policies and procedures to make reference to jurisdictional cultural awareness plans, reiterating the importance of building relationships with the local Aboriginal and Torres Strait Islander stakeholders. Allocating sufficient resources while important, was also recognised as potentially ‘huge’ and feasibility was questioned; highlighting the resource limitations within the HEP and the need for feasible and innovative solutions to resource allocation in developing a culturally capable setting.

Leadership is a widely acknowledged element required for any kind of change; however respondents noted that it is crucial, but ensuring there is appropriate Aboriginal and Torres Strait representation at the senior leadership level- as well as assessment of leadership actions needs developing.
Culturally capable learning environments were also recognised as a both ways experience, with a ‘shared understanding’ looking at the needs of Aboriginal and Torres Strait Islander students and staff in terms of cultural safety, and also, the needs of non-Indigenous staff and students in interacting with this material. Mentoring, debriefing and supportive open spaces was a common thread underpinning these points, as was the sense of a shared understanding and collaboration in terms of addressing needs.

While 93% of respondents agreed that active and meaningful engagement with Aboriginal and Torres Strait Islander communities was key to developing organisational competence, there were a number of important comments provided in response to this requirement, highlighting the need for organisational strategies, in collaboration with community representatives and stakeholders, to consider. The need for measures of accountability and the degree that HEP are ‘honest and open’ in reporting to communities was raised.

The importance of finding realistic, transparent and committed (even mandatory) forms of evaluating HEPs progress was a strong theme across responses.

**Implementation of the Framework**

Finally, in terms of implementing the Framework, respondents were provided with a list of implementation factors proposed by the project team, as critical for success. These factors are:

<table>
<thead>
<tr>
<th>Factors critical for success</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Senior leadership in higher education being genuinely supportive of Aboriginal and Torres Strait Islander health within curricula and resourcing it appropriately.</td>
</tr>
<tr>
<td>- Importance of ALL staff who teach health professionals to have professional development (initial and on-going) which ensures that they develop intercultural capabilities.</td>
</tr>
<tr>
<td>- Need to recruit and retain both Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander staff with the appropriate expertise and who have the respect of the Aboriginal and Torres Strait Islander community to teach Aboriginal and Torres Strait Islander health, and provide them with appropriate support and workloads.</td>
</tr>
<tr>
<td>- Professional development programs which assist staff teaching in this area to manage anticipated student and staff resistance.</td>
</tr>
<tr>
<td>- Significant role which Accreditation Authorities play in determining the visibility of Aboriginal and Torres Strait Islander Health within curricula, through the design and assessment of Accreditation Standards.</td>
</tr>
</tbody>
</table>
- Need for professional development of Accreditation Authorities in determining whether the framework is appropriately embedded.

- Need for flexibility in curriculum design

Further to these statements, respondents identified the need for the Framework to consider the anticipated resistance that students may face whilst attempting to exercise new knowledge, skills and attributes, as well as the resilience building skills for Aboriginal and Torres Strait Islander students to endure the lack of understanding, knowledge, skills and understanding of their culture they may experience in the cross-cultural interface of the learning setting.
Appendix A Workshop Data Results - Proposed Teaching Principles

Worksheet Responses for Proposed Teaching Principles

<table>
<thead>
<tr>
<th>Principles</th>
<th>Qualitative Feedback</th>
<th>Quantitative Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principle 1</td>
<td>- Too much focus on health service- need focus on wellbeing/ social determinants</td>
<td><img src="#" alt="Principle 1 Diagram" /></td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander peoples have distinctive needs with regard to health service provision which needs to be holistic</td>
<td>- Emphasise diversity of Aboriginal and Torres Strait Islander cultures/ local context</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Diversity must not override individual experience</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Diverse needs linked to social determinants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- ‘Distinctive needs’ is deficit terminology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Holistic ambiguous – whole person better</td>
<td></td>
</tr>
</tbody>
</table>

Principles adapted from Universities Australia 2011, based on Grote 2010
<table>
<thead>
<tr>
<th>Principle 2</th>
<th>Principle 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The distinct needs of Aboriginal and Torres Strait Islander peoples, nature of these factors and their influence on the communities need to be included in foundational content</strong></td>
<td><strong>The provision of holistic health services to enhance the wellbeing of Aboriginal and Torres Strait Islander people is an integral component in the education of health practitioners</strong></td>
</tr>
<tr>
<td>- Whole principle superfluous (covered in 2 &amp; 4)</td>
<td>- Clarification of holistic required</td>
</tr>
<tr>
<td>- Clarity of working needed (ie what is foundational)</td>
<td></td>
</tr>
<tr>
<td>- Need to link journey of learning - that is foundational followed by vertical integration</td>
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<tr>
<td>- Highlight diversity/individual</td>
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<tr>
<td>- Distinct ‘needs’ deficit terminology – change</td>
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<tr>
<td>- Reflection is critical- must be emphasised</td>
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</table>

<table>
<thead>
<tr>
<th>Principle 2</th>
<th>90</th>
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</thead>
<tbody>
<tr>
<td>Principle 3</td>
<td>90</td>
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</tbody>
</table>

- not sure
- no
- yes
**Principle 4**
Foundational content on Aboriginal and Torres Strait Islander issues should be introduced in the initial year of education for the health workforce and integrated throughout the curricula.

- Define foundational
- Similarity with Principle 2 – can integrate

**Principle 5**
A strengths based perspective of culture, diversity and identity should be used to facilitate learning and reflection on attitudes and values.

- Define strengths based – important approach
**Principle 6**
Meaningful involvement of Aboriginal and Torres Strait Islander staff and non-Indigenous staff to strengthen partnerships with community members in development of curricula is essential to ensure appropriate and respectful teaching and presentation of local Aboriginal and Torres Strait Islander perspectives.

- Issues around ‘meaningful’ & ‘respectful engagement – understanding of resource intensity.

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**Principle 7**
Learning settings should be safe and provide positive encounters for all Aboriginal and Torres Strait Islander and non-Indigenous participants.

- Need to define what is safe and teacher capabilities required to enact
- Crucial role of storytelling/ yarning

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</table>
Principle 8
A wide range of teaching and learning strategies, including authentic case studies, should be used
- Overwhelming support for immersion experiences
- Simulated learning theory/practice, third space

Principle 9
Activities that promote development of reflective skills, self-awareness and critical analysis should be integral components of learning and assessment
- End point of curriculum and what should be taught throughout
- Clarification of what reflection actually means
**Principle 10**  
Reflection and self-awareness activities should provide opportunities for non-Indigenous students to explore their understanding of their own cultural values and attitudes along with the concepts of white privilege

- Contention around wording of ‘white privilege’ limiting, or inappropriate, in multicultural classroom setting
- Need greater focus on racism and its breadth, particularly concepts of systemic racism
- Is reflection the same from Aboriginal and Torres Strait Islander/ non-Aboriginal and Torres Strait Islander positions?

**Principle 11**  
Training and on-going support and/or mentoring mechanisms need to be provided for Aboriginal and Torres Strait Islander and non-Indigenous educators that recognise the emotional load encountered

- Importance of student inclusion
**Principle 12**
Aboriginal and Torres Strait Islander staff should not be routinely delegated the responsibility of leading and dealing with Aboriginal and Torres Strait Islander matters, this should be a mandated shared responsibility.

- Crucial role of Aboriginal and Torres Strait Islander consultation on this principle

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**Principle 13**
While Aboriginal and Torres Strait Islander students can make a valuable contributions to enhance learning amongst their peers with appropriate support, they should not be assigned this responsibility nor seen as the spokesperson representing all Aboriginal and Torres Strait Islander peoples.

- Widespread recognition and agreement
### Appendix B Workshop Data Results – Proposed Curriculum content

**Worksheet Responses for Proposed Curriculum Content**

<table>
<thead>
<tr>
<th>Principles</th>
<th>Qualitative Feedback</th>
<th>Quantitative Findings</th>
</tr>
</thead>
</table>
| **Principle 1**  
*Concept and definition of Cultural Competence and importance for health service providers* | - Definition of cultural ‘competence’ and clarity, around similar terms (cultural ‘safety’, ‘literacy’, ‘capability’ ‘competence’)  
- Consider restating to ‘towards cultural competence’  
- Requires clear learning outcomes to address assessment/ measurement | ![Bar Chart for Principle 1] |

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12 Contented adapted from Universities Australia 2011, based on Grote 2010
### Principle 2
**Concepts of race, cultures, ethnicity and worldviews**
- Perspectives – local and global - need clarity around how these fit here
- Context is everything – local must be forefront
- Multiculturalism (many cultures) and ‘mono-culturalism’ (one human species), race (ism)
- Critical self-reflection within the ability to explore these notions

### Principle 3
**Pre- and post-colonial Aboriginal and Torres Strait Islander history in Australia**
- Explicit links to current health outcomes and health care access
- Handled/taught with sensitivity - link to teaching capabilities
- Incorporate strengths based information/ Agency of Aboriginal and Torres Strait Islander people (not just deficit/ trauma)
- Intergenerational trauma (grief and loss) – opportunities to engage at community level to understand
- Pre-colonisation way of life and strengths focus
- Use of dual terms important - easy to lose people who may resist/reject the language
- Recent policies (for example NT intervention) politics and environment
**Principle 4**

Diversity of the Aboriginal and Torres Strait Islander peoples

- Speaking rights – only speak for own group, not all ‘black’ people
- Diversity between Aboriginal, Aboriginal and Torres Strait Islander, understanding language etcetera
- Cultural evolution and individuality in diversity
- Explicit focus on misconceptions of Aboriginal and Torres Strait Islander culture being ‘one’ culture
- Urban, rural, remote concepts – stereotypes

![Principle 4 Chart]

**Principle 5**

Aboriginal and Torres Strait Islander cultures and practices (including the Dreaming, kinship systems, social/cultural systems)

- Partnerships as principles of delivery – need to identify incorporation of elders in delivery
- Who teaches this content? What is appropriate?
- Need to localise content but recognise the risk of excluding groups in localising content
- Make explicit that practices are not the same everywhere i.e. diversity again

![Principle 5 Chart]
Principle 6

Concepts of health and well-being for Aboriginal and Torres Strait Islander people and the significance of family and connection to country

- Including related Evidence Based practice
- Holistic health, not just biomedical model
- Traditional health practices

Principle 7

Current statistics regarding demographics and health status (life expectancy) of Aboriginal and Torres Strait Islander peoples and disparities

- Different/ more innovative approaches to data presentation required
- Include positive data (very common theme)
- Use statistics to contextualise across diversity of groups

(Report Title)
**Principle 8**

Contemporary (and local) issues of concern affecting Aboriginal and Torres Strait Islander communities, and how these may be taken into consideration with regard to health professionals and their delivery of services

- Concerns around the focus (local)
- Concerns around positioning within student life-cycle (i.e. 1st yrs/3rd yrs/prior to clinical placements etcetera)
- Who decides what the issues are? i.e. there needs to be a framework for community consultation
- At the same time recognition of the ‘currency’ of local information for some groups over others, and how that plays out in informing learning

**Principle 9**

Social determinants of health e.g. how social and/or environmental factors may have adverse effects on the health and wellbeing of Aboriginal and Torres Strait Islander people (life expectancy and closing the gap initiatives)

- Deficit based – social determinants not only about ‘negative’ statistics
- Use of certain vocabulary and connotations – alternatives such as ‘determinants’, ‘social and cultural determinants’ etcetera

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</table>
**Principle 10**

Myths, misconceptions and stereotypes of Aboriginal and Torres Strait Islander people

- Very contested principle, due to deficit base, generalisation and focus on negative
- Considerable discussion around the ‘how’ this is taught and requirements for effective implementation

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**Principle 11**

Reflection on cultural identity, whiteness (white privilege and power), values, beliefs, prejudices and propensity to stereotype

- Very contested principle, due to deficit base, generalisation and focus on negative
- Naming conventions – look for alternatives to ‘white’ privilege term
- The manner of implementation e.g. a need for sensitive handling of the subject
- Less binary focus (i.e. black/white – there are other cultures in the class)
<table>
<thead>
<tr>
<th>Principle 12</th>
<th>Racism and anti-racism practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Very contested principle, due to deficit base, generalisation and focus on negative</td>
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</tr>
<tr>
<td>- The manner of implementation e.g. a need for sensitive handling of the subject</td>
<td></td>
</tr>
<tr>
<td>- Strategies for handling racism and is there real university commitment to that both in content but also in learning process?</td>
<td></td>
</tr>
<tr>
<td>- Ways of implementing learning e.g. simulation</td>
<td></td>
</tr>
<tr>
<td>- Positioning within university (i.e. leadership), and within curriculum (foundational to all else)</td>
<td></td>
</tr>
</tbody>
</table>

- Discussion around how complex it is to identify ‘how’ to do this effectively

<p>| Principle 13 | Cross-cultural communication models and skills for working in partnership with Aboriginal and Torres Strait Islander people and communities |</p>
<table>
<thead>
<tr>
<th>Principle 14</th>
<th>Identifying the role and function of the Aboriginal and Torres Strait Islander health</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Role of community control</td>
<td></td>
</tr>
<tr>
<td>- Also how to work effectively with Aboriginal Health Workers/Practitioners</td>
<td></td>
</tr>
</tbody>
</table>
Workers/Practitioners, and how they will complement the work you do.
## Appendix C Online Consultation Findings

*Findings of feedback on proposed Framework definitions listed in order of most agreed with to least*

<table>
<thead>
<tr>
<th>Definition</th>
<th>Reference</th>
<th>% Agreed</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pedagogy</strong></td>
<td>the method and practice of teaching, especially as an academic subject or theoretical concept</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Oxford Dictionary).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Intercultural Space**     | contested space between two knowledge systems where things are not clearly black or white, Indigenous or Western. In this space are histories, politics, economics, multiple and interconnected discourses, social practices and knowledge technologies which condition how one comes to look at the world, how one comes to know and understand changing realities in the everyday, and how and what knowledge is operationalised in one’s daily life and includes tacit and unspoken knowledge, and assumptions by which sense and meaning is made in one’s everyday world | 94%      | • Remove black and white reference (offensive)  
• Convoluted- needs shortening and clarifying  
• Also known as ‘cultural interface’ |
|                             | (Nakata 2007 p9).                            |          |                                                                          |
| **Cultural Respect**        | is recognising and continually advancing the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander peoples. Cultural Respect is about shared respect and is achieved when the health system is a safe environment for Aboriginal and Torres Strait Islander peoples and where cultural differences are respected. It is a commitment | 92%      | • Respect includes understanding diversity  
• Definition does not address ‘coping’ priorities of Aboriginal and Torres Strait Islander people  
• Include ‘doing no harm’ to culture at individual, family or community level |
to the principle that the Australian health care system that constructs and provides services will not willingly compromise the legitimate cultural rights, practices, values and expectations of Aboriginal and Torres Strait Islander peoples. The goal of Cultural Respect is to uphold the rights of Aboriginal and Torres Strait Islander peoples to maintain protect and develop their culture and achieve equitable health outcomes

**Cultural Humility**

lifelong commitment to self-evaluation and critique, to redress the power imbalances in the service provider-client dynamic, and to develop a mutually beneficial and non-paternalistic partnership with communities on behalf of individuals and defined populations

(Tervalon and Murray-Garcia 1998).

| 88% | • Include notion of mutual respect, understanding and collaboration to achieve agreed aspirations and goals  
• Not an often used term – needs to be incorporated into registrations of health professionals  
• Include notion of being willing to be humble |

**Indigenous cultural competence**

knowledge and understanding of Indigenous Australian cultures, histories and contemporary realities and awareness of Indigenous protocols, combined with the proficiency to engage and work effectively in Indigenous contexts congruent to the expectations of Indigenous Australian peoples

(Universities Australia, 2011 p171).

| 86% | • Complexities around what protocols and expectations are  
• Not measured by the level of professional positions- must ensure local protocol  
• Only Aboriginal and Torres Strait Islander people can ever be ‘culturally competent’ but non-Indigenous people can strive to enhance their capacity  
• Cultural competency as a principle should be the same regardless of culture- curriculum should not include Indigenous CC and CC definitions as confusing  
• Contestation around realistic achievability of this |
| **Professional Cultural Capability** | (American Psychological Association, 2003). | 83% | • Needs to indicate there is a level of proficiency required (not just sensitivity)  
Suggestions to use an Australian reference were also made, notably from the Queensland Health Cultural capability framework\(^\text{13}\) |
|---|---|---|---|
| **Cultural Security** | (Coffin, 2007). | 80% | • Make statement flow more easily by removing the brackets  
• Use visuals provided by Coffin in the publication. |
| **Racism** | (Pedersen, 2006, pp236-237) | 78% | • Need to link definition to under what conditions action might be considered as Racism (Racial Discrimination Act link) |

\(^\text{13}\) State of Queensland 2010, Queensland Health Aboriginal and Torres Strait Islander, Cultural Capability Framework 2010 – 2033. State of Queensland, Brisbane
The promotion of self-interest becomes more important than fairness, equity, justice and truth. As a political and economic force, it is always essential to view racism with regard to the consequences of providing access to power to some while excluding others.

<table>
<thead>
<tr>
<th>Culture</th>
<th>Congress of Aboriginal and Torres Strait Islander Nurses and Midwives Limited, CATSINaM. 2013 p4</th>
<th>75%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need to characterise the nature of the groups e.g. change to “by one cultural group against other cultural groups”. The notion of race is and ideology rather than a biological fact hence the use of “cultural”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use the ‘Racism it stops with’ campaign definitions as more current and less jargon 14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suggestion that the definition by Paradies, Harris and Anderson (2008) would be more appropriate as racism is defined as avoidable and unfair actions that further disadvantage the disadvantaged or further advantage the advantaged15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16 Universities Australia 2011, Guiding Principles for the Development of Indigenous Cultural Competency in Australian Universities. Department of Education, Employment and Workplace Relations (DEEWR), Canberra, ACT, p.3
dynamic and changes because people's contexts change

<table>
<thead>
<tr>
<th>Cultural Safety</th>
<th>Eckermann et al, 2006 p213).</th>
<th>70%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Safety</td>
<td>An environment which is safe for people; where there is no assault, challenge or denial of their identity, or who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity and truly listening</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td>Eckermann et al, 2006 p213).</td>
<td>70%</td>
</tr>
<tr>
<td>Cultural Awareness</td>
<td>Cultural Awareness</td>
<td>Smedley et al cited in Thomson 2005 p3).</td>
</tr>
<tr>
<td>Cultural Awareness</td>
<td>a health professional's awareness of various cultural, social and historical factors applying to Indigenous peoples generally, and to specific Indigenous groups and/or communities; encouraging health professionals to reflect on their own culture and acknowledge biases and the tendency to stereotype with a view to better appreciating diverse values, beliefs and behaviours. Cultural awareness has also been used interchangeably with 'cultural sensitivity' in cultural training</td>
<td>69%</td>
</tr>
<tr>
<td>Cultural Awareness</td>
<td>a health professional’s awareness of various cultural, social and historical factors applying to Indigenous peoples generally, and to specific Indigenous groups and/or communities; encouraging health professionals to reflect on their own culture and acknowledge biases and the tendency to stereotype with a view to better appreciating diverse values, beliefs and behaviours. Cultural awareness has also been used interchangeably with ‘cultural sensitivity’ in cultural training</td>
<td>69%</td>
</tr>
</tbody>
</table>

- Remove word ‘assault’
- Link definition to human rights
- Involves actions that recognize, respect and nurture the unique cultural identity of Aboriginal and Torres Strait Islander people and safely meets their needs, expectations and rights. It is working from the cultural perspective of the client (service user) not from your own perspective (as service provider)
- Adapting practice to patient individual needs
- Taking a positivist approach
- Recognition of origins of the term (i.e. Maori nurse Irihapeti Ramsden)

- Need to shorten the statement/ write in plain English for learners
- Cultural awareness and sensitivity are not interchangeable – awareness does not mean evaluation of person’s understanding
- Cultural awareness usually about the first part of definition (increasing understanding); it does not necessarily achieve latter
- Cultural awareness needs to include all cultural groups, not just Indigenous
- Need definition to be stronger to highlight participation of health provider to close gaps (for example 'acknowledge and constructive conversation to address biases and stereotypes')
<table>
<thead>
<tr>
<th><strong>Whiteness</strong></th>
<th>the cultural, historical and sociological aspects of people identified as white, and the social construction of whiteness as an ideology tied to social status</th>
<th><a href="http://en.wikipedia.org/wiki/Whiteness_studies">http://en.wikipedia.org/wiki/Whiteness_studies</a></th>
<th>67%</th>
</tr>
</thead>
</table>
| Source **(ie Wikipedia)** needed was not credible enough. Nelson’s definition was suggested as an alternative  
There were also comments that the terms is “highly offensive and promotes colourism” | | | |

<table>
<thead>
<tr>
<th><strong>Cultural Competence</strong></th>
<th>a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross cultural situations</th>
<th>(Cross et al 1998).</th>
<th>65%</th>
</tr>
</thead>
</table>
| Include knowledge, skills  
Comments that cultural competency is unachievable as a destination, or that competency does not necessarily mean effective. Need a definition to capture it is ongoing  
Old definition; needs to be updated | | | |

<table>
<thead>
<tr>
<th><strong>Cultural Responsiveness</strong></th>
<th>describes the capacity to respond to the healthcare issues of diverse communities</th>
<th>(Victorian Government 2009).</th>
<th>61%</th>
</tr>
</thead>
</table>
| Must include reference to capacity of individuals within the system/service they are in  
Responsiveness needs to be meaningful to the distinctiveness of the group  
Needs reference on culture  
Statement ambiguous – whose responsibility is it to respond?  
Response needs to be multidisciplinary and inclusive of Aboriginal and Torres Strait Islander needs, views and priorities | | | |

The following definition was also proposed as an alternative  
Responses that acknowledge the existence of, show interest in, demonstrate knowledge of, and express appreciation for the client’s ethnicity and culture and that place the client’s problem in a cultural context (Atkinson and Lowe, 1995 cited in Burkard et al 2006).
## Appendix D Online Consultation Results - Proposed Teaching Principles

<table>
<thead>
<tr>
<th>Principles</th>
<th>Qualitative Feedback</th>
<th>% agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Principle 1</strong>&lt;br&gt;Aboriginal and Torres Strait Islander peoples have distinctive needs with regard to health service provision which needs to be holistic</td>
<td>- Need to make link between ‘distinctive circumstances’ and colonisation, social determinants etcetera explicit</td>
<td>94%</td>
</tr>
<tr>
<td><strong>Principle 2</strong>&lt;br&gt;The distinct needs of Aboriginal and Torres Strait Islander peoples, nature of these factors and their influence on the communities need to be included in foundational content</td>
<td>- Need to make link between ‘distinctive circumstances’ and colonisation, social determinants etcetera explicit</td>
<td>94%</td>
</tr>
</tbody>
</table>
| **Principle 3**<br>The provision of holistic health services to enhance the wellbeing of Aboriginal and Torres Strait Islander people is an integral component in the education of health practitioners | - The need to identify the benefits of a holistic health service – yes, but the provision of it, no  
- Need clear explanation about ‘holistic’ within an Aboriginal and Torres Strait Islander context – the complex and far reaching nature of this term and implications in practice | 88%      |
| **Principle 4**<br>Foundational content on Aboriginal and Torres Strait Islander issues should be introduced in the initial year of education for the health workforce and integrated throughout the curricula | - Need to explicitly state that this content is accessible so at the end of their studies would expect health professional graduates:  
  • To act in a respectful and safe manner.  
  • To not come in with any bias’s and or pre-conceived ideas about Aboriginal and Torres Strait Islander people.  
  • Respect and understand the role of their Aboriginal and Torres Strait Islander colleagues in the workplace and be able to work with them, and have an understanding that they are the cultural brokers who have the cultural expertise.  
  • To have mentors in the workplace that can help them when needed to be support them to understand the | 100%     |
<table>
<thead>
<tr>
<th>Principle 5</th>
<th>A strengths based perspective of culture, diversity and identity should be used to facilitate learning and reflection on attitudes and values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Yes, but must still allow honest and critical discussion</td>
</tr>
<tr>
<td>Principle 6</td>
<td>Meaningful involvement of Aboriginal and Torres Strait Islander staff and non-Indigenous staff to strengthen partnerships with community members in development of curricula is essential to ensure appropriate and respectful teaching and presentation of local Aboriginal and Torres Strait Islander perspectives</td>
</tr>
<tr>
<td></td>
<td>- Need to define context of 'community' for each HEP – local footprint</td>
</tr>
<tr>
<td>Principle 7</td>
<td>Learning settings should be safe and provide positive encounters for all Aboriginal and Torres Strait Islander and non-Indigenous participants</td>
</tr>
<tr>
<td></td>
<td>- Not all learning experiences can be 'positive'- particularly in the context of poverty and social determinants- experience may be distressing for learner, but still productive.</td>
</tr>
<tr>
<td></td>
<td>- Need explanatory notes about what a safe setting is</td>
</tr>
<tr>
<td>Principle 8</td>
<td>A wide range of teaching and learning strategies, including authentic case studies, should be used</td>
</tr>
<tr>
<td></td>
<td>- Adult learning principles including visual, auditory, and kinaesthetic modes should be included.</td>
</tr>
<tr>
<td>Principle 9</td>
<td>Activities that promote development of reflective skills, self-awareness and critical analysis should be integral components of learning and assessment</td>
</tr>
<tr>
<td></td>
<td>- Yes but not beating people up psychologically</td>
</tr>
<tr>
<td>Principle 10</td>
<td>Reflection and self-awareness activities should provide opportunities for non-Indigenous students to explore their understanding of their own cultural values and attitudes along with the concepts of white privilege</td>
</tr>
<tr>
<td></td>
<td>- Caution around term ‘white privilege’ – not all privileged students are white, and not all white people are privileged</td>
</tr>
<tr>
<td>Principle 11</td>
<td>- Include innovative initiatives to teach racism</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Training and on-going support and/or mentoring mechanisms need to be provided for Aboriginal and Torres Strait Islander and non-Indigenous educators that recognise the emotional load encountered</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Principle 12</th>
<th>- It is unclear what context this is being considered in. Leadership and addressing Aboriginal and Torres Strait Islander matters should come from Aboriginal and Torres Strait Islander staff, with the support of non-Indigenous staff. Leadership and addressing matters relating to the promotion and development of cultural safety should be a shared responsibility between all staff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal and Torres Strait Islander staff should not be routinely delegated the responsibility of leading and dealing with Aboriginal and Torres Strait Islander matters, this should be a mandated shared responsibility</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Principle 13</th>
<th>- Widespread recognition and agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>While Aboriginal and Torres Strait Islander students can make a valuable contributions to enhance learning amongst their peers with appropriate support, they should not be assigned responsibility nor seen as the spokesperson representing all Aboriginal and Torres Strait Islander peoples</td>
<td>100%</td>
</tr>
</tbody>
</table>
Appendix E Proposed Organisational Cultural Competence Requirements

1. Effective and inclusive policies and procedures
2. Monitoring mechanisms and allocation of sufficient resources to foster culturally competent behaviour and practice at all levels
3. Leadership and strong advocacy to facilitate increase in Aboriginal and Torres Strait Islander focus of the curriculum.
4. Proactive provision of support and services to Aboriginal and Torres Strait Islander students
5. Strengthening the capacity and skills of existing Aboriginal and Torres Strait Islander staff
6. Support, including professional development, for non-Indigenous staff to improve their intercultural capabilities in the area of Aboriginal Torres Strait Islander health
7. Recruiting and investing in Aboriginal and Torres Strait Islander staff and non-Indigenous staff with knowledge, a shared understanding and ability to negotiate complex issues related to Aboriginal and Torres Strait Islander people and equip them with skills to be able to teach in this area.
8. Inclusion of Aboriginal and Torres Strait Islander cultures and knowledge as a visual and valued aspect of organisational life, governance and decision making
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A national Aboriginal and Torres Strait Islander health curriculum framework is seen as a necessary step to create a health workforce better able to respond to the needs of Aboriginal and Torres Strait Islander people and their communities. Due to the dominance of Western culture the majority of health graduates have little or no understanding of how to provide care that is culturally appropriate for Aboriginal and Torres Strait Islander peoples. The majority – largely due to educational traditions—tend to operate unquestioningly with the assumptions of their professional, racial and ethnic identity and consequently fail to modify their practice and communication to accommodate different ways of knowing and being, including different conceptualisations of wellbeing.

The introduction of an Aboriginal and Torres Strait Islander health curriculum framework has the potential to begin health and social care professionals on the life-long learning journey needed to develop the capabilities to deliver culturally safe services. The process, should also assist graduate health and social care professionals to transform health service organisations to be more inclusive and culturally safe. The curriculum framework is intended to complement the work which is already being undertaken in many universities and to ensure that there is a minimum level of capability.

“When I visited one of my older cousins in hospital, I found her sitting outside with six of her young grandchildren and four of her adult children. My cousin’s oldest son excitedly told me that my student nurses were looking after his mum and doing a wonderful job. The student nurses were so accommodating and totally understood much of the cultural issues especially around family. I met one of the nurses who proudly told me that she was putting into practice what she had learnt and sang the praises of the university to members of my family. I became so emotional that I was speechless; honestly, all I could do was smile at everyone.”
1. Background

This HWA project supports the Aboriginal and Torres Strait Islander Health Worker Project Final Report – “Growing Our Future” (2011) and is directly linked to:

- Recommendation 23: Embed mandatory cultural competency curricula, including an understanding of the role of the Aboriginal and Torres Strait Islander Health Worker, in vocational and tertiary education for health professionals.

All health profession graduates need to be both clinically and culturally competent to genuinely affect positive health outcomes. This is true for the whole population, but is particularly important for Aboriginal and Torres Strait Islander peoples, whose health outcomes are unacceptably poor. Australia has one of the world’s highest life expectancies, we need to extend this to our Aboriginal and Torres Strait Islander communities.

Workforce distribution issues and a lack of cultural competency skills across the health professions can affect the ability and willingness of Aboriginal and Torres Strait Islander people to seek the care that they need. Therefore Aboriginal and Torres Strait Islander people need to have health care delivered in a way they understand, and that takes into account cultural differences.

Aboriginal and Torres Strait Islander Australians are often reluctant to access health services because of discrimination, misunderstanding, fear, poor communication and lack of trust in service providers [Durey et al., 2011; Shahid et al., 2009; Shahid et al., 2009]. Evidence suggests that racism against Aboriginal and Torres Strait Islander Australians occurs in health care often unreported and unchallenged (Henry et al., 2004; Johnstone & Kanitsaki, 2009). Despite expectations that service providers will view all patients objectively and impartially within the biomedical model of health care, findings from the US identified unconscious bias in service providers towards African Americans that led to disparities in treatment and poorer health outcomes (van Ryn, 2002). Australian research has also found that Aboriginal and Torres Strait Islander people are subject to discrimination, however inadvertent, and offered less options for treatment and procedures in health care where inequities persist in most major illnesses including cancer, cardiovascular disease, kidney disease and oral health and mental health (Boffa, 2008; Corrigan, 2004; Vos et al., 2009).

Aboriginal and Torres Strait Islander Australians have twice the in-hospital mortality rate and a 40% lower rate of angiography and percutaneous coronary interventions than other Australians (National Heart Foundation of Australia & Australian Healthcare and Hospitals Association, 2009 November) and are also six times more likely (age adjusted) to discharge themselves from hospital against medical advice (AIHW, 2008).

Studies also suggest that Aboriginal and Torres Strait Islander patients are more likely to access services where service providers communicate respectfully, have some understanding of Aboriginal culture, build good relationships with Aboriginal and Torres Strait Islander patients and where Aboriginal or Torres Strait Islander health workers are part of the health care team [Durey et al., 2011; Shahid et al., 2009; Taylor et al., 2009].

A culturally competent health workforce is vital to ensure culturally safe practices, environments and services meet the needs and are accessible to Aboriginal and Torres Strait Islander people to improve their health outcomes. Better health outcomes for Aboriginal and Torres Strait Islander people are facilitated by more informed clinical practice by practitioners who have appropriate attitudes toward and who are better prepared for working with Aboriginal and Torres Strait Islander people through application of evidence based guidelines in Aboriginal primary health care.
A common misperception is that health professionals only come in contact with Aboriginal and Torres Strait Islander patients in rural and remote locations, or through Aboriginal and Torres Strait Islander-specific medical services. Most Aboriginal and Torres Strait Islander people in fact, live in urban areas and access mainstream health services. Therefore for health professionals whose main focus is not Aboriginal and Torres Strait Islander health, an acceptable level of knowledge and capability is necessary to effectively engage with Aboriginal and Torres Strait Islander consumers to improve health outcomes.

The responsibility for quality health care for Aboriginal and Torres Strait Islander people is one that must be shared. Non-Indigenous colleagues play a critical role, which is why all graduates need to be equipped to work across the entire range of Australian socio-cultural contexts, including in Aboriginal and Torres Strait Islander health (Anderson et. al, 2009).

Curricula including Aboriginal and Torres Strait Islander histories, cultures, values and experiences, and knowledge of the role and function of the Aboriginal and Torres Strait Islander health worker/practitioner will better equip health professionals with the knowledge they require for working with Aboriginal and Torres Strait Islander consumers.

As part of the 2011 Universities Australia report on developing cultural competency five guiding principles were identified, which recognise that universities themselves need to become culturally competent if they are to develop graduate students with the same capability. In other words, merely embedding Aboriginal and Torres Strait Islander content into the curriculum is not sufficient. The five guiding principles from Universities Australia include:

1. University governance: Indigenous people should be actively involved in university governance and management.
2. Teaching and learning: all graduates of Australian universities should be culturally competent.
3. Indigenous research: university research should be conducted in a culturally competent way that empowers Indigenous participants and encourages collaborations with Indigenous communities.
4. Human resources: Indigenous staffing will be increased at all appointment levels and, for academic staff, across a wider variety of academic fields.
5. Community engagement: universities should operate in partnership with local Indigenous communities and should help disseminate culturally competent practices to the wider community.

**A word about terminology**

It is noted that there is limited consensus around the exact definitions of terms and the overlap between terms when referring to cultural competence, cultural safety, cultural security, cultural responsiveness, and cultural awareness. As the terms are somewhat contested, working definitions of these and other relevant terminology is included in Section 11 of this paper.
2. Theoretical perspectives

The history of Australia’s development as a nation based on colonisation and the White Australia Policy has resulted in “whiteness” becoming the neutral or invisible discourse against which all other racial and ethnic identities are measured. For example, when one speaks of ethnic groups one does not include European Australians; to be ethnic in Australia is to be “other” and this is reflected in education systems, policy and in every mainstream institution. What this results in is the replication of existing discourses as power structures remain unchallenged and unchanged. Effective cultural competency education thus requires individuals (and particularly European Australians) to explore their own racial and ethnic identity and the power and privilege associated with that positioning.

Importantly, the Universities Australia report (2011) recommendations were developed in consultation with the Aboriginal and Torres Strait Islander Higher Education Advisory Council and states “Cultural competence includes the ability to critically reflect on one’s own culture and professional paradigms in order to understand its cultural limitations and effect cultural change” (2011, p. 3). The effective teaching of Indigenous Australian cultural competence is complex as it speaks directly to an individual’s own racial and cultural identity. Consequently, teaching Indigenous cultural competence curricula to non-Indigenous students can result in resistance, hostility, as well as feelings of guilt and shame, dependent on the student’s existing experiences and racial identity formation. The conceptualisation of cultural competence capability development as a process reinforces the need for multiple learning experiences and cross-cultural encounters.

Theorisations of Indigenous cultural competence in Australia support the notion that cultural competence is not achieved through a single experience, but is instead sequential, cumulative and achieved through multiple learning experiences. Furthermore, successful cultural competence requires considerable reflection (Coffin, 2007). In Australia there is also a critical debate in Aboriginal and Torres Strait Islander communities regarding what constitutes cultural competence—is this the correct terminology—and whether it can ever be achieved by non-Aboriginal people.

Generally speaking, however, cultural competence is considered in the literature to be part of a continuum of capability development or is used as an umbrella term to describe a range of skills, knowledge and attitudes implied by such terms as cultural awareness, cultural safety and cultural security. According to Coffin (2007) cultural awareness is the first step, and typically this form of cross-cultural education provides information about basic cultural protocols and appropriate, respectful ways of being in Aboriginal communities. Cultural safety, however, is more sophisticated and requires individuals to combine cultural awareness with an ability to adjust their treatment of an Aboriginal person (evident through actions and gestures). Significantly, cultural safety is a term that developed in the 1980s in New Zealand in response to the “colonial history of Aotearoa (New Zealand) and specifically out of Maori consumer dissatisfaction with nursing care” (Eckermann et al., 2010, p. 184). Following on from cultural safety, cultural security includes brokerage and protocols where (a) all parties involved are equally important and informed; and (b) where an Aboriginal context is formally recognised through the involvement of community and Elders (Coffin, 2007, pp. 22-23). The Australian Safety and Quality Framework for Healthcare (Australian Commission on Safety and Quality in Healthcare 2010) specifies consumer centred care as one of its three core principles and includes provision of care that is easy for clients to access when they need it, ensuring healthcare staff respect and respond to client choices, needs and values and includes partnerships between clients, their family, carers and healthcare providers.
According to the National Health and Medical Research Council (2006, p. 4), a health system that is culturally competent:

- Acknowledges the benefits that diversity brings to Australian society.
- Helps health providers and consumers to achieve the best, most appropriate care and services.
- Enables self-determination and ensures a commitment to reciprocity for culturally and linguistically diverse consumers and their communities.
- Holds governments, health organisation and managers accountable for meeting the needs of all members of the communities they serve.

One of the common pitfalls is that the terms cultural awareness, safety, security and competence are often used loosely and interchangeably (Coffin, 2007), risking not only the complexity of cultural competence being overlooked, but also a tendency for students and graduates to assume that they have attained the level of competence required or, in the case of academics, sufficiently addressed the “issue” in their curriculum. The application of a critically diverse approach to cultural competency development for health graduates is thus essential, particularly if one of the goals of competency development is for health graduates to have an understanding of the role of Aboriginal health workers and practitioners, to enable them to work effectively as intercultural professionals. Without a critical perspective on cultural competency education Aboriginal and Torres Strait Islander health professionals risk being stereotyped, resulting in current power relations and the associated racism in health service delivery remaining unquestioned and unchanged.

**Question A:**

Do the theoretical perspectives outlined provide the appropriate underpinning needed for an Aboriginal and Torres Strait Islander health curriculum framework?

If not, how should it change?
3. Key elements of the health curriculum framework

It is important to identify the key elements of a curriculum framework and it is proposed both structural and contextual elements are included.

The Universities Australia report on Guiding Principles for Developing Indigenous Cultural Competency in Australian Universities [2011, p9] makes specific teaching and learning recommendations which require consideration including:

1. Embedding discrete Indigenous knowledges and perspectives in all university curricula to provide students with the knowledge, skills and understandings which form the foundations of Indigenous cultural competency.
2. Inclusion of Indigenous cultural competency as a formal graduate attribute or quality.
3. Incorporation of Indigenous Australian knowledges and perspectives into programs according to a culturally competent pedagogical framework.
4. Training teaching staff in Indigenous pedagogy for teaching Indigenous studies and students effectively, including developing appropriate content and learning resources, teaching strategies and assessment methods.
5. Creating reporting mechanisms and standards which provide quality assurance and accountability of Indigenous studies curricula. (Universities Australia, 2011, p9).

There are also contextual factors which may be regarded as key elements leading to success of curriculum approaches, such as:

- Leadership,
- Staff professional development to ensure provision of culturally safe teaching spaces,
- Explicit curriculum taught by staff who are adequately prepared for teaching in an intercultural space,
- Institutional support and valuing of Indigenous perspectives,
- Indigenous community engagement and partnerships which are community led, respectful and reciprocal,
- Financial and human resources to ensure the sustainability of the program.

Question B:

Are the key elements appropriate?

Are there other key elements which should be included in the Aboriginal and Torres Strait Islander health curriculum framework?
4. Principles underpinning the curriculum framework

The principles which are proposed to underpin this framework are based on a review of the literature by Universities Australia (2011) and Grote (2008). The following principles are proposed for the framework:

1. Aboriginal and Torres Strait Islander peoples have distinctive circumstances with regard to health service provision because of unique colonial, social, cultural, economic, political, historical and contemporary experiences.

2. The distinct circumstances of Aboriginal and Torres Strait Islander peoples, and their influence on the communities need to be included in foundational content. This foundational content should provide opportunities for students to critique the role of their respective health professions in the lives of Aboriginal and Torres Strait Islander people both past and present.

3. The provision of holistic health services to enhance the wellbeing of Aboriginal and Torres Strait Islander people is an integral component in the education of health practitioners.

4. Foundational content on Aboriginal and Torres Strait Islander issues should be introduced in the initial year of training for the health workforce and integrated throughout the curricula over the course of study. It should be explicitly taught as linked to improving Aboriginal and Torres Strait Islander health outcomes.

5. A strengths based perspective of culture, diversity and identity should be used to facilitate learning and reflection on attitudes and values.

6. Meaningful involvement of Aboriginal and Torres Strait Islander staff and partnerships with community members in development of curricula is essential to ensure appropriate and respectful teaching and presentation of Aboriginal and Torres Strait Islander perspectives (including recognition and remuneration).

7. Learning settings should be safe and provide positive encounters for all Aboriginal and Torres Strait Islander and non-Indigenous participants.

8. A wide range of teaching and learning strategies, including authentic case studies, should be used.

9. Activities that promote development of reflective skills, self-awareness and critical analysis should be integral components of learning and assessment.

10. Reflection and self-awareness activities should provide opportunities for non-Indigenous students to explore their understanding of their own cultural values and attitudes along with the concepts of white privilege (students need to be provided with support and strategies to deal with racism).

11. Training and on-going support and/or mentoring mechanisms need to be provided for Aboriginal and Torres Strait Islander and non-Indigenous educators that recognises the emotional load encountered when teaching this (for e.g. staff need to be provided with support and strategies to deal with racism).

12. The responsibility of leading and addressing Aboriginal and Torres Strait Islander matters is a shared responsibility between Aboriginal and Torres Strait Islander and non-Indigenous staff.

13. While Aboriginal and Torres Strait Islander students can make a valuable contributions to enhance learning amongst their peers with appropriate support, they should not be assigned this responsibility, nor seen as representatives of all Aboriginal and Torres Strait Islander peoples.

14. The development of cultural competence is non-linear and context specific i.e. where an individual may be competent working in one Aboriginal and Torres Strait Islander community, they will not necessarily be competent in another, and will be required to develop new knowledge and skills to be able to work effectively.
5. Curriculum content

The theoretical framework proposed in Section 2 of this paper and a review of the literature, indicate that there are three dimensions which should be explored in order to develop cultural competence: knowledge, skills and values or attitudes. In order to develop the knowledge, skills and attitudes, a broad range of topic areas have been identified by Universities Australia (2011, p71). It is proposed that the curriculum content is drawn from this document and includes:

- Concept and definition(s) of cultural competence and its importance for health service providers.
- Concepts of race, cultures, ethnicity and worldview.
- Pre-colonial and post-colonial Aboriginal and Torres Strait Islander history in Australia for example including European invasion; terra nullius; Indigenous wage forfeitures, 1905 Act, Stolen Generation, Royal Commission into Aboriginal Deaths in Custody, Reconciliation, National Apology.
- Cultural richness and diversity of Aboriginal and Torres Strait Islander people and their languages.
- Aboriginal and Torres Strait Islander cultures and practices (including the spirituality and belief systems, kinship, social structures).
- Impacts of policies and legislation on Aboriginal and Torres Strait Islander people in the past and present.
- Concepts of health and well-being for Aboriginal and Torres Strait Islander peoples and the significance of family and connection to country.
- Human rights.
- Current statistics regarding demographics and status of Aboriginal and Torres Strait Islander people and disparities between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander people (health, education, SES, etcetera) and how these are interdependent.
- Contemporary (and local) issues of concern and how these may be taken into consideration with regard to health professional and their delivery of services (for example how social or environmental factors may have negative effects on health and wellbeing of clientele in a particular community).
- Myths and misconceptions about and stereotypes of Aboriginal and Torres Strait Islander people.
- Notions of whiteness, white privilege and power.
- Reflection on cultural identity, whiteness, privilege, values, beliefs, attitudes, prejudices and propensity to stereotype.
- Racism and anti-racism practices.
- Inter-cultural communication models and skills for working in partnership.
- Evidence based practice for Aboriginal and Torres Strait Islander health and application of a population based approach and its impact on clinical care.
- Application of client centred and primary health care approaches for Aboriginal and Torres Strait Islander people.
- Identifying when Aboriginal health workers are required and strategies for working with them.

**Question D:**

Does the curriculum content adequately describe the requirements for an effective Aboriginal and Torres Strait Islander health curriculum framework?

If not, how should the curriculum content be amended?
6. Assessment

The Medical Deans of Australia and New Zealand and the Australian Indigenous Doctors Association (2012) reviewed the extent to which the CDAMS framework (Philips 2004) had been implemented and recommended teaching of discrete, compulsory and assessable units on Indigenous history, cultures, societies, experiences and interactions with health systems and policies, complemented with Indigenous examples and content throughout the medical program. The report found that lack of compulsory units and assessment led to devaluing of Aboriginal and Torres Strait Islander health within the curriculum and allowed students who were unable to demonstrate appropriate knowledge, skills and attitudes towards Aboriginal and Torres Strait Islander people to graduate.

Many tools and methods are available to assess intercultural competence. Assessments may take the form of quantitative (that is tests/exams to assess knowledge), qualitative (that is case studies, reflective journals, essays, e-portfolios, critical analysis of incidents or themes, oral presentations), practical (simulation, role play, client assessment, clinical practice/fieldwork assessment) and self-assessment.

Who should assess whether or not students are culturally competent is a highly contested issue. An assessment goal would be for Aboriginal and Torres Strait Islander patients and their families to make a determination of whether students can demonstrate cultural competence and provide culturally safe health care services. Standard assessment practice in health professions requires that discipline experts assess student competence in specified areas of practice. For example, students treating clients with predominantly musculo-skeletal conditions would often be assessed by a clinician with expertise in this area. The same principle could be applied in the context of Indigenous cultural competence whereby students are assessed by Aboriginal and Torres Strait Islander people or staff who have expertise in Aboriginal and Torres Strait Islander health.

How should cultural competency be assessed?

How should cultural competence of staff and students be determined?
7. The role of health professional accreditation

The National Boards for each of the registered health professions approve the registration and accreditation standards which must be met in order for graduates and practitioners to register. The purpose of a professional course accreditation process is to ensure the quality of a profession and its work on behalf of public interest and public safety. Education providers are required to ensure their graduates have the required knowledge, skills, behaviours and attitudes to practice competently (ANMAC 2012). It would be reasonable therefore, to expect that professional accreditation and competency standards would include the requirement to provide care for Aboriginal and Torres Strait Islander peoples in a culturally safe and respectful manner.

An environmental scan of the professional accreditation and/or professional competency standards was undertaken for the following professions: audiology, chiropractic, dentistry, dietetics, exercise physiology, medicine, midwifery, nursing, nutrition, occupational therapy, optometry, oral health, orthoptics, orthotics and prosthetics, osteopathy, paramedicine, pharmacy, physician assistant, physiotherapy, podiatry, psychology, radiation science social work, sonography and speech pathology. The methodology for data collection included: a web search for health profession accreditation and/or professional standards documentation for the above or aforementioned professions. Each set of standards and/or competencies was then reviewed to ascertain whether there were specific statements which supported the development of cultural capabilities, important/vital for the provision of culturally safe care for Aboriginal and Torres Strait Islander people and their families. Additional information pertaining to the accreditation process, strategies in place which give effect to assessment of the standards and training of accreditors was also sought.

There are wide variations in accreditation standards and professional competencies with respect to the extent to which they address the health and social care needs of Aboriginal and Torres Strait Islander people. Most standards make some reference to the need to provide culturally safe or competent care.

Of the 26 professions listed above, 15 had some mention of Aboriginal and Torres Strait Islander health issues, or the need to adapt provision of health care to ensure it is culturally respectful, and most of the remaining 11 professions had a generic statement indicating the need to provide culturally competent care.

Where there is inclusion of Aboriginal and Torres Strait Islander health perspectives in accreditation standards or professional competencies, it is mostly in the context of curriculum content. Few professions indicated requirements for Aboriginal and Torres Strait Islander students, staff, clinical practice, or engagement with Aboriginal and Torres Strait Islander communities. Exceptions were medicine, nursing, occupational therapy, pharmacy and social work. Information regarding the training of accreditors and the strategies by which accreditation or professional standards were measured or monitored to address provision of health services to Aboriginal and Torres Strait Islander people, was unable to be ascertained.

Proessions which demonstrated the strongest statements in their accreditation standards and/or professional competencies were medicine, nursing, occupational therapy and social work. Most professions have accreditation standards or professional competencies which require graduates to demonstrate they are able to adapt their practice in recognition of cultural requirements. However, the extent to which this is measured or monitored through accreditation is difficult to determine.
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Question F: What role should authorities play in specifying the requirements for teaching and learning, research, human resources and community engagement in relation to Aboriginal and Torres Strait Islander health within accreditation standards?
8. The role of higher education providers

An environmental scan of current entry level health curricula to determine the inclusion of Aboriginal and Torres Strait Islander health content and related competencies working with Aboriginal and Torres Strait Islander people has also been undertaken. Health professions courses at each of the 39 Australian universities were reviewed via a desktop audit to identify Aboriginal and Torres Strait Islander content in entry level health profession courses. The syllabus of all units which included the words Aboriginal, Indigenous, cultural, diversity, cultural competence were included. Entry level courses included bachelor level, postgraduate diploma and masters [including masters extended] level courses.

There was considerable difficulty in determining which units in curricula contained Aboriginal and Torres Strait Islander health, and therefore the data should be interpreted with caution. The extent to which there are readily identifiable specific units of study which include Aboriginal and Torres Strait Islander health in health professional curricula is highly variable, ranging from 0% to 75%. Nursing had the highest proportion of courses with a dedicated unit on Aboriginal and Torres Strait Islander health, followed by midwifery and social work.

Whilst it was difficult to determine the extent to which Aboriginal and Torres Strait Islander health content existed in medical curricula through the environmental scan, the Medical Deans – Australian Indigenous Doctors Association National Medical Education Review (2012), found that in 2011 all Australian medical schools were implementing more Indigenous health content than they were in 2003. However, there was significant variation in the comprehensiveness and effectiveness of implementation of the CDAMS Curriculum Framework.

Graduate attributes

Most universities have a set of graduate attributes or capabilities which graduates must demonstrate on successful completion of their course. A graduate attribute which related to Aboriginal and Torres Strait Islander people was evident in only nine of 39 universities.

Reconciliation Action Plans (RAP)

One quarter of universities have a RAP, whilst half have a Reconciliation Statement. The extent to which Aboriginal and Torres Strait Islander issues are embedded within curricula may be a reflection of the need for greater recognition by universities of the need for reconciliation action.

There is considerable room for increasing Aboriginal and Torres Strait Islander health within curricula for a wide variety of health professions. Efforts to improve curriculum strategies for improving Aboriginal and Torres Strait Islander health within higher education will need to occur in environments where the majority of universities are yet to develop graduate attributes which reflect respect for Aboriginal and Torres Strait Islander people and have a Reconciliation Action Plan.

Question

What approaches might assist education providers to develop strategies for teaching and learning, research, human resources and community engagement in relation to Aboriginal and Torres Strait Islander health?
9. Organisational cultural competence

In order for Aboriginal and Torres Strait Islander cultures and health to be effectively taught, supported and assessed within curricula, consideration needs to be given to the organisational cultural environment in which this occurs and the extent to which it is culturally competent. Cross et al (1998) defined institutional cultural competence as “a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross cultural situations”. Drawing on Universities Australia (2011 p109) and key informant interviews, organisational cultural competence requires:

1. Effective and inclusive policies and procedures.
2. Monitoring mechanisms and allocation of sufficient resources to foster culturally competence behaviour and practice at all levels of the institution.
3. Requires active and meaningful engagement with Aboriginal and Torres Strait Islander communities through: representation on key decision making bodies; reporting of Aboriginal and Torres Strait Islander staff and student outcomes; and performance indicators for Aboriginal and Torres Strait Islander outcomes included in the key performance indicators for senior staff.
4. Leadership and strong advocacy to facilitate Indigenisation of the curriculum.
5. Proactive provision of support and services to Aboriginal and Torres Strait Islander students.
6. Capacity strengthening of Aboriginal and Torres Strait Islander staff.
7. Professional development of non-Indigenous staff.
8. Recruiting and investing in both Aboriginal and Torres Strait Islander and non-Indigenous staff with knowledge, a shared understanding, strength, and who are able to negotiate complex issues and equip them with skills to be able to teach in this area.
9. Inclusion of Aboriginal and Torres Strait Islander cultures and knowledges as a visual and valued aspect of organisational life, governance and decision making.

Recognising that the education of health professionals occurs in both a university and clinical/fieldwork environment, organisational cultural competence needs to exist in both environments in order for students to effectively develop the knowledge, skills and attributes required for effective practice. It is proposed that the Aboriginal and Torres Strait Islander health curriculum framework incorporate these requirements.

**Question H:**

Are the organisational cultural competence requirements appropriate for an effective Aboriginal and Torres Strait Islander health curriculum framework? If not, how should the requirements be amended?

How should health and education sectors collaborate to embed an Aboriginal and Torres Strait Islander health curriculum framework into entry level health profession education?
10. Implementation of the health curriculum framework

HWA is keen to ensure an Aboriginal and Torres Strait Islander health curriculum framework can be successfully implemented, and that critical implementation issues are identified, assessed and addressed. During the project, key implementation issues raised have included:

- Critical importance of senior leadership in higher education genuinely supportive of Aboriginal and Torres Strait Islander health within curricula and resourcing it appropriately.
- Importance of all staff who teach health professionals to have professional development (initial and on-going) which ensures that they develop intercultural capabilities.
- Need to recruit and retain both Aboriginal and Torres Strait Islander and non-Indigenous staff with the appropriate expertise and who have the respect of the Aboriginal and Torres Strait Islander community to teach Aboriginal and Torres Strait Islander health, and provide them with appropriate support and workloads.
- Professional development programs which assist staff teaching in this area to manage student (and often staff) resistance.
- Significant role which Accreditation Authorities play in determining the visibility of Aboriginal and Torres Strait Islander health within curricula, through the design and assessment of accreditation standards.
- Need for professional development of accreditors in determining whether the framework is appropriately embedded.
- Need for flexibility in curriculum design.

Question 1:

Are there additional implementation issues that should be considered?
11. Working definitions

The following definitions are proposed for use with the Aboriginal and Torres Strait Islander health curriculum framework:

**Culture** - involves complex systems of concepts, values, norms, beliefs and practices that are shared, created and contested by people who make up a cultural group and are passed on from generation to generation. Cultural systems include variable ways of seeing, interpreting and understanding the world. They are constructed and transmitted by members of the group through the processes of socialisation and representation. Culture is dynamic and changes because people’s contexts change (Congress of Aboriginal and Torres Strait Islander Nurses Limited, CATSIN. 2013 p4).

**Cultural awareness** - a health professional’s awareness of various cultural, social and historical factors applying to Indigenous peoples generally, and to specific Indigenous groups and/or communities; encouraging health professionals to reflect on their own culture and acknowledge biases and the tendency to stereotype with a view to better appreciating diverse values, beliefs and behaviours. Cultural awareness has also been used interchangeably with 'cultural sensitivity' in cultural training (Smedley et al cited in Thomson 2005 p3).

**Cultural competence** - a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross cultural situations (Cross et al 1998).

**Cultural humility** - lifelong commitment to self-evaluation and critique, to redress the power imbalances in the service provider-client dynamic, and to develop a mutually beneficial and non-paternalistic partnership with communities on behalf of individuals and defined populations (Teravalon and Murray-Garcia 1998).

**Cultural respect** - is recognising and continually advancing the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander people. Cultural respect is about shared respect and is achieved when the health system is a safe environment for Aboriginal and Torres Strait Islander people and where cultural differences are respected. It is a commitment to the principle that the Australian health care system that constructs and provides services will not wiltingly compromise the legitimate cultural rights, practices, values and expectations of Aboriginal and Torres Strait Islander people. The goal of cultural respect is to uphold the rights of Aboriginal and Torres Strait Islander people to maintain protect and develop their culture and achieve equitable health outcomes (Australian Health Ministers’ Advisory Council, 2004 p7).

**Cultural responsiveness** - describes the capacity to respond to the healthcare issues of diverse communities (Victorian Government 2009).

**Cultural safety** - an environment which is safe for people; where there is no assault, challenge or denial of their identity, or who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity and truly listening (Eckermann et al, 2006 p213).

**Cultural security** - incorporates cultural awareness (awareness of Aboriginal and Torres Strait Islander cultural issues and needs but not linked to action) and cultural safety (health providers working with individuals or organisations through practices not standardised into policies or procedures) into cultural security (links understanding to action that is embedded in policies and procedures). Culturally secure care listens to the needs of Aboriginal and Torres Strait Islander people and makes sustained improvements to practice (Coffin, 2007).

**Indigenous cultural competence** - knowledge and understanding of Indigenous Australian cultures, histories.
and contemporary realities and awareness of indigenous protocols, combined with the proficiency to engage and work effectively in Indigenous contexts congruent to the expectations of Indigenous Australian people (Universities Australia, 2011 p171).

**Intercultural space** - contested space between two knowledge systems where things are not clearly black or white, Indigenous or Western. In this space are histories, politics, economics, multiple and interconnected discourses, social practices and knowledge technologies which condition how one comes to look at the world, how one comes to know and understand changing realities in the everyday, and how and what knowledge is operationalised in one’s daily life and includes tacit and unspoken knowledge, and assumptions by which sense and meaning is made in one’s everyday world (Nakata 2007 p9).

**Pedagogy** - the method and practice of teaching, especially as an academic subject or theoretical concept (Oxford Dictionary).

**Professional cultural capability** - the understanding and performing of tasks consistent with one’s professional qualifications in ways which are sensitive to cultural and individual differences, and anchored to evidence-based practices (American Psychological Association, 2003).

**Racism** - a pervasive force of exploitation by one group against other groups where the protection and promotion of self-interest becomes more important than fairness, equity, justice and truth. As a political and economic force, it is essential to view racism with regard to the consequences of providing access to power to some while excluding others (Pedersen, 2006, pp236-237)

**Whiteness** - the cultural, historical and sociological aspects of people identified as white, and the social construction of whiteness as an ideology tied to social status [http://en.wikipedia.org/wiki/Whiteness_studies]

**Question:** Do the proposed definitions adequately define the essential concepts for a curriculum framework?
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Please provide any examples you are aware of where Aboriginal and Torres Strait Islander health is being successfully taught and assessed (including enabling factors, staffing, professional development and resourcing required to facilitate its inclusion).

Thank you

Health Workforce Australia thanks you for taking the time to provide your perspective and advice.

Enquiries about the report are available at health.workforce@health.gov.au
Submitting your feedback

Please review the draft Aboriginal and Torres Strait Islander health curriculum framework paper and provide your feedback in accordance with one of the preferred options below:

Option 1: Complete your feedback using this form and email it to AandTSIHCF@hwa.gov.au
Option 2: Hard copy – send a printed copy of your completed form to:

Associate Professor Sue Jones
Aboriginal and Torres Strait Islander Health Curriculum Framework
Curtin Teaching and Learning
GPO Box U1987
Perth WA 6845

Feedback form

Instructions

Please provide responses using the template provided. The questions are designed to help you to focus your response and help HWA when analysing submissions. You do not need to answer every question and you are welcome to add any additional comments.
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