Culturally secure practice in midwifery education and service provision for Aboriginal women.


This thesis is presented for the degree of Doctor of Philosophy of The University of Western Australia.

Western Australian Centre for Rural Health
School of Primary, Aboriginal and Rural Health Care
Faculty of Medicine, Dentistry and Health Sciences

April 2016
A note on the use of terminology.

In the Australian context the term “Indigenous” refers to Aboriginal and Torres Strait Islander peoples. It is used in the thesis when included in the title of reports, references content in those reports where the term is used, or is used in quotations. The term “Aboriginal and Torres Strait Islander” is frequently abbreviated to “Aboriginal” and that is the usage in the thesis, except where the full term is used in reports, references content in those reports where the term is used, or is used in quotations. These terms are used interchangeably by government bodies, the academy and by Aboriginal people themselves, and hence it is not possible to impose consistency.

A lack of consistency also surrounds the use of terms to describe culturally respectful health service delivery. Terms including cultural competence, cultural safety and cultural security are widely used in the literature and in public policy, and are sometimes used interchangeably. However, they each have varied frames of reference, theoretical underpinnings and meanings. This thesis has privileged the term cultural security in the title and overarching research objective as it has its origins in an Australian Aboriginal context. It is closely related to the concept of cultural safety that arose in Aotearoa/New Zealand and is widely used in Canada, and more recently, Australia.

Shane Houston, a descendant of the Gangulu people of Central Queensland, defined cultural security as:

“an ethical commitment that the construct and provision of services offered by the health system will not compromise the legitimate cultural rights, views, values and expectations of Aboriginal people. It is a recognition, appreciation and response to the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health systems administration” (Houston, 2009, p. 105).

All terms related to culturally respectful health care are defined, contextualised and critically analysed in the thesis. It is recognised that terminology is fluid, is often used inconsistently, and that preferences vary according to the setting.
Abstract

The concept of cultural competence and its application in health care settings rests on the premise that clinical encounters and patterns of health service utilisation are influenced by cultural background. The concept arose in the late 1980s in the United States and focuses upon attitudes, behaviours and organisational policies that enhance health care delivery in cross-cultural settings. Its development and application were a response to increasingly diverse population trends and well documented health disparities among minority groups. While the impact of social determinants of health was acknowledged, differential treatment of patients by service providers was also considered a contributing factor to disparate health outcomes. As a consequence, cultural variations in health beliefs and practices among patients, health providers’ attitudes, behaviours and communication skills, and the presence of institutional racism in health care settings became a focus of attention, and health professional training programs introduced cross-cultural education in their curricula. While a link between culturally competent health professionals and enhanced access and satisfaction with services was established, there remains limited evidence to associate cultural competence with improved health outcomes for minority groups.

Developments in the United States were mirrored in Australia about a decade later, although coloured by uniquely Australian experiences. Increased cultural diversity in Australia due to post World War Two immigration resulted in health services ill-equipped to provide culturally appropriate care to patients from non-English speaking backgrounds. Furthermore, it had been recognised for a very long time, that health service delivery and accessibility was woefully inadequate for the first Australians: Aboriginal and Torres Strait Islander populations whose health, based on all indicators, contrasted starkly with that of the wider population. Two significant inquiries in the 1990s identified links between Aboriginal disadvantage, marginalisation, and poor health outcomes, and drew attention to a professional workforce ill-equipped to provide culturally respectful care. The concept of cultural competence, and notions of cultural safety and security where emphasis is placed on the recipients of services, entered public discourse, and the higher education sector recognised its responsibility to prepare graduates to work respectfully with Aboriginal people and communities.

This study arose out of initiatives in Australian universities, especially in health science faculties, to incorporate core content on Aboriginal cultures and health in curricula. An opportunity to explore the impact of this content on student learning was provided by the introduction of a unit Indigenous Cultures and Health as part of a new, interprofessional common first year for all undergraduate health science students at a Western Australian
university. This study focuses on midwifery students’ responses to content in the unit, knowledge acquisition, attitude change, cultural immersion experiences, and preparedness to deliver culturally secure care to pregnant and birthing Aboriginal women.

The study population comprised two groups: undergraduate and postgraduate midwifery students. The postgraduate students, who were already qualified nurses, did not complete the unit but provided a useful source of comparison with the undergraduate cohort. The multi-phased mixed methods study employed classroom observations, questionnaires, and in-depth interviews to inform the overarching objective: to explore the concept of culturally secure practice in midwifery education and its application in service provision for Aboriginal women. It received ethics approval from the Western Australian Aboriginal Health Ethics Committee, and from two Western Australian universities.

Findings from the undergraduate study revealed that a well-designed and innovative unit that privileges Aboriginal voices in the classroom, and is conceived with substantial Aboriginal input, can enhance knowledge and shift attitudes in a positive direction. In a safe learning environment characterised by established guidelines for open discussions, students confronted uncomfortable truths about our shared history, but also developed a capacity for empathy and critical reflection. While content was met with pockets of resistance, student responses were overwhelmingly positive. However, questions remain over the longer term impact of content delivered in the unit, as a significant decline in retention of knowledge and positive attitudes towards Aboriginal people was observed among students in subsequent years of the program. Postgraduate students, despite their clinical experience, were less inclined than undergraduates to feel confident about their knowledge of Aboriginal cultures and health, although their attitudes were very positive. Remote clinical placements, while short in duration, were found to have a profound effect on student learning, providing a rare opportunity to observe the importance of local contexts and cultural protocols, especially those related to women’s business (knowledge and practices around pregnancy, birthing and nurturing of children) in Aboriginal communities.

Conclusions drawn from the study suggest that receptivity to Aboriginal content in health professional programs is optimised by the creation of a safe learning environment, and the innovative inclusion of Aboriginal voices in the classroom. It was also evident that vertically integrated Aboriginal content is required to consolidate and maximise those gains made following intensive instruction, and that opportunities for clinical placements in Aboriginal settings and cultural immersion experiences, should be more readily available to students. It is recommended that future studies investigate the extent to which knowledge gained in training programs is applied in health care settings. The way in which culturally competent health
professionals are supported or impeded in their work to improve health outcomes for Aboriginal Australians also requires exploration. Finally, further research into how culturally competent care contributes towards reducing health inequities is required.
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<tbody>
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<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>ACCHO</td>
<td>Aboriginal Community Controlled Health Organisations</td>
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<tr>
<td>AEC</td>
<td>Australian Electoral Commission</td>
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<td>AHMAC</td>
<td>Australian Health Ministers’ Advisory Council</td>
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<tr>
<td>AHW</td>
<td>Aboriginal Health Worker</td>
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<tr>
<td>AIATSIS</td>
<td>Australian Institute of Aboriginal and Torres Strait Islander Studies</td>
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<td>AIDA</td>
<td>Australian Indigenous Doctors’ Association</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<tr>
<td>AMICW</td>
<td>Aboriginal Maternal and Infant Care Workers</td>
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<tr>
<td>ANMAC</td>
<td>Australian Nursing and Midwifery Accreditation Council</td>
</tr>
<tr>
<td>ANMC</td>
<td>Australian Nursing and Midwifery Council</td>
</tr>
<tr>
<td>APY</td>
<td>Anangu Pitjantjatjara Yankuntjatjara</td>
</tr>
<tr>
<td>BMC</td>
<td>Biomedical Central</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse Populations</td>
</tr>
<tr>
<td>CAMDH</td>
<td>Centre for Aboriginal Medical and Dental Health</td>
</tr>
<tr>
<td>CATSIN</td>
<td>Congress of Aboriginal and Torres Strait Islander Nurses</td>
</tr>
<tr>
<td>CATSINaM</td>
<td>Congress of Aboriginal and Torres Strait Islander Nurses and Midwives</td>
</tr>
<tr>
<td>CDAMS</td>
<td>Committee of Deans of Australasian Medical Schools</td>
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<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
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<tr>
<td>CPD</td>
<td>Continuous Professional Development</td>
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CTG
Close the Gap

FASD
Foetal Alcohol Spectrum Disorder

IHEAC
Indigenous Higher Education Advisory Council

IHU
Indigenous Health Units

INEWG
Indigenous Nursing Education Working Group

IOM
Institute of Medicine

LIME
Leaders in Indigenous Medical Education

MMR
Maternal Mortality Rate

NCCC
National Centre for Cultural Competence

NHMRC
National Health and Medical Research Council

NHS
National Health Service

NIHEC
National Indigenous Health Equity Council

NIHES
National Indigenous Health Equality Summit

NMBA
Nursing and Midwifery Board of Australia

NMSP
National Maternity Services Plan

OATSIH
Office of Aboriginal and Torres Strait Islander Health

PCF
Participant Consent Form

PIF
Participant Information Form

QUT
Queensland University of Technology

RACGP
Royal Australian College of General Practitioners

RCNA
Royal College of Nursing Australia

RCS
Rural Clinical Schools

SCATSIH
Standing Committee on Aboriginal and Torres Strait Islander Health
UA  Universities Australia
UDRH  University Departments of Rural Health
UWA  University of Western Australia
WHO  World Health Organisation
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Statement of Attribution

To Whom It May Concern

I, Professor Sandra Thompson, principal supervisor for the research project “Culturally secure practice in midwifery education and service provision for Aboriginal women” provided critical feedback during the drafting and revision of the following manuscripts:


The coordination of the study, the analysis of data and the drafting of the manuscripts for publication was completed by Rosalie D Thackrah. I give my permission for these articles to be included in this thesis.

Name: Sandra Thompson

Signature:

Date: 22 March 2016
I, Associate Professor Angela Durey, co-supervisor for the research project “Culturally secure practice in midwifery education and service provision for Aboriginal women” reviewed and provided critical feedback on the following manuscripts prior to submission:


The coordination of the study, the analysis of data and the drafting of the manuscripts for publication was completed by Rosalie D Thackrah. I give my permission for these articles to be included in this thesis.

Name: Angela Durey Signature: [signature]

Date: 23/03/2016
List of Presentations

Research proposal presentation: Research seminar, School of Nursing and Midwifery, Curtin University, Perth, Western Australia. 11th April 2012.

Research proposal presentation: Research seminar, School of Primary, Aboriginal and Rural Health Care, University of Western Australia. 21st June 2012.


Round Table Symposium presentation: ‘Confronting uncomfortable truths: a look beneath the surface of student engagement with Aboriginal content in their program’. Having the Hard Conversations. Poche Centre for Indigenous Health and Well-Being. Flinders University, South Australia. 21-22 April 2015.

Seminar presentation: ‘Confronting uncomfortable truths: a look beneath the surface to explore university student engagement with Aboriginal content and learning’. Western Australian Centre for Rural Health, University of Western Australia, Geraldton. 14th August 2015.
Conference presentation: ‘Re-thinking health and wellness on the Lands: successful strategies to promote women’s health in remote Australian Aboriginal communities’. Fifth International Conference on Health, Wellness and Society, Universidad de Alcalá, Madrid, Spain. 3-4th September 2015.
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Many colleagues at Curtin University facilitated the various administrative requirements needed to commence this study, and I particularly wish to thank Professor Phillip Della, Professor Marion Kickett, Associate Professor Sue Jones, and midwife extraordinaire Jennie Wood. Classroom observations would not have been possible without the agreement and support of tutor Kate Taylor, to whom I am very grateful. My thanks are also extended to Lisa Wallace who, while working on the Ngaanyatjarra Lands, supervised and inspired the midwifery students in her care.

The midwifery students and midwives who participated in this study gave generously of their time and showed enormous commitment to their profession, and to the notion of equity in health care. The study was dependent upon their involvement, and those who participated in interviews made a substantial contribution. I am still moved when I recall those exchanges: what transpired and how much I learned from our conversations. I hope that the findings and recommendations from this study will go some way towards improving a system of health care, which you found wanting.

I was very fortunate to receive financial assistance while completing this study. To Emeritus Professor Jan Piek, I extend my grateful thanks for the support provided by a National Health and Medical Research Council Capacity Building Grant (533547; Building Mental Wealth: Improving mental health for better health outcomes among Indigenous Australians), administered by Curtin University, and to Professor Sandra Thompson for recommending me as a worthy recipient of funds. I also acknowledge financial support from an Australian
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Lastly, but importantly, I sincerely thank my wonderful sons, Simon and Andrew, who understand more than anyone why my doctoral research was postponed for so many years, and my need to attend to this “unfinished business”. Thank you for your love and support.
Chapter One: Introduction and Overview

1.1 Introduction to the chapter

This chapter introduces the research problem, identifies factors that provided the impetus for the study and presents the research objectives and questions. A snapshot of the researcher’s background offers insights into personal and professional experiences that influenced the formulation of the research topic. The chapter concludes with an orientation to the thesis and outlines the sequence and content of chapters and associated publications.

1.2 The research problem

The complex interplay between culture and health which has been extensively interrogated by social scientists and clinicians, suggests that cultural background influences health beliefs and practices, access to and patterns of health service utilisation, and disparities in health outcomes among minority groups (Betancourt, 2003; Good, James, Good & Becker, 2003; Kleinman, 1981; Kleinman & Benson, 2006; Taylor, 2003). While few deny the importance of this relationship, it has been suggested that the use of the term “culture” in medical settings fails to recognise the dynamic, diverse and fluid nature of the concept, which is intricately connected to the social context of people’s lives (Carpenter-Song, Nordquest Schwallie & Longhofer, 2007; Kirmayer, 2012). “Culture” refers to a system of shared meanings or guidelines that are inherited and provide a lens through which the world is viewed, but variations within groups commonly occur (Helman, 2007). Factors such as socio-economic status, language and experiences of racism interact with cultural orientation and can influence clinical encounters. A patient’s culture is best understood as comprising layers of meaning shaped by social structures, those recurring patterns of interactions through which people relate to one another, rather than defined by stereotypical attributes associated with a particular group (Lo & Stacey, 2008).

Cultural competence training for health professionals emerged in the United States in the late 1980s as a response to the growing diversity of the population and recognition of associated health disparities. It focused upon attitudes, behaviours and organisational policies that enhance health care delivery in cross-cultural settings and over the next two decades cultural competency became embedded in professional accreditation standards (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). In Australia, interest in cultural competence as a strategy to improve health service delivery for culturally diverse populations followed developments in the United States. Disparities in health outcomes are stark and confronting among Aboriginal and Torres
Strait Islanders, so improved access to services, better communication, respect for cultural knowledge and recognition of the corrosive and debilitating impact of racism are all seen as required to address failures in health service delivery.

Australian medical schools led efforts to develop a more culturally inclusive curricula aimed at improving health service delivery to Aboriginal populations. In 2004 the Committee of Deans of Australasian Medical Schools (CDAMS) published the “Indigenous Health Curriculum Framework”. Mastery of this content was subsequently included in accreditation guidelines (Phillips, 2004). The Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) established in 1997 and led by former Senior Australian of the Year Dr Sally Goold, was also very active in this area and lobbied extensively for the inclusion of Aboriginal content in nursing and midwifery programs (Indigenous Nursing Education Working Group [INEWG], 2002). Developments in curricula were also occurring in other health professional programs, especially psychology, and in 2011 Universities Australia, the peak body representing all national universities, recommended that “Indigenous cultural competency” be identified as a graduate attribute. The concept encompassed knowledge and understanding of cultures, histories, protocols and a capacity to engage and work effectively with Indigenous Australians (Universities Australia, 2011).

As Aboriginal content in health professional programs became more widespread, interest has grown in the pedagogical process: receptivity to content by students; managing disquiet and resistance; who should teach the content; where it should be placed in the curriculum; how it should be assessed; provision of clinical placements in Aboriginal settings; and whether students exposed to this content would become culturally competent practitioners and influence health outcomes. Answers to some of these questions emerged from medical student studies but little was known about the impact of Aboriginal content in nursing and midwifery programs where it has become routinely included in curricula, although not necessarily in the form of a discrete unit.

An opportunity to explore some of these issues arose with the introduction of an inter-professional, common first year for all health science students at a Western Australian university in 2011. An Aboriginal unit titled Indigenous Cultures and Health was included in the common first year, and although it was identified as a half unit in terms of credit points, it ran across a full semester with two hours of mandatory contact time each week. Concurrently, there was a drive to promote inter-professional education, which is underpinned by the belief that students from different programs benefit from interacting with one another in classes and in clinical settings. However, not all midwifery students had this opportunity due to the number
and specific nature of their placements and continuity of care appointments that require regular off-campus commitments with pregnant women. Instead, most classes were arranged to accommodate these demands, and in the case of Indigenous Cultures and Health, the small midwifery student group remained intact. This allowed for an in-depth investigation of midwifery students’ responses to the unit and was fortuitous in other ways too. “Women’s business” which relates to knowledge and practices surrounding pregnancy, birthing and the nurturing of children (Dunbar & Ford, 2011) is a sensitive area for many Aboriginal women and young girls. Furthermore, Aboriginal maternal and infant health outcomes continue to lag behind those in the wider community and relocation for birthing causes distress for many remote women (Kildea & Van Wagner, 2012). Ideally, well trained, culturally responsive midwives who develop strong, respectful and trusting relationships with pregnant and birthing Aboriginal women can encourage appropriate health care utilisation into the future and facilitate on-going promotion of health. This study provided an opportunity to explore the training of midwifery students to provide culturally secure care to Aboriginal women where security is associated with knowledge, understanding and the incorporation of Aboriginal cultural values in the provision of health services (Houston, 2009).

1.3 The research objectives and questions

The research problem as described has one overarching objective: to explore the concept of culturally secure practice in midwifery education and its application in service provision for Aboriginal women. A number of specific objectives arise from this including to:

- critically analyse the concept of “cultural competence” and related terminology, drawing upon national and international developments;
- review selected educational initiatives that prepare future health professionals to work with Aboriginal Australians;
- describe midwifery students’ engagement with Aboriginal content and compare findings with those from medical student studies;
- explore the impact of a compulsory, first year Aboriginal unit on student knowledge acquisition and attitude change;
- explore the impact of a compulsory, first year Aboriginal unit on the retention of knowledge and attitude change in subsequent years of a student’s program;
- determine the extent to which training for culturally secure practice is applied in clinical practice settings; and
utilise this information to provide recommendations for the future development of Aboriginal content in midwifery and other health science programs.

Research questions associated with these objectives include:

1. What constitutes culturally competent care in health service delivery and can it improve health outcomes for minority groups?
2. What approaches are used to prepare midwifery students to work with and care for pregnant and birthing Aboriginal women?
3. How do midwifery students respond to Aboriginal content in their program?
4. What factors influence student receptivity and resistance to Aboriginal content in their program?
5. Does experiential learning help students contextualise and apply content delivered in the classroom?
6. Do students perceive that they are adequately prepared to care for Aboriginal women and their babies at graduation?
7. How can this information be utilised to refine and improve programs to facilitate culturally informed health care delivery across the health sciences?

These objectives and questions are addressed in the various stages of the research process and aim to elucidate and enhance knowledge in the area and contribute to a better understanding of the dynamics of teaching and learning with respect to Aboriginal content in health science programs. It is anticipated that recommendations that arise out of the study will lead to improvements in the delivery of Aboriginal content and further interest in exploring the application of learnings in health care settings.

1.4 Personal positioning

My involvement in Aboriginal health and education dates back to the mid-1970s when, as a freshly minted non-Aboriginal teacher with a major in anthropology, a graduate diploma in education and two years teaching experience, I secured a position as an Aboriginal Education Officer with the Commonwealth Department of Education. Even then the title seemed odd as all those employed in this role were non-Aboriginal people; it was many years before this changed. We were tasked with implementing the new Aboriginal Secondary Grant and Study Grant schemes and this involved extensive travel throughout Western Australia to visit Aboriginal students in secondary schools; we also monitored the progress and provided support to the small but growing number of students in higher education programs. I visited reserves on the outskirts of Carnarvon and Kalgoorlie, missions where students boarded, and talked to
students’ families who lived throughout the State, often in conditions that shocked me to the core.

I studied anthropology under the tutelage of Ronald and Catherine Berndt who imbued in me and many of my generation enormous respect for Aboriginal people and cultures. With this came a sense of shame and bewilderment about the living conditions, poor health and low levels of education that existed in such an affluent country. Trips to rural and regional areas sharpened my understanding: I confronted racism among teachers whose training had not equipped them to work with Aboriginal students, headmasters who suggested I was peddling false hope to students about their futures, and health professionals at local clinics who seemed indifferent or perhaps overwhelmed by the tragedy unfolding in their midst. I also met others who inspired me: doctors, nurses, teachers and community workers who agitated for change and demanded Aboriginal involvement in government decision-making. Equally influential were the many Aboriginal people I met: parents, grannies and teenagers, some of whom, despite the odds, went on to make substantial contributions to their communities and the nation. Enduring friendships followed.

Fast forward to the late 1980s when, equipped with a Master of Arts degree that explored attitudes towards poverty in Australia, I began lecturing in health sociology in a university health science faculty. I quickly realised that Aboriginal content in programs was almost non-existent. The 1991 publication of Janice Reid and Peggy Trompf’s *The Health of Aboriginal Australia* and the accompanying instructors’ manual provided me with much needed resources to include this content in my teaching.

In a concurrent position at another university I had an opportunity to visit Papunya in the Northern Territory in the early 1990s. Accompanied by a western doctor, I met an esteemed Ngangkari man (Aboriginal traditional healer) and learned about traditional health beliefs and practices and their importance in the community. The experiences and knowledge I gained in Papunya and later in Dhaka, Bangladesh, where I was introduced to slum-dwelling pregnant and postpartum women and their families, heightened my awareness of the complex relationship between culture and health and enriched my teaching. Over time, as I established relationships with Aboriginal academics on campus and with local community members, I sought their involvement in the teaching of this content. Paul Kelly, the celebrated Australian singer and songwriter reminds us that from little things big things grow, and so it came to pass: a core unit on Aboriginal health designed and taught with substantial input from Aboriginal staff was incorporated into undergraduate nursing and midwifery programs. It took until 2006 and was the first iteration of the unit on which this study is based. It was launched by Dr Sally Goold
from CATSIN whom I had invited to the university as part of an academic-in-residence program. It was sufficiently groundbreaking for our small team to receive the 2010 Neville Bonner Award for Teaching Excellence in Indigenous Education from the Australian Learning and Teaching Council.

My involvement in the development and teaching of this unit coincided with an approach from a publisher about a new book on Aboriginal health for health professionals. With initial ambivalence, I embarked on the project in an editorial role with support from Dr Joan Winch and later Professor Kim Scott, who joined me as co-editor. My aim for all chapters to be written or co-written by Aboriginal contributors was realised and the book *Indigenous Australian Health and Cultures: An Introduction for health professionals* was published in 2011. This was also the year that the new Aboriginal health unit commenced as part of the interprofessional common first year for health science students. The development of the unit was Aboriginal led and teaching was shared between Aboriginal and non-Aboriginal staff. The *Indigenous Cultures and Health* unit went on to receive a national award for innovation in teaching in 2014. As I had no direct involvement in the preparation of the new unit (I was finalising a book for publication and teaching overseas) and had excluded myself from the teaching team, I was in a position to be a non-participant observer of its implementation and its impact on students. At last my project began to take shape and form, and before long had a tentative title. Still, the genesis of my interest goes back to the 1970s in the schools, missions, reserves and health clinics of regional and rural Australia, and was consolidated over decades of teaching where I could influence the future practice of health science students.

1.5 An orientation to the thesis

The thesis is structured traditionally: it comprises an abstract, six chapters, a reference list and four appendices. Six published articles have been integrated into the chapters and an additional publication, a book chapter, has been included as an Appendix. The decision to publish articles and present the work in the style of a thesis by publication was made in an effort to disseminate the findings as widely as possible and make a contribution to a rapidly expanding body of knowledge. This style of thesis is widely recognised as having strengths including benefits to the researcher from peer-reviewed feedback and a growing publication list. Statements of attribution for work completed in the articles are located at the front of the thesis.

This chapter has outlined the research problem, the main objectives and the key questions addressed in the study. Reflections on the researcher’s background including factors that
shaped the development of the study have been presented and an orientation to the thesis follows.

Chapter Two contextualises the study: it provides an overview of the demographic characteristics of Australia’s Aboriginal populations; it explores the contribution of various models of health to the understanding of disparate health outcomes; it considers Aboriginal traditional health beliefs and practices, especially those associated with birthing; and it highlights developments in maternity service provision for Aboriginal women, and in the higher education sector where midwifery training occurs.

Chapter Three provides an extensive review of international and Australian literature related to cultural competence in health service delivery and higher education. It examines the contested terrain associated with terminology, pedagogical approaches to the teaching of cross-cultural health content, and traces developments that led to the inclusion of compulsory Aboriginal content in professional programs including medicine, nursing and midwifery. The chapter also includes an article: Refining the concept of cultural competence: building on decades of progress published in the Medical Journal of Australia, which explores social science critiques of the concept of cultural competence.

Chapter Four describes and justifies the mixed methods research design adopted in the study. The research objectives and questions are presented in the context of the literature and the study population is described. The various components of the study design, the process of data collection and analysis, and issues relating to validity, reliability and ethics are all explored in the chapter.

Chapter Five presents the undergraduate and postgraduate research findings. The undergraduate findings that comprise the main component of the study are located in five published articles. The first two articles are based on classroom observations and interviews conducted to explore the impact of the Indigenous Cultures and Health unit on first year midwifery students. Confronting uncomfortable truths: Receptivity and resistance to Aboriginal content in midwifery education published in Contemporary Nurse provides a detailed overview of the design and implementation of the unit and students’ responses to its content. The second article, based on observations of the teaching and learning process and interviews, is titled ‘Friendly racism and white guilt’: midwifery students’ engagement with Aboriginal content in their program. This article looks more closely at the challenges confronted by teaching staff and students in the unit, together with the classroom dynamics, which created tensions and required careful management.
Cross-sectional survey data collected from each of the undergraduate year groups is presented in *Exploring undergraduate midwifery students’ readiness to deliver culturally secure care for pregnant and birthing Aboriginal women* published in BMC Medical Education. This article describes pre-unit and post-unit findings on knowledge acquisition and attitude change among students in the *Indigenous Cultures and Health* unit.

The last two articles explore students’ experiences and learning derived from a remote clinical placement on the Ngaanyatjarra Lands in Western Australia. ‘*Listening to the silence quietly*: investigating the value of cultural immersion and remote experiential learning in preparing midwifery students for clinical practice,’ published in BMC Research Notes, describes the impact of a cultural immersion program on student learnings. The second article, *Promoting women’s health in remote Aboriginal settings: Midwifery students’ insights for practice*, published in the Australian Journal of Rural Health, looks specifically at student learnings related to health promotion among Aboriginal women on the Lands. The final section of this chapter presents the postgraduate student survey findings. While the postgraduate survey response rate was much lower, the findings are of interest in their own right, and particularly as a point of comparison with the undergraduate cohort.

**Chapter Six** draws together the key points of discussion in the published articles and considers the implications of the undergraduate and postgraduate findings. Reflections on the study, its significance and limitations, the main conclusions and recommendations, and lastly, potential areas for future research, bring the thesis to a close.

**1.6 Chapter summary**

This chapter introduced the research topic, explained why the study was undertaken and presented the research objectives and questions. A glimpse into the researcher’s background was given together with a chronology of experiences that gave rise to the study. Lastly, an orientation to the structure of the thesis was provided, including the content in each chapter. The study context which frames the research problem is presented in the following chapter.
Chapter Two: The Study Context

2.1 Introduction to the chapter

This chapter provides the context of the research project. Key demographic characteristics of Australia’s Aboriginal populations frame a discussion of maternal and infant health outcomes. Reference is made to models of health, Aboriginal perspectives on health and illness, and cultural beliefs surrounding pregnancy and childbirth. Government policy developments, maternity service provision, professional competencies and workforce issues are discussed in relation to Aboriginal maternal and infant health and education and training. Some topics are considered in more detail in the literature review in Chapter Three.

2.2 Demographic characteristics of Australian Aboriginal populations

Population estimates based on the most recent national census data suggest that in 2013 there were 713,589 people who identified as Indigenous Australians. This equates to 3% of the Australian population (Australian Indigenous healthinfo.net, 2015). In the 2011 census, 90% of Indigenous Australians identified as Aboriginal, 6% as Torres Strait Islanders and 4% as both. New South Wales recorded the largest number of Indigenous Australians (220,902) while the Northern Territory had the highest proportion at 30% (Australian Indigenous healthinfo.net, 2015). In Western Australia the Indigenous population was 93,778 which equates to 3.6% of the State’s population and 13% of the national Indigenous population (Australian Indigenous healthinfo.net, 2015).

The age distribution of the Indigenous population in 2011 reveals substantial variations at the upper and lower age categories when compared with the non-Indigenous population (see Figure 2.1). The Indigenous population is much younger, with more than a third under the age of 15 years, while at the other end of the life span only 4% are aged 65 years and above. This compares with one fifth of the non-Indigenous population that is under 15 years and 14% aged 65 years and above (Australian Indigenous healthinfo.net, 2015).
The different age distribution in Indigenous populations reflects higher fertility and mortality rates compared with the non-Indigenous population and is a pattern more typical of the developing world. The implications of higher fertility rates are considered in Section 2.3. Higher mortality rates reflect a greater burden of disease throughout the life cycle and are associated with the ongoing socio-economic disadvantage that followed colonisation, dispossession and loss of cultural identity. Revised estimates of expectation of life for those born in 2010-12 indicate a gap of approximately 10 years between Indigenous and non-Indigenous Australians (Australian Bureau of Statistics [ABS], 2013). The leading cause of death for Indigenous Australians is cardiovascular disease, closely followed by cancer. Coronary heart disease and lung cancer occur at twice the rates of the non-Indigenous population and diabetes, another leading cause of death, occurs at seven times the rate of that in the wider community. Young and middle-aged Indigenous men are particularly vulnerable to coronary heart disease and suicide as causes of premature death (Australian Institute of Health and Welfare [AIHW], 2014).

2.3 Aboriginal maternal and infant health

In 2013 the ABS reported that in the previous year 18,295 births were registered where one or both parents identified as an Indigenous Australian. This represents 6% of all births and underestimates the true figure as Aboriginal status is not always recorded and time delays in
registration are common (Australian Indigenous healthinfo.net, 2015a). Of these births, 72% were to parents who were both Indigenous (30%) or where the mother identified as Indigenous (42%). The remaining births were to women whose partner identified as Indigenous (Australian Indigenous healthinfo.net, 2015a). Given that in 2013 Indigenous Australians accounted for only 3% of the national population, it is clear that this population has higher fertility rates than those in the wider community. More instructive, however, is the comparison of age-specific fertility rates between Indigenous mothers and all mothers presented in Table 2.1. Age-specific fertility rates refer to “the annual number of births per 1,000 women in five-year age-groups from 15 to 44 years” (Australian Indigenous healthinfo.net, 2015a). Western Australian rates are highlighted in the Table below, drawing attention to the high number of Indigenous women giving birth at relatively young ages in comparison with other States.

<table>
<thead>
<tr>
<th>Status of mother/age-group (years)</th>
<th>Jurisdiction</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>NT</th>
<th>Australia</th>
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</thead>
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<tr>
<td>Indigenous mothers</td>
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<td>All mothers</td>
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Table 2.1. Age-specific fertility rates, by Indigenous status of mother, selected jurisdictions, Australia, 2012.

<table>
<thead>
<tr>
<th>Status of mother/age-group (years)</th>
<th>Jurisdiction</th>
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<tr>
<td></td>
<td>NSW</td>
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<td>25-29</td>
<td>102</td>
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<td>30-34</td>
<td>127</td>
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<td>35-39</td>
<td>74</td>
</tr>
<tr>
<td>40-44</td>
<td>17</td>
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</table>

Notes:

1. Rates per 1,000 women in each age-group; the 15-19 years age-group includes births to women aged 14 years or younger, and the 40-44 years age-group includes births to women aged 45 years or older

2. Figures are not provided for Tasmania and the ACT because of the small numbers involved and doubts about the level of identification of Indigenous births, but numbers for these jurisdictions are included in figures for Australia


Indigenous mothers not only have more children than women in the wider community but, as Table 2.1 reveals, they start their families at a much younger age. In 2012 nearly 20% of Indigenous births occurred among teenagers in the 15-19 year old age group, whereas in the wider community teenage births accounted for just less than 4% of all births. The median age of Indigenous mothers for a first delivery was 24.8 years compared with 30.7 years among mothers in the wider community (Australian Indigenous healthinfo.net, 2015a).

Pregnancy and birthing remains riskier for Indigenous women compared with their non-Indigenous counterparts. The Australian Institute of Health and Welfare’s (AIHW) report
Maternal deaths in Australia: 2006-2010 (2014) revealed an Indigenous Maternal Mortality Rate (MMR) of 16.4 per 100,000 women, approximately three times the rate for non-Indigenous women. This rate, which includes direct and indirect maternal deaths (indirect deaths include suicide and cardiac conditions) and incidental causes, has dropped from a peak in 2000-2002 (AIHW, 2014). The authors urge cautious interpretation of the figures however, as they fluctuate over time and do not allow for the rarity of maternal deaths and the small Indigenous population size, making calculation of statistical differences problematic.

The AIHW (2014) report identified the leading causes of Indigenous maternal deaths as sepsis (21%) and cardiac and psychosocial conditions (18% each). This contrasts with non-Indigenous women where the main causes of death were hypertensive disorders and non-obstetric haemorrhage (15.3%), cardiac conditions (15%) and amniotic fluid embolism (12%). Cause-specific MMRs for Indigenous women revealed an eight-fold heightened risk of death by sepsis compared with non-Indigenous women (AIHW, 2014). Geographical location was not a predictor of maternal mortality for Indigenous women despite the fact that 27% gave birth in remote or very remote settings. The provision of culturally competent maternity services has been identified as one of a number of strategies to address the higher risk of maternal death in Indigenous women and developments in this area are reviewed in Chapter Three.

Birth weight, an identified risk factor for infant morbidity and mortality, is another characteristic that varies according to Indigenous status. In 2011 Indigenous babies were more than twice as likely to be defined as low birth weight (less than 2,500 grams) with 12.6% of births falling into this category (Australian Indigenous healthinfo.net, 2015a). There are numerous factors that increase the likelihood of low birth weight including the age and nutritional status of the mother, socio-economic disadvantage and substance and alcohol misuse, especially during pregnancy. Some factors are inextricably linked such as poverty, stress, unemployment and rates of smoking, with higher tobacco usage in the Indigenous population (D’Antoine & Bessarab, 2011). Data from the Close the Gap (CTG) Progress and Priorities Report (2015) suggested that while smoking rates have decreased from 51% in 2001 to 41% in 2012-13, they remain at unacceptably high levels. The report also confirmed that while Aboriginal people are twice as likely to abstain from drinking alcohol compared with non-Aboriginal people, at risk drinking, which in pregnant women is linked to Foetal Alcohol Spectrum Disorder (FASD), continues to present challenges in many communities, in addition to injuries, accidents and suicides. The prevalence of FASD among Aboriginal infants is estimated at between 2.76 and 4.7 per 1,000 live births compared with between 0.06 and 0.68 for all Australians (CTG Campaign Steering Committee & Oxfam Australia, 2015).
Low birth weight infants are either small for gestational age or born prematurely. While there has been a decline in pre-term births (before 37 weeks gestation) among Aboriginal women, in 2011 they still accounted for 12.5% of all live births compared with 7.5% of live births for non-Aboriginal women (CTG Campaign Steering Committee & Oxfam Australia, 2015). Low birth weight remains a major determinant of perinatal mortality (death shortly before or after birth), which occurs approximately 1.5 times more frequently among Aboriginal infants (AIHW, 2014). In addition to smoking and substance misuse during pregnancy, high rates of genitourinary tract infections have been associated with low birth weight. Screening and treatment of pregnant Aboriginal women is the focus of a number of promising primary health care interventions, including the Townsville Mums and Babies Program (D’Antoine & Bessarab, 2011).

Regular antenatal care can identify and treat pregnancy complications and promote healthy behaviours. Despite increased attendance over recent years, nationally only 56% of pregnant Aboriginal women receive antenatal care in their first trimester compared with 75% of non-Aboriginal women. Overall, figures indicate that 99% of pregnant Aboriginal women had at least one antenatal care visit (83% had five or more) although for many, first visits occurred late in pregnancy (AIHW, 2014).

2.4 Responses to differential health outcomes: the contribution of various models of health

While the biomedical, social and biopsychosocial models of health view health and disease from different vantage points and have acknowledged strengths and weaknesses, all contribute to a better understanding of the prevalence, causes and treatment of disease and illness and the impact of social circumstances on health outcomes, especially in Aboriginal communities. The biomedical model which is underpinned by western science is the dominant paradigm in medicine today. Critiques have identified key limitations of the ‘diseased bodies’ approach associated with biomedicine, namely, the failure to treat patients as unique individuals who have subjective experiences of illness; reductionism, which ignores the complexity of health and illness; victim blaming; and a lack focus on prevention (Germov, 2014). Many medical practitioners themselves have drawn attention to these limitations and address them in their own professional practice (Kleinman & Benson, 2006). With its focus on acute treatment, immunisation and surgical intervention, biomedicine has saved and prolonged the lives of many, although it is recognised that improvements to public health infrastructure have been equally important in reducing mortality from infectious diseases (McKeown, 1988 cited in Germov, 2014). This places a spotlight on the social context of health and illness and the ways
in which biomedicine, public health measures and the circumstances of people’s lives all contribute to health outcomes.

The focus of the social model of health is upon inequalities between different groups based on economic status, sex, ethnicity and other differentiating variables that influence health and illness. The ground breaking work of Wilkinson and Marmot (1998) on the social determinants of health posed questions about health inequities within and between countries and highlighted what had been known for a long time – “that health follows a social gradient: the higher the social position, the better the health” (Marmot, 2006, p.2). Greater control over one’s work and life was also found to be associated with better health. The “causes of the causes” approach adopted by Marmot distinguishes between behavioural risk factors and those that are biological markers. For example, a biological marker such as cholesterol is important to identify so that intervention can reduce high rates and decrease the risk of subsequent disease. The social determinants of high cholesterol rates however, which are linked with diet and alcohol consumption (behavioural risks) must also be addressed (Marmot, 2006). Consideration of why people consume high fat, salty foods or misuse alcohol (the “causes of causes”) shifts the focus to the nature of the society in which we live: the market place, the cost and distribution of food, cultural patterns of consumption, levels of education and access to services, all of which influence the risk of disease (Marmot, 2006).

In his capacity as Chair of the World Health Organisation’s (WHO) Commission on Social Determinants of Health (CSDH), Marmot noted that

. . . the high burden of illness responsible for appalling premature loss of life arises in large part because of the conditions in which people are born, grow, live, work, and age . . . the unequal distribution of health-damaging experiences . . . is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics.

(CSDH, 2008, p. 1)

Recommendations that arose from the CSDH report culminated in three principles of action:

1. Improve the conditions of daily life - the circumstances in which people are born, grow, live, work and age.

2. Tackle the inequitable distribution of power, money and resources – the structural drivers of those conditions of daily life – globally, nationally and locally.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health. (CSDH, 2008, p.2).

The Commission’s aspiration was to close the health gap within and between countries in a generation. Evidence of health disparities is well established. Marmot and Wilkinson (2006, p.1) commenced their book *The Social Determinants of Health* with the following statement:

In the Scottish city of Glasgow, people living in the most deprived districts have life expectancy 12 years shorter than those living in the most affluent (NHS Health Scotland 2004). In some American cities, the differences are even greater. Among countries, too, the differences in life expectancy are large, even within Europe. Life expectancy for men in Russia is 58.4 years – a full 20 years less than in Sweden and Iceland (WHO 2005).

This reinforces the notion that despite enormous advances in medical science, health outcomes remain unevenly distributed. To address global health disparities, research linking the social determinants of health to inequities in health outcomes must be translated into action. Investment in the early years was identified by the Commission as a key starting point that has the potential to reduce health inequities in the required timeframe (CSDH, 2008). The entire life course is influenced by experiences in early childhood (prenatal development to the age of eight years) and investment in these vital years from pre-pregnancy through pregnancy and childbirth, and the early years of child development, are considered essential to building children’s capacities (CSDH, 2008). This implies that close attention must be paid to maternal health, the circumstances and experiences of pregnant and birthing mothers, and their access to health care and health promoting environments in subsequent years.

As with the biomedical model of disease, the social model of health has limitations. Weaknesses of the approach include lack of attention to individual responsibility for health, the complexity and utopian nature of some of the solutions, and an overemphasis on the harmful effects of biomedicine (Germov, 2014). Interventions can be difficult to implement when health is viewed as a social responsibility and solutions to health inequity are located in people’s living and working conditions, and cultural differences. Despite these limitations, it is widely accepted that both models play a vital role in improving health outcomes and addressing health disparities.

Falling somewhere between these two approaches lies the biopsychosocial model of health, a model more closely related to the biomedical model. This alternative model developed by George Engel posits that health and illness derive from the interactions of biological,
psychological, and social factors (Heil, 2014). The individual rather than the group forms the focus of attention and, like the biomedical model of health, its approach is curative. Prevention strategies emphasise individual risk factor reduction although the impact of social interactions is acknowledged. Thus, in addition to biological factors, an individual’s inner-world, their experiences and social relationships are all considered to impact on health and illness (Heil, 2014). While the biopsychosocial model of health was conceived as a response to the limitations of the biomedical model and its contribution to understanding health and illness is important, the focus upon health interventions directed at individuals rather than communities and populations, remains a source of contention (Germov, 2014).

In the Australian Aboriginal context, the social model of health with its focus on social determinants has played an important role in highlighting the relationship between historical factors, subsequent socioeconomic disadvantage and poor health outcomes. Acknowledgement of the relationship between the maintenance of cultural knowledge and traditions and improvements in physical and social and emotional wellbeing has also spawned numerous health promotion programs in Aboriginal communities.

2.5 Social determinants of Aboriginal health

The arrival of the British in Australia in 1788 introduced new diseases, created conflict and displaced Aboriginal people from their lands, often through violence and death; this had serious consequences for Aboriginal people in terms of high mortality rates, lack of access to traditional food sources and disruption to cultural beliefs and practices (Reynolds, 1982). Smallpox, tuberculosis and influenza decimated populations which had no immunity. Various Acts of Parliament attempted to protect Aboriginal communities from the ravages inflicted by colonisation however the harshness of the legislation was often counter-productive and resulted in the removal of many children from their families (Pilkinson, 1996; Saggers, Walter & Gray, 2011).

Recognition of and responses to the deleterious impact of colonisation on Aboriginal Australians occurred later than in other European settler societies such as Canada and New Zealand. There, treaties were negotiated and in some cases, limited sovereignty was acknowledged (Saggers et al., 2011). It was not until 1965 that voting rights were extended to all Aboriginal people in Australia (Australian Electoral Commission [AEC], 2006): their inclusion in the national census did not occur until after the 1967 Referendum was passed. A further 25 years elapsed before the High Court of Australia declared the legal concept of *terra nullius* (land belonging to no-one) invalid. The landmark Mabo judgement of 1992 recognised
the survival of Aboriginal property rights and heralded the era of the National Native Title Tribunal and legally recognised Aboriginal land claims (AIHW, 2015).

The enormous social disadvantage suffered by Aboriginal people as a result of colonisation is reflected in contemporary patterns of health status. Exclusion from full participation in post-colonial Australian society due to restricted access to education and employment, the presence of institutional racism and limited citizenship and voting rights left a legacy of poverty, trauma and distrust (Carson, Dunbar, Chenhall & Bailie, 2007). Health outcomes are determined by a complex interaction of many factors including biological, behavioural, and psychological factors, and socio-economic and environmental circumstances (AIHW, 2015). For Aboriginal Australians, some of these factors are directly or indirectly linked to past policies and practices, and on-going discrimination, racism and disadvantage. In a recent study the AIHW investigated the contribution of the various factors implicated in health disparities between Aboriginal and non-Aboriginal Australians (AIHW, 2015). Findings indicated that socio-economic factors explain the largest proportion of the health gap (31%); behavioural/biomedical risk factors account for 11%; and a further 15% of the gap in health outcomes is explained by a combination of socio-economic and behavioural/biomedical factors. The final contributing component (43%) comprised unexplained factors including poor access to health services (AIHW, 2015).

Recognition of the social determinants of health and how these factors interact with other health determinants can provide a useful framework to address health disparities between Aboriginal and non-Aboriginal Australians. Anderson (2007, p.31) notes however, that social health models vary according to “. . . particular social processes that are emphasised”. In Aboriginal contexts, family structures, the welfare economy, access to health care and the impact of cultural difference and racism, are all factors that mediate the production of health inequalities, although they are not always emphasised in social models of health or policy interventions. Anderson (2007) also draws attention to the importance of government and policy-making processes, the role of social networks and the impact of social integration on health outcomes, all factors that have particular relevance in Aboriginal communities. Hence, to make a valuable contribution to the understanding of and responses to health inequities, social determinant approaches to health must reflect social processes that are meaningful to specific populations and emphasise the complexity of interacting variables.

2.6 Aboriginal perspectives on health and illness

Despite variations between one cultural group and another, McMurray and Param (cited in Hampton & Toombs, 2013, p. 75) noted that “the most recognisable feature shared by
many Indigenous cultures is a holistic, ecological, spiritual view of health and well-being”. Holistic health promotes “. . . physical, mental, spiritual and social well-being in order to achieve balance and harmony for the individual” (Hampton & Toombs, 2013, p. 75). Researchers have observed that explanations of illness were traditionally located in the environment, and in the social and supernatural world. Post-colonial contact with new settlers later became incorporated into this illness belief system (Mobbs, 1991; Maher, 1999). Mobbs (1991) identified five Aboriginal categories of illness, namely, natural; environmental; direct supernatural; indirect supernatural; and emergent or Western in origin. Another group of characteristics identified the strong; the weak; the wounded; and the sick, where the latter group are struck down by supernatural or spiritual influences (Mobbs, 1991; Maher, 1999).

The interconnections between land, kinship obligations, religion and health were and remain integral to Aboriginal life and social responsibilities may sometimes take precedence over individual health concerns (Maher, 1999). Culturally prescribed divisions exist between women’s business and men’s business. “Women’s business includes all aspects of reproduction: menstruation, pregnancy, childbirth, contraception, abortion and female ceremonial business . . .” while men’s business includes “. . . hunting, conflicts, the land, male anatomy and male ceremonial business” (Maher, 1999, p. 232). Knowledge and use of bush medicines is widespread in rural and remote regions and traditional healers (for example, Ngangkari and Mabarn men) who are called upon in cases of spiritual intervention are held in high esteem. Their skills are recognised by some mainstream medical services as evidenced by the Ngangkari Healers Program in the Anangu Pitjantjatjara Yankuntjatjara (APY) lands of South Australia (Australian Indigenous health info.net, 2016).

The overview of traditional beliefs surrounding health and illness provided by Mobbs (1991) and Maher (1999) is compatible with the definition of health proposed in the National Aboriginal Health Strategy (1989, p. x) in which “health is not just the physical well-being of the individual, but the social, emotional and cultural well-being of the whole community. This is a whole of life view and it also includes the cycle of life-death-life”. Houston (2009, p.104) too has emphasised the centrality of culture and identity to Aboriginal perceptions of health and illness. He described a multifaceted notion of culture as seen through Aboriginal eyes:

It is an inherited strength and obligation, it has a spiritual dimension, it is law and history and tradition, a way for Aboriginal people to live together and a framework for interaction with the non-Aboriginal world, and it is song and dance and other objects of Aboriginal people. Culture is both a set of rules or behaviours and a template that is inherited from one generation to another.
Houston (2009) noted that lack of attention to the close connection between culture and health at the service interface results in less than optimal care, with misunderstandings; resistance; lack of compliance and follow-up; and latent service provider racism all potential consequences. His call for a culturally secure health service that is respectful and more responsive to the cultural needs of Aboriginal people is considered in Section 2.7, and in more detail in Chapter Three.

2.6.1 Cultural beliefs and practices surrounding pregnancy and childbirth

References in the literature to traditional Aboriginal beliefs and practices concerning conception, pregnancy and birthing are predominantly confined to specific locations in rural and remote regions (for example, see Carter et al., 1987; Dunbar & Ford, 2011; Hancock, 2006; Kildea, 2006; Kildea & Wardaguga, 2009; Simmonds, 2002) reflecting the fact that less is known about the strength and relevance of traditional knowledge in urban settings. Issues pertaining to Aboriginal women’s health are usually encompassed by the term women’s business. Dunbar & Ford’s (2011, p. 40) definition of Aboriginal women’s business as “knowledge and practice concerning ‘new life’ aspects, nurturing children and ‘growing up’ strong Aboriginal women . . . knowledge is transferred during ceremonies that pay respects to the ancestral dreaming of their country” is consistent with the definition cited earlier by Maher (1999), but expands the notion to include the raising of children and intergenerational knowledge transfer.

Grandmothers’ Law, a term used widely in Central Australia, refers specifically to intergenerational knowledge and skills associated with women’s business that are transferred from older women to younger women during their first pregnancy, the birthing process and immediately afterwards (Dunbar & Ford, 2011; Kildea & Wardaguga, 2009). Other terms used to identify individuals and the process of knowledge transfer, include koonie koonie (in the Wagait region of the Northern Territory) and birthing mothers in Arnhem Land (Dunbar & Ford, 2011). In many remote areas the association between women’s business, connection to place and dreamtime beliefs which explain creation, remains strong. Dunbar’s research in East Arnhem Land suggested that women are attuned to health messages about diet and exercise during pregnancy (Dunbar & Ford, 2011). They frequently include fresh bush foods in their diet and abstain from other bush foods depending upon their spiritual significance. They are, however often reluctant to attend health centres due to concerns about invasive questioning and relocation for birthing. Delivery closer to home enables female family members to provide support and participate in and maintain important traditions. These include smoking ceremonies.
which are performed to strengthen the mother and baby (Dunbar & Ford, 2011; Kildea & Wardaguga, 2009).

Aboriginal women have called for birthing services in their remote communities for many years and this has been well documented. A report on birthing on country models of maternity care (Kildea & Van Wagner, 2012) arose out of the National Maternity Services Plan (NMSP) (Australian Health Ministers’ Advisory Council [AHMAC], 2010). The report explored international evidence-based programs that support community-based maternity services designed and delivered for Aboriginal women. These birthing on country services allow for the inclusion of traditional practices, recognise connection with land and country and incorporate a holistic understanding of health (Kildea & Van Wagner, 2012). Section 2.8.2 provides a more detailed overview of the scope, aims and outcomes of the NMSP while Section 3.4.3 in Chapter Three reviews the birthing on country report.

Despite many similarities in birthing practices in Aboriginal communities in Australia, it is important to recognise the uniqueness of the experience for all women. A range of factors influence women’s knowledge and decision-making including socio-economic circumstances, spirituality, their partner, past experiences with health care services, and their family and the community in which they live (Hancock, 2006; Kildea & Wardaguga, 2009). Younger women may be less inclined to follow the advice of their Elders with regard to traditional beliefs and practices and Elders too are not a homogeneous group – many are keen to encourage young women to accept western care, but would like to see them accompanied to hospital (Simmonds et al., 2010). Financial and opportunity costs often make this a difficult option, especially for families in rural and remote settings, although female relatives continue to play an important role in encouraging and supporting younger women during antenatal visits (Reibel, Morrison, Griffith, Chapman & Woods, 2015; Simmonds et al., 2010).

2.7 Health service provision to Aboriginal Australians

Mainstream services, while widely used by Aboriginal people where accessible, have often been delivered without regard to cultural sensitivities, despite more recent emphasis on the provision of culturally inclusive health care. Disregard for Aboriginal perspectives on health and illness together with very poor health status led to the formation of Aboriginal-controlled health services in the 1970s (Taylor & Guerin, 2010). Houston (2009, p.105) noted that “. . . for many Aboriginal people, hospitals and other non-Aboriginal institutions are significant symbols of their relative marginalisation in Australian society”. He suggested that while cultural security in health service provision has emerged as a significant feature in birthing, primary care and health
Partnerships between mainstream service providers and Aboriginal organisations have the potential to modify mainstream practices and at the same time enhance capacity in Aboriginal-controlled health services. In a review of 24 published articles on Aboriginal and mainstream health service partnerships, Taylor and Thompson (2011) identified the benefits and challenges associated with collaboration. They found that partnerships with Aboriginal services “. . . offer a powerful mechanism for helping build mainstream providers’ sociocultural awareness and overcoming paternalistic care where mainstream health providers see themselves as the experts . . .” (Taylor & Thompson, 2011, p. 302). The authors noted that effective two-way partnerships occur when Aboriginal knowledge is honoured and culturally appropriate clinical care is provided, while at the same time Aboriginal health professionals are given opportunities to increase their clinical capacity. However, challenges were identified with partnerships including mistrust, a remnant of Australia’s colonial history; different value systems; power sharing arrangements and role ambiguity (Taylor & Thompson, 2011). Time invested in relational processes was considered time well spent in efforts to produce successful collaboration between mainstream service providers and Aboriginal organisations.

Durey, Thompson and Wood (2012) explored cross-cultural misunderstandings and the concept of institutional racism, a mechanism that perpetuates power imbalances in health service delivery. They called for communication skills that “. . . accommodate different styles of interaction and different understandings of and responses to illness” and suggested that all health care practitioners should “critically reflect on how their own beliefs and values about Aboriginal Australians impact on the quality of care” (Durey et al., 2012, p. 22). Only through a process of critical reflection can personal biases and assumptions, which are often imposed on patients, be identified. The authors suggested that doctors, as leaders in health care delivery, are well placed to argue for the systemic cultural change in hospitals that is required to enhance Aboriginal patients’ access, participation and adherence to treatment (Durey et al., 2012). The training of culturally competent medical practitioners and a review of health service delivery literature is provided in Chapter Three.

Unsurprisingly, many of the issues identified as problems in health service delivery for Aboriginal people are also present in midwifery service provision. More recently the midwifery profession has been pro-active in addressing these problems through regulatory requirements and education, although much work remains to be done. Developments in the midwifery
profession and their impact on the provision of culturally secure care for pregnant and birthing Aboriginal women are presented below.

2.8 Recent developments in government policy and maternity service provision

2.8.1 Closing the Gap priorities and initiatives

The Closing the Gap strategy which committed to reducing the life expectancy gap between Aboriginal and non-Aboriginal Australians was initiated by the Council of Australian Governments (COAG) in December 2007. In March 2008, following the National Apology to the Stolen Generations by then Prime Minister Kevin Rudd on February 13th 2008, the National Indigenous Health Equality Summit (NIHES) deliberated on Indigenous health equity targets. The Close the Gap Statement of Intent reinforced the importance of governments working in partnership with Aboriginal people and identified 2030 as the timeframe by which equity in health outcomes should be achieved (Australian Indigenous healthinfo.net, 2015b). Later in the year the National Indigenous Health Equity Council was formed and the government committed to the release of annual reports which charted progress towards identified targets. The eighth annual Prime Minister’s Report and the Close the Gap Progress and Priorities Report were published in February 2016.

Another initiative that arose during this period was the formulation of the National Aboriginal and Torres Strait Islander Health Plan in 2013. This evidence-based policy framework formed part of the COAG Closing the Gap agenda to improve Aboriginal and Torres Strait Islander health over the decade 2013-23 (Department of Health, 2013). The Plan identified “health enablers” and “whole of life” priorities: within these priorities, goals and strategies to achieve them are presented. With respect to health enabler priorities, the two goals that have particular relevance to this study are: the need for “a culturally respectful and non-discriminatory health system” with all health care delivered free of racism and “human and community capability” which recognises community and individual strengths and the need to optimise community involvement in the control and delivery of health care. Whole of life priorities focus on “the broader factors affecting health as people move through the stages” (Department of Health, 2013). Maternal Health and Parenting is the goal most directly associated with midwifery practice and states that Aboriginal mothers and babies should receive the best possible care and support to ensure a good start in life. Unsurprisingly, birth weight is identified as very important “... in a sense it is the first outcome” but attention is also drawn to the perinatal mental health of mothers, culturally appropriate maternal health services as close to home as possible and early access (during the first trimester) to antenatal care (Department of
The importance of cultural practices, community, family and economic security to the social and emotional wellbeing of mothers is recognised, as are maternal risk factors associated with low birth weight and other outcomes such as FASD that impede a child’s healthy development.

Key strategies to achieve the goals identified are numerous and invariably highlight existing strategies and the need for on-going implementation of their recommendations. For example, the realisation of a culturally respectful and non-discriminatory health system is closely linked to successful implementation of the National Anti-Racism Strategy (Australian Human Rights Commission, 2012), whereas building capacity in communities to optimise community involvement in health care delivery requires attention to the recommendations of the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011-15 (Department of Health, 2011). The National Maternity Services Plan (AHMAC, 2011) and the National Immunisation Program (Department of Health, 2015) are both relevant to achieving the goal of Aboriginal mothers and babies receiving the best possible health care and support. The impact of the National Aboriginal and Torres Strait Islander Health Plan is monitored and evaluated using the Health Performance Framework reporting system and annual reporting to the Australian Parliament. Progress is also documented within the broader framework of the Closing the Gap reporting mechanisms (Department of Health, 2013).

### 2.8.2 National Maternity Services Plan (NMSP)

The aim of the NMSP published in 2011 was to provide a “. . . strategic national framework to guide policy and program development over five years . . . to improve, coordinate and ensure greater access to maternity services in Australia” (AHMAC, 2011). Priority areas included access, service delivery, workforce and infrastructure, with each area linked to action outcomes. With reference to Aboriginal women, service delivery and workforce priority areas identified the need for a culturally competent workforce, an expansion of care for vulnerable women, and development and expansion of an Aboriginal maternity workforce together with the existing rural and remote maternity workforce. A safe, quality, woman-centred system is at the heart of the infrastructure priority (AHMAC, 2011).

A document titled The characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander women (Kruske, 2013) was an initial response to Action 2.2 in the NMSP: “Develop and expand culturally competent maternity care for Aboriginal and Torres Strait Islander people” (AHMAC, 2011). Preliminary indicators of culturally competent maternity care were identified with a longer term objective to determine access to this care, to
expand programs, identify mechanisms for the evaluation of cultural competence and ultimately evaluate culturally competent maternity care for Aboriginal and Torres Strait Islander women. The document made reference to key characteristics that are incorporated in quality primary maternity services. These include:

1. high quality care enabled by evidence-based practice
2. care is coordinated according to the woman’s clinical need
3. health professionals work together in a collaborative multidisciplinary approach
4. continuity of care through pregnancy, birth and the early postnatal period
5. enable woman-centred care which gives women a sense of control of their birthing experience
6. care is culturally appropriate and reduces health inequalities
7. enable continued access to best practice care at the local level

(AHMAC, 2008, cited in Kruske, 2013, p.4)

Kruske (2013) noted that based on these characteristics, many Aboriginal and Torres Strait Islander women are denied quality primary maternity care as service needs are often prioritised over the needs of women, especially for those in rural and remote areas. The development of a culturally competent maternity workforce is an acknowledged priority area in the Closing the Gap Council of Australian Governments reform agenda (Australian Indigenous healthinfo.net, 2015b).

The implementation plan for the middle years of the NMSP (2012-13) identified “signs of success” including identification of the characteristics of culturally competent care and the expansion of programs providing culturally competent maternity care to Aboriginal and Torres Strait Islander women. It reported that cultural competence was embedded in “... all training, education and ongoing professional development of the whole maternity workforce” (AHMAC, 2014). Consideration to the development of a birthing on country pilot program produced in consultation with Aboriginal and Torres Strait Islander women resulted in a birthing on country framework (see Section 3.4.3). With respect to the expansion of care to vulnerable women, it was reported that perinatal mental health screening was available to all women accessing maternity services with training, mentoring and supervision provided to staff undertaking this screening, although availability and delivery of the service are not necessarily the same thing. Progress was reported with respect to the development of and support for an Aboriginal and Torres Strait Islander health workforce, including maternity services, with numbers edging
higher over the three year period (AHMAC, 2014). At the time of writing, progress achieved during the final years of implementation of the NMSP (2014-15) was yet to be published, although keenly anticipated by those working in the field.

### 2.9 The argument for a culturally competent health care workforce

Gaps in health service provision to Aboriginal Australians and poor health outcomes based on key indicators strengthen arguments for a culturally inclusive health care system. While a review of literature associated with the rise of cultural competence and associated concepts and definitions is presented in Chapter Three, it is important to note that the language of cultural competency is now widely used in Australian health policy frameworks and professional regulatory body documents. This development gathered pace following the National Health and Medical Research Council’s (NHMRC) paper *Culturally competency in health: A guide for policy, partnerships and participation in cross-cultural contexts* (NHMRC, 2006). The report by the Australian Health Ministers’ Advisory Council (AHMAC) *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-9* also provided guidance to service providers and practitioners working in Aboriginal contexts (see Section 3.3.1 for an overview of this report). Similarly, as noted in Section 2.8.2, the NMSP identified the need for a culturally competent maternity workforce as a priority area.

These documents and a raft of others produced over the last decade acknowledged that existing approaches to service delivery aimed at improving health outcomes for Aboriginal people have been unsuccessful. Increasingly there was recognition that “. . . practitioners, service providers and policy makers in the health sector need to take account of the pervasive historical legacy of colonisation, diverse environmental experiences and contemporary social and economic circumstances of Aboriginal people” (Walker, Schultz & Sonn, 2014. p. 199). An understanding of these factors combined with critical self-reflection about one’s own values and belief systems, encourages the development of empathy and capacity to view the world through a different cultural lens (Walker et al., 2014). These are essential attributes of health professionals working in Aboriginal contexts and assist in the development of trust and successful relationship building. They also facilitate the provision of a culturally safe environment in which health care takes place.

As the argument for a culturally responsive health care system gained traction over the last decade, so too did the higher education sector’s commitment to train a culturally competent health care workforce. The context of these developments is considered in the following section and reviewed in more detail in Chapter Three.
2.10 Universities as agents of change: a commitment to implement Indigenous cultural competency in the higher education sector

This section contextualises developments in Australian universities that influenced the directions of this research project. An important milestone in this respect was the collaborative project *Indigenous Cultural Competency in Australian Universities*, undertaken by Universities Australia and the Indigenous Higher Education Advisory Council (IHEAC) in 2009-11. The project developed a *National Best Practice Framework for Indigenous Cultural Competency in Australian Universities* which was underpinned by the notion that the higher education sector must commit to:

- a review and implementation of appropriate accountability and reporting structures, policies and procedures;
- cultural competency training of university staff;
- increasing institutional engagement with Indigenous communities and organisations;
- Indigenisation of the curriculum within sound pedagogical frameworks;
- pro-active provision of support and services to Indigenous students and staff;
- the widening of Indigenous involvement in the life and governance of the university through the inclusion of Indigenous cultures and knowledge as a visual and valued part of university life and decision-making.

(Universities Australia, 2011, p. 3)

Indigenous cultural competence was defined as:

> Student and staff 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, p. 3)

The authors noted that the Royal Commission of Inquiry into Aboriginal Deaths in Custody (1991) was the first major national inquiry to document the severity of Aboriginal socio-economic disadvantage and to draw attention to the standard and appropriateness of professional services delivered to Aboriginal people (Universities Australia, 2011). The Commissioners argued that many professionals worked within a neo-colonial framework, had little knowledge or understanding of Aboriginal cultures and histories and lacked practical skills to work respectfully in these contexts (Universities Australia, 2011). They recognised that meaningful
reconciliation between Aboriginal and non-Aboriginal Australians depends upon widespread civic education about our shared history, inclusive citizenship and acknowledgement of Aboriginal forms of learning: on-going ignorance and arrogance in the dominant society had produced divisiveness and alienation.

A stocktake of existing Indigenous cultural competency initiatives and programs in Australian universities and the findings of pilot programs at Edith Cowan University and the universities of Wollongong, Newcastle and Western Australia informed the final National Best Practice Framework. Consideration was also given to international examples of best practice for embedding Indigenous content into curricula, especially in comparable countries such as Canada, New Zealand and the United States of America. A companion website was developed to provide resources and curriculum guidelines for the implementation of the Framework recommendations (Universities Australia, 2011).

Five key guiding principles for embedding Indigenous cultural competency into higher education institutions were presented in the Framework under the following themes: university governance; teaching and learning; Indigenous research; human resources; and community engagement. With reference to teaching and learning, the guiding principle stated that “all graduates of Australian universities should be culturally competent” and that this outcome would “help to close the gap in the socio-economic disparity experienced by the majority of Indigenous Australians” (Universities Australia, 2011, p. 9). Recommendations to assist the implementation of this guiding principle included embedding Indigenous knowledges and perspectives into all university curricula; the inclusion of Indigenous cultural competency as a formal graduate attribute; the utilisation of a culturally competent pedagogical framework in curriculum development; staff training in Indigenous pedagogy; and reporting mechanisms and quality assurance measures linked to Indigenous studies curricula (Universities Australia, 2011). It should be noted that while some universities had developed and implemented such initiatives, the document emphasised responsibilities across the whole higher education sector.

The authors argued that it is the responsibility of universities who are educating the next generation of professionals “. . . to engage students in a critical inquiry into the nature of their profession – its history, assumptions and characteristics, its role in structuring Australian society, and its historical and contemporary engagement with Indigenous communities and Indigenous people” (Universities Australia, 2011, p. 19). Graduates who are informed about Indigenous Australians and their knowledge systems are better equipped to be agents of change in their professional organisations and workplaces. This is not to suggest however, that students will be automatically receptive to the content or, if they are, will not encounter organisational resistance.
to their suggestions for change. It was recommended that strategies to deal with these potential problems also be addressed in curricula.

## 2.11 Midwifery education

### 2.11.1 National Competency Standards for the Midwife

Until 2010, the development and maintenance of national competency standards in midwifery were handled by the Australian Nursing and Midwifery Council (ANMC). Following the new National Registration and Accreditation Scheme in 2010 and the ANMCs appointment as the independent accrediting authority for the nursing and midwifery professions, the ANMC became known as the Australian Nursing and Midwifery Accreditation Council (ANMAC). Earlier work by the ANMC in consultation with State regulatory authorities resulted in position statements and guidelines on the development of competency standards and the first edition of the *National Competency Standards for the Midwife* was published in 2006. These standards remain unaltered but the original publication is now the property of the Nursing and Midwifery Board of Australia as the responsible regulatory body.

Competency standards provide “...the detail of the skills, knowledge and attitudes expected of a midwife to work within the midwifery scope of practice” (ANMC, 2006, p.10). Competencies fall within four domains: legal and professional practice; midwifery knowledge and practice; midwifery as primary health care; and reflective and ethical practice. Key elements are identified in each competency and cues elucidate how competencies are actioned. While all domains and competencies have a bearing on the delivery of services to Aboriginal women, the domain “midwifery as primary health care” makes specific reference to the needs of these women in Competency 10: “Ensures midwifery practice is culturally safe” (ANMC, 2006, p.23). Element 10.1 expands the competency: “Plans, implements and evaluates strategies for providing culturally safe practice for women, their families and colleagues”, while cues are identified as:

- Incorporates knowledge of cross cultural and historical factors into practice.
- Demonstrates respect for differences in cultural meanings and responses to health and maternity care.
- Recognises the specific needs of Aboriginal and Torres Strait Islander women and their communities.
- Recognises and respects customary law. (ANMC, 2006, p. 23)
Other competencies in this domain refer to the protection of the rights of women, families and communities, the importance of collaborative midwifery practice and the active support of midwifery practice as a public health strategy. In particular, this last strategy draws attention to the social determinants of health and the need to consider issues of equity of access to services for marginalised populations (ANMC, 2006).

In 2007 the ANMC endorsed an updated position statement which required the “Inclusion of Aboriginal and Torres Strait Islander Peoples Health and Culture Issues in Courses Leading to Registration or Enrolment” (ANMC, 2007, p. 9). This statement, which was supported by the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN), required education providers to include content on Aboriginal history, health and cultures in nursing and midwifery programs to better prepare students to work in a culturally safe way with Aboriginal patients. It is likely that this development was influenced by the publication of the “gettin em n keepin em” report of the Indigenous Nursing Education Working Group (INEWG) which recommended the implementation of compulsory content on Indigenous cultures, health and history in all undergraduate nursing and midwifery curricula (INEWG, 2002).

2.11.2 Codes of ethics and professional conduct for midwives in Australia

The competency standards document is closely related to two codes: the Code of Ethics and the Code of Professional Conduct for midwives in Australia, revised versions of which were drafted in 2006 and published in 2008. The Code of Ethics identifies eight value statements which include that midwives value: quality care for each woman and her infant; respect and kindness for self and others; the diversity of people; access to quality care for each woman and her infant; informed decision-making; a culture of safety; ethical management of information and a socially, economically and ecologically sustainable environment promoting health and wellbeing (NMBA, 2008).

The companion professional conduct document sets out expected national standards of professional conduct under three broad principles: that midwives should practice competently in accordance with legislation, standards and professional practice; within a woman-centred framework; and that practice should be reflective and ethical (NMBA, 2008). Ten conduct statements associated with these principles provide guidance to midwives on expected professional conduct and have much in common with the Code of Ethics and the competency standards documents, which are to be read in conjunction. The explanation attached to Conduct Statement Four: “Midwives respect the dignity, culture, values and beliefs of each woman and her infant(s) in their care, and the woman’s partner and family, and of colleagues” makes it clear that midwifery practice must be non-discriminatory, culturally safe, respectful of cultural
knowledge and proactive in the observance of any discriminatory attitudes and behaviours (NMBA, 2008).

The values for guiding the behaviour and ethical standards of midwives and clinical practice requirements that are set out in these documents are relevant not only to practicing midwives and students, but also to those involved in teaching and research and ultimately to the recipients of midwifery services. Women-centred midwifery practice is the framework upon which these codes are based and competency standards rest. While the special cultural needs of Aboriginal women are recognised, numerous factors impede the delivery of the best possible care, including geographical location, the complexity of the health care system and the level of trust that women have in health care providers. Midwifery programs that not only provide students with knowledge about Aboriginal health and cultures but also clinical practice opportunities in diverse Aboriginal settings, go some way towards ensuring that the competency standards and codes formulated by the profession are put into practice and are meaningful to the communities they serve. **Figure 2.2** provides a timeline of significant milestones in the process towards developing a more culturally competent midwifery workforce.

**Figure 2.2** Timeline of significant milestones in the on-going development of a culturally competent midwifery workforce.

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002-2006</td>
<td>&quot;gettin em n keepin em&quot; report (INEWG, 02); National Competency Standards for the Midwife (ANMC, 06)</td>
</tr>
<tr>
<td>2007</td>
<td>Closing the Gap strategy (COAG); update of position statement on Aboriginal content in programs (ANMC)</td>
</tr>
<tr>
<td>2008</td>
<td>National Apology; Closing the Gap Statement of Intent; Code of Ethics &amp; Code of Professional Conduct (NMBA)</td>
</tr>
<tr>
<td>2009</td>
<td>National Maternity Services Plan (ANMAC)</td>
</tr>
<tr>
<td>2011</td>
<td>National ATSI Health Plan; National Best Practice Framework for Indigenous Cultural Competence in Australian Universities (UA)</td>
</tr>
<tr>
<td>2012</td>
<td>National Anti-Racism Strategy; &quot;Characteristics of culturally competent maternity care for ATSI women&quot; for NMSP (Kruske); Birthing on country report (Kildea &amp; Van Wagner)</td>
</tr>
<tr>
<td>2013</td>
<td>National ATSI Health Plan; National Best Practice Framework for Indigenous Cultural Competence in Australian Universities (UA)</td>
</tr>
</tbody>
</table>
2.11.3 Aboriginal maternity workforce issues

While the focus of this research is on Aboriginal content in midwifery curricula and its impact on students and service delivery, the NMSP makes it clear that the provision of culturally competent care is also dependent upon increasing the numbers in the Aboriginal maternity workforce and supporting and retaining these workers (AHMAC, 2011). The AIHW (2013) reported that there has been a large decrease in the numbers of midwives in Australia since 2009 from over 50,000 to just under 34,000 compared with a 10% increase in the number of registered nurses. It is suggested that many dual registered nurse/midwives are not actively working in midwifery. Aboriginal midwives numbered only 186, equating to 0.8% of all employed midwives, although under the category “nurses and midwives” 2601 identified as Aboriginal, representing 0.9% of employed nurses and midwives (AIHW, 2013). Either way, Aboriginal nurses and midwives are seriously under-represented in the health care workforce.

Despite low numbers, a comprehensive study of Aboriginal health labour force patterns published by the AIHW (2009) revealed that the number of Aboriginal medical practitioners and nurses has been on an upward trajectory since the late 1990s. The total number of registered nurses also increased over this period and at a higher rate than for Aboriginal nurses and there was a decline in the number of enrolled nurses, both Aboriginal and non-Aboriginal (AIHW, 2009). Some measurement difficulties have been identified with the data including variable response rates, identification of Indigenous status and the amalgamation of “nursing and midwifery” as a category.

Aboriginal Health Worker (AHW) numbers have also steadily increased, with the largest percentage (29%) working in hospitals (AIHW, 2009). Health Workforce Australia (2014) reported that the Aboriginal Health Worker workforce almost doubled from 672 to 1256 between 1996 and 2011. AHWs have a minimum baseline qualification in primary health care or clinical practice, and national competencies introduced in 2007 underpin these qualifications (AIHW, 2009). AHWs can specialise and strengthening their role in partnership with midwives and obstetricians has produced positive results in a number of States (Stamp et al., 2008). Interviews with Aboriginal Maternal and Infant Care Workers (AMICW) in South Australia revealed the breadth of their role, including antenatal education and care, support during labour and the postnatal period and breastfeeding. Crucial aspects of the role included the provision of culturally safe services and advocacy for Aboriginal women in hospital (Stamp et al, 2008). Although there is a shortage of Aboriginal midwives, AHWs and AMICWs continue to provide vital services to mothers and infants in communities. While their roles are significant and valued
in their own right, access to professional development pathways into nursing, midwifery or medicine is one promising strategy to enhance the numbers of Aboriginal health professionals.

2.12 Chapter summary

This chapter has provided a context for the research which explores culturally secure practice in midwifery education and service provision for Aboriginal women. An overview of Aboriginal maternal and infant health outcomes was followed by a discussion of models of health, the application of a social determinants approach in Aboriginal settings, and the importance of traditional health beliefs and practices, especially surrounding pregnancy and birthing. The *Closing the Gap* policy framework and developments in higher education and the midwifery profession that support Indigenous cultural competency were discussed in light of recent government and industry reports. Finally, reference was made to maternity workforce issues, including the national shortfall in Aboriginal health professionals. This chapter sets the scene for a review of the extensive literature surrounding the rise of cultural competence, its development and application in various settings, and its critics who propose alternative concepts that have utility in Aboriginal contexts.
Chapter Three: Review of the Literature.

3.1 Introduction to the chapter

This chapter is divided into three sections. The first section reviews selected international cultural competence literature in health service delivery and higher education. Reference is made to definitions and terminology, key debates and developments in the field, measurement tools and pedagogical approaches to cross-cultural education. The concept of cultural competence is critically analysed and gaps in knowledge identified. The second section explores developments in cultural competence in the Australian context. Literature reviewed focuses on the rise of the concept of Indigenous cultural competence, teaching and learning approaches to the inclusion of Aboriginal content in Australian higher education curricula and organisational initiatives in this area. The third section reviews selected literature on cultural competence within midwifery education and practice as it relates to Australian Aboriginal populations. Midwifery training, culturally safe practice interventions, Aboriginal authoritative knowledge with respect to pregnancy and birthing, birthing on country and future challenges and research directions are discussed. Within the context of potential policy developments in remote Australian Aboriginal settings, reference is made to literature on birthing initiatives among the Inuit of Northern Canada.

The past two decades have seen a rapid increase in research papers and commentary on cultural competence as the complex relationship between culture and health is interrogated. The focus of this chapter is upon selected peer-reviewed journal articles, book chapters and grey literature, including reports from government and non-government organisations. Material reviewed directly informs the principal research objective: exploring the concept of culturally secure practice in midwifery education and its application in service provision for Aboriginal women. Material not relevant to this objective was excluded. A published article that critiques the concept of cultural competence is also included in this chapter.
3.2 Cultural competence in health service delivery and higher education: an overview of international developments

3.2.1 Significant milestones: the Georgetown monograph, the National Center for Cultural Competence and the “Unequal Treatment” report

The concept of cultural competence and its application in health service delivery emerged from a series of seminal monographs published by Cross, Bazron, Dennis and Isaacs (1989) at Georgetown University Child Development Centre, Washington DC. The aim of the first monograph was to provide “a philosophical framework and practical ideas for improving health service delivery to children of colour who are severely emotionally disturbed” (Cross et al., 1989, p. 1.) “Children of colour” referred to African Americans, Asian Americans, Hispanic Americans and Native Americans. Key themes identified in the monograph include a strengths-based approach; recognition that cultural competence is a developmental process that must pervade policy-making, administration, practitioner and consumer sectors of an institution or agency; and the requirement for services to be adaptable and creative in responding to the needs of culturally diverse recipients (Cross et al., 1989).

Within this context, cultural competence was defined as “a set of congruent behaviours, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations” (Cross et al., 1989, p. 13). The urgency of the task to transform health service delivery for minority groups was reinforced by demographic calculations: by the year 2000 it was estimated that 40% of clients would be from minority groups (Cross et al., 1989). This concept of cultural competence is based upon a developmental continuum with “cultural destructiveness” at one end and “cultural proficiency” at the other. Various stages along the continuum are identified including incapacity, blindness, pre-competence, competence and proficiency. The stages are defined as follows:

- Cultural destructiveness: attitudes and practices (as well as policies and structures in organisations) are destructive to a cultural group.
- Cultural incapacity: lacking the capacity to respond effectively to the needs, interests, and preferences of culturally and linguistically diverse groups.
- Cultural blindness: the predominant philosophy is one that views and treats all people as the same.
- Cultural pre-competence: there is awareness of strengths and areas for growth to respond effectively to culturally and linguistically diverse populations.
• Cultural competence: acceptance and respect for culture is consistently demonstrated in policies, structures, practices and attitudes.
• Cultural proficiency: culture is held in high esteem and used as a foundation to guide all endeavours.

(Cross et al., 1989, pp. 14-17)

Movement along the continuum is influenced by many factors including exposure to culturally diverse groups and the enhancement of knowledge and shifting of attitudes in response to educational programs. Cross et al. (1989) identified five components of a culturally competent system of care: valuing diversity; capacity for cultural self-assessment; consciousness of the dynamics inherent when cultures interact; institutionalised cultural knowledge and developed adaptations to diversity. It is considered vital that these components be reflected across all levels of a system or agency and be underpinned by a set of values that respect cultural diversity.

The significance of this ground breaking monograph cannot be over-estimated. Its “whole of organisation” approach to addressing limitations in health service delivery to minority populations spawned a burgeoning field of literature on cultural competence in the health professions. While ideas have been re-examined, contested and refined, the early work of Cross and colleagues was very influential and ultimately led to the establishment of the National Center for Cultural Competence (NCCC) at Georgetown University, Washington DC. Established in 1995, the NCCC is located in the Georgetown University Centre for Child and Human Development (http://nccc.georgetown.edu/about.html). The NCCC’s Report of Significant Accomplishments (2011, p. 1) noted that the aim of the NCCC was to:

. . . provide national leadership and contribute to the body of knowledge on cultural and linguistic competence within systems and organisations and the relevance of these practices to: 1) respond to the growing diversity in the US, it’s [sic] territories and tribal communities; 2) address health and mental health care disparities and inequities; and 3) design services and supports that take culture and language into consideration within the contexts of social determinants and life course approach(es) in MCH (Maternal and Child Health).

The focus of the NCCC is upon “translating evidence into policy and practice” in three main areas: measurement and assessment of cultural and linguistic competence; expanding the body of knowledge that guides policy and practice and influencing academia, particularly with respect to curricula and pedagogies (NCCC, 2011, p. 1). The NCCCs widely used Cultural Competence Health Practitioner Assessment tool, developed in 2001, is a validated self-
assessment instrument designed to enable health care providers to assess their capabilities to work with culturally diverse and under-served communities. Nurses accounted for nearly 60% of the 13,791 visitors to the site in 2010-11 (NCCC, 2011, p. 2).

The work of the NCCC gained momentum at a time when disparities in health for minority groups were highlighted in the significant Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Smedley, Stith, & Nelson, 2002). This report systematically examined the extent of racial/ethnic disparities in health care in the United States and identified the culture of medicine as a contributing factor. It is widely accepted that many determinants of disparities in health outcomes for minority groups are social in nature and largely external to the health delivery system. For example, economic disadvantage, racism and lower levels of employment, education and health insurance, are all implicated in poorer health outcomes (Betancourt et al., 2003). However, for minority groups who access the health care system, disparities remain even after controlling for variables such as socio-economic status. This observation, highlighted in numerous case studies in the *Unequal Treatment* report, draws attention to the importance of cultural variations in health beliefs and practices, behaviours and communication between patients and health care providers (Betancourt et al., 2003).

The IOM report explored the impact of health system, provider and consumer factors on health care and confirmed the presence of disparities based on racial/ethnic identification. The requirement that “cross-cultural education should be integrated into the training of all current and future health care professionals” is included in its recommendations (Betancourt & King, 2003, p. 289). Many academic institutions and health care organisations began to develop cultural awareness programs that aimed to heighten practitioner sensitivity to the socio-cultural context of patients’ lives. Ultimately these were refined and expanded to include issues that went beyond cultural awareness, including the presence of systemic institutional racism in health care settings. Lo and Stacey (2008) noted that in 2003 the Office of Minority Health established standards for *Culturally and Linguistically Appropriate Services* and universities responded by including cultural competency training in medical schools.

3.2.2 Earlier influences

The impact of culture in clinical encounters had not gone unnoticed prior to the publication of the IOM report. Kleinman, Eisenberg and Good’s (1978) seminal article *Culture, Illness and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research* highlighted the importance of culture in clinical settings and Kleinman’s (1981) book *Patients and Healers in
the Context of Culture drew upon a decade of empirical research in China. Kleinman, a professor of psychiatry and medical anthropology at Harvard University, is well known for his “explanatory models approach”, an interview technique that elicits patients’ perceptions and experiences of their illness and is widely used in American medical schools (Kleinman & Benson, 2006). This approach, which falls under the ambit of “cross-cultural medicine”, is closely aligned with earlier notions of “patient-centred care”, or “seeing through the patient’s eyes” (Saha, Beach & Cooper, 2008, p. 1276). As discussed later, Kleinman is a critic of the “fashionable” term “cultural competency” and suggests that there is little robust evidence to support the notion that “. . . attention to culture really improves clinical services”, despite its significance in the clinic and its capacity to enhance health service utilisation (Kleinman & Benson, 2006, p. 1673).

Another precursor to the rise of cultural competence in the health professions was the transcultural nursing movement, which gained momentum in the 1960s and 1970s in the United States (Thomson, 2005, p. 6). Leininger (1997, p. 342), who established this movement, described transcultural care as “. . . formal areas of study and practice in the cultural beliefs, values and life ways of diverse cultures and in the use of knowledge to provide culture-specific or cultural-universal care to individuals, families and groups of particular cultures”. Early developments in transcultural nursing models focused on ethno-specific cultural knowledge, however, as Downing, Kowal and Paradies (2011) noted, self-awareness and reflexivity on the part of health professionals are now recognised as essential aspects of the care-giving process and integral to transcultural nursing practice. Grote (2008), in a review of cultural competency literature, suggested that Leininger’s “Sunrise Model” encouraged emic (insider) and etic (outsider) perspectives on cultural practices and noted that a holistic understanding of health care can only be achieved by considering a range of patient characteristics, including cultural values, politics and law, kinship patterns, religion and education. While early iterations of the transcultural model failed to consider organisational and systemic barriers to reducing inequities in health care delivery, these failings have been addressed by more recent proponents of the model now called “transcultural competence” (Grote, 2008, p. 13).

3.2.3 Alternative international terminology and refinements to the concept of cultural competence

While transcultural nursing models and the concept of cultural competence gained traction in the United States, nurses and midwives in Aotearoa/New Zealand developed their own model of cultural safety that responded to the health care needs of Maori (Downing et al., 2011). Cultural safety was defined as:
The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.

(Le Kaunihera Tapuhi o Aotearoa: Nursing Council of New Zealand, 2011, p. 7)

The concept of cultural safety was formalised in 1988 at a hui (meeting), a national gathering of nurses and students in Christchurch. At a subsequent hui for Maori nursing teachers in 1989, a set of cultural safety standards were developed and became known as Kawa Whakaruruwhau (Papps & Ramsden, 1996; Thompson, 2005). Proponents of this concept distinguished it from the transcultural nursing movement by placing emphasis upon power differentials in health care settings and on the consumers of health care who define whether cultural safety is present. Downing et al., (2011, p. 249) noted that cultural safety was designed to:

... address the way in which colonial processes and structures shape and negatively impact Maori health ... emphasis is placed on assisting the health worker to understand processes of identity and culture, and how power imbalances or relationships can be culturally unsafe.

This concept required understanding of the social, political and historical contexts that influenced health care delivery and Maori health outcomes. The focus is upon the system of care as well as the participants, including providers and consumers. The Nursing Council of New Zealand (1996, p. 7) noted that “... the ideas and theories of cultural safety arose from the painful experience of many Maori with the health service provided by Governments since the nineteenth century”. The provision of culturally safe care is intricately linked to the Treaty of Waitangi, which guarantees Maori control over Maori issues, a concept known as tino rangatiratanga (Nursing Council of New Zealand, 1996).

It is unsurprising that the concept of cultural safety, which developed in response to Maori dissatisfaction with health care delivery, has been adopted in other post-colonial settings, including Canada and Australia. For example, the National Aboriginal Health Organisation in Canada advocates that cultural safety be grounded in the historical context of Aboriginal experience (Kirmayer, 2012). The term “Aboriginal” in the Canadian Constitution includes First
Nations, Metis and Inuit peoples (Indigenous Physicians Association of Canada and Association of Faculties of Medicine of Canada, 2009). Unlike cultural competence, which emphasises knowledge acquisition, cultural safety is a politically charged concept that focuses attention on the recipients of care and the power imbalances that characterise clinical encounters. These imbalances are framed in terms of socio-economic, historical and political circumstances that adversely affect health outcomes for Aboriginal populations (Kirmayer, 2012). The concept of cultural safety has been criticised for its focus on the vulnerabilities of health service recipients, thus contributing to the “essentialising” process, rather than recognising strengths brought to the clinical encounter by diverse cultural groups. Furthermore, as with most approaches to culturally inclusive care, little is known about the implementation of cultural safety and its impact on improved health outcomes (Kirmayer, 2012).

In the 1990s, the concept of cultural competence was refined and varied frames of reference for culturally inclusive health care arose. Tervalon and Murray-Garcia (1998) proposed the concept of “cultural humility” as a response to narrowly defined and assessed cultural competence strategies in United States’ medical schools. They noted that cultural competence is viewed as “... an easily demonstrable mastery of a finite body of knowledge, an endpoint evidenced largely by comparative quantitative assessment ...” (Tervalon & Murray-Garcia, 1998, p. 118). Cultural humility, on the other hand, required practitioners to engage in self-reflection, consider the power imbalances present in clinical encounters and develop respectful partnerships with local communities.

Tervalon in particular, has promoted the concept of cultural humility widely, including in Australia as a keynote speaker at the Poche Centre for Indigenous Health and Well-Being Symposium and Roundtable Having the Hard Conversations at Flinders University, South Australia in 2015. A paediatrician and community activist from an African-American background, Tervalon has been described as “being outspoken about being humble”. She suggested that the term humility:

remind(s) us to not be so arrogant or prideful or really think that we have to be all-knowing and all-knowledgeable ... which of course we can’t be ... cultural humility encourages physicians to politely ask about the needs and practices of those seeking treatment - and to avoid assumptions or snap judgments based on gender, ethnicity, economic status, or other aspects of a patient’s identity.

(Tervalon, 2012, http://berkeleyhealth.berkeley.edu/2012/10/)
Tervalon and Murray-Garcia (1998) acknowledged the importance of practitioner awareness of diverse health beliefs and practices, but caution against the false sense of security that such information provides, and the consequent stereotyping that may arise. They also highlighted the limited value attached to enhanced knowledge that is not accompanied by attitude and behaviour change. At the heart of the education process should be the provision of:

. . . intellectual and practical leadership that engages physician trainees in an on-going, courageous, and honest process of self-critique and self-awareness. Guiding trainees to identify and examine their own patterns of unintentional and intentional racism, classism, and homophobia is essential.

(Tervalon & Murray-Garcia, 1998, p. 120)

Patient-focused interviewing and care is fundamental to the practice of cultural humility as it demands recognition of the patient’s knowledge about themselves and their experiences and requires the physician to step back from their role as “expert” or, at the very least, to appreciate the notion of a therapeutic partnership (Tervalon & Murray-Garcia, 1998). The concept of cultural humility with its emphasis on patient-centred care is not dissimilar to Kleinman’s (1981) “explanatory models approach”. Like Kleinman, these authors eschew the “cultural trait” mentality and instead emphasise the process, relationship and advocacy aspects of culturally inclusive care. While cultural humility is viewed as a process that has defined measurable outcomes, Tervalon and Murray-Garcia (1998) noted that measurement of behaviour change and improved health outcomes is under-researched and this remains true today.

Campinha-Bacote (2002) also refined the concept of cultural competence and its application in a nursing context. The notion of “cultural desire” is considered the “key to unlocking cultural competence” (Campinha-Bacote, 2003, p. 239). It has been suggested that Campinha-Bacote’s model is perhaps the most influential in the cultural competence field as it can be applied to health care delivery, policy development and culturally sensitive research (Nash, Meiklejohn & Sacre, 2006). The model, *The Process of Cultural Competence in the Delivery of Health Care Services*, includes a number of interrelated components: cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. It builds on the ideas of earlier writers in the field, especially Sue (1990), whose work was applied to psychological counselling, and its development was influenced by Campinha-Bacote’s experience as a psychiatric nurse. The model “. . . blends the fields of transcultural nursing, medical anthropology and multicultural counselling” (Campinha-Bacote, 2002, p. 181). While the first four components of the model are self-explanatory, cultural desire is defined as:
. . . nurses’ motivation to “want to” engage in the process of becoming culturally aware, culturally knowledgeable, and culturally skilful, and seeking cultural encounters. . . [it] includes a passion for and commitment to the process of cultural competence and will inspire us to examine uncomfortable subjects, such as racism.

(Campinha-Bacote, 2003, p. 239)

Self-examination is fundamental to this model and in this respect it can be compared with other models discussed, however it differs in that each component is interdependent rather than developmental in nature. The concept of cultural desire is closely related to that of cultural humility as it includes a willingness to learn from others as cultural informants. Campinha-Bacote (2002, p. 183) herself notes “. . . this type of learning is a life-long process that has been referred to as ‘cultural humility’ ”.

The “Purnell Model for Cultural Competence” was also developed in a nursing context in the late 1990s but is widely used across practice disciplines in many countries (Purnell, 2002). Schematically, the model depicts a circle, the outlying rim of which represents global society. Moving inwards, subsequent circles denote community, family and the individual. Twelve pie-shaped wedges which depict related cultural domains form the interior of the concentric circles and include concepts such as heritage, communication, workforce issues, nutrition, pregnancy and child-rearing practices, spirituality and health practices (Purnell, 2002). This nonlinear model aims to provide general and culturally-specific knowledge to health care providers and has been used in research, clinical practice, education and administration. A summary of various international approaches to culturally inclusive health care delivery discussed in this section is provided in Table 3.1.
Table 3.1 Culturally inclusive health care delivery: international approaches in the United States of America, Canada and New Zealand.

<table>
<thead>
<tr>
<th>Culturally-inclusive approaches</th>
<th>Early iterations and settings</th>
<th>Health disciplines and focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transcultural nursing (Leininger); Transcultural Competence.</td>
<td>Late 1950s-early 1960s USA</td>
<td>Nursing, midwifery. Study of cultural beliefs, values and practices of diverse groups and use of knowledge in provision of care; cultural characteristics identified; culturalism.</td>
</tr>
<tr>
<td>Cross-cultural medicine; “explanatory models; mini-ethnographies (Kleinman); patient -centred care.</td>
<td>1970s USA</td>
<td>Medical anthropology; medicine including psychiatry; health sociology. Interview technique elicits patients’ perspectives on illness to understand meaning; efforts to determine what matters most to the patient about the experience of illness and treatment; critique of “culture of medicine”.</td>
</tr>
<tr>
<td>Cultural awareness/ cultural sensitivity.</td>
<td>1970s USA, Canada</td>
<td>Anthropology, medicine, nursing, midwifery, allied health. Limited first step used in cultural training programs; recognition that more than awareness is needed to effect behavioural change and paralleled development of cultural competence &amp; safety concepts.</td>
</tr>
<tr>
<td>Cultural competence: (Cross et al.; Betancourt; Purnell; Campinha-Bacote &amp; others)</td>
<td>Late 1980s USA, Canada</td>
<td>Medicine, nursing, midwifery, allied health including psychology and social work. Health disparities; health care system &amp; providers; racism; organisational, systemic and clinical; knowledge, attitudes and skill development.</td>
</tr>
<tr>
<td>Cultural safety (Ramsden)</td>
<td>Late 1980s New Zealand; Canada</td>
<td>Nursing, midwifery, medicine, psychology, social work. Defined by those who receive care; attention to power imbalances due to colonial history; response to limitations of transcultural nursing.</td>
</tr>
<tr>
<td>Cultural humility (Tervalon &amp; Murray-Garcia)</td>
<td>Late 1990s USA</td>
<td>Medicine, nursing, midwifery. Response to narrowly defined and assessed concepts of cultural competence; examines unintentional &amp; intentional racism, classism and homophobia.</td>
</tr>
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</table>
3.2.4 Clarifying, applying and critiquing the concept of cultural competence (Article 1)

The origin, early influences and alternative terminology in the field of cultural competence have been outlined, with brief reference made to limitations of the concept. The following discussion looks more closely at cultural competence and reviews literature that addresses the scope, application, measurement and impact of the concept on health outcomes among culturally diverse populations. It includes a published article: Refining the concept of cultural competence: building on decades of progress (Thackrah & Thompson, 2013).

The most prolific writers in the field of cultural competence are located in the United States and given that the concept arose in this setting, this is unsurprising. Commentary on the concept has contested definitions and interpretations of cultural competence and the narrow use of the term “culture”; explored the “culture of medicine” and its role in perpetuating health inequities; and questioned the lack of rigorous evidence linking cultural competence to a reduction in health disparities in minority groups. In the first decade of the twenty-first century, as the concept was more widely used, it underwent closer scrutiny, with some writers identifying it with a new form of racism due to its apolitical stance and the “white” middle-class image attributed to many health professionals (Pon, 2009; Sakamoto, 2007). A considerable body of literature has also explored the integration of cultural competence into health professional training programs, especially medical and nursing schools. It should be reiterated that the focus of cultural competence is on the behaviour and practice of health care providers. While social determinants external to health care delivery are acknowledged as important contributors to disparate health outcomes, they are not the focus of cultural competence strategies.

Joseph Betancourt and colleagues at the Harvard Medical School and Massachusetts General Hospital in Boston made substantial contributions to cultural competence literature in the first decade of this century. The influence of earlier thinking is evident in Betancourt et al.’s (2003, p. 294) reference to a culturally competent health care system as one that “. . . acknowledges and incorporates - at all levels – the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs”. In addition, they noted that health systems must be aware of the interaction between health beliefs and behaviours, disease and treatment outcomes among culturally diverse groups, and the social context of patients’ lives that may operate independently of culture.
In an attempt to better define and operationalise the concept of cultural competence, Betancourt et al., (2003) reviewed the literature to identify: sociocultural barriers to care among culturally diverse groups, levels at which the barriers occurred, potential cultural competence interventions to address the identified barriers, and finally, to develop a framework incorporating the interventions to reduce health disparities based on racial/ethnic background. An important outcome of their review was the identification of organisational, structural and clinical barriers to the delivery of health care and the development of a new, practical framework that included interventions at each level of service delivery. A revised definition of cultural competence reflects this focus:

“Cultural competence” in health care entails: understanding the importance of social and cultural influences on patients’ health beliefs and behaviours; considering how these factors interact at multiple levels of the health care delivery system (e.g. at the level of structural processes of care or clinical decision-making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations.

(Betancourt et al., 2003, p. 297)

Significant organisational barriers identified include the under-representation of minority groups in the workforce and leadership positions of health care organisations, which results in a disconnect between organisations and the communities they serve. While structural barriers impact on all lower socioeconomic status recipients of care, they are particularly pertinent in culturally diverse populations, and include lack of interpreter services, long waiting times and complicated referral processes and pathways. Lastly, clinical barriers, which relate to interactions between patients and providers, often turn on poor communication and low levels of trust. Different sociocultural beliefs and practices that are not understood or accepted by providers lead to patient dissatisfaction, lower levels of compliance and ultimately poorer health outcomes (Betancourt et al., 2003).

Proposed interventions to address organisational and structural barriers include recruitment efforts in minority populations to increase the numbers working in hospitals and training institutions, linguistically appropriate educational materials, and improved design and functioning of health delivery systems. Interventions to address clinical barriers focus on the requirement of cross-cultural curricula in health provider training programs, with particular attention paid to provider attitudes and practices (Betancourt et al., 2003). These interventions form the planks of the practical framework where cultural competence is seen as “... a key cornerstone in efforts to eliminate racial/ethnic disparities in health and health care” (Betancourt et al., 2003, p. 300).
The identification of barriers to culturally inclusive health care, potential interventions and a framework to guide implementation arose out of an in-depth investigation conducted by Betancourt, Green and Carrillo (2002) and published as *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*. The study explored the range of definitions of cultural competence and reviewed models of culturally competent care in different settings, including programs located within academic institutions, government, managed care and community health settings. They reported that experts working in the field saw a close connection between cultural competence, the quality improvement movement and the elimination of health disparities among cultural minorities, despite the fact that only a few studies make this link. The urgent need to “... translate cultural competence into quality indicators or outcomes that can be measured” was also identified (Betancourt et al., 2002, p. 6).

This important study provided Betancourt and colleagues with the raw material that not only added conceptual clarity to the concept of cultural competence but also provided a framework for its implementation. It led Betancourt (2003) to investigate cross-cultural medical education, where he assessed its impact, evaluation strategies and links between cross-cultural curricula and improved health outcomes among culturally diverse groups. Subsequently, he explored the links between quality improvement and cultural competence strategies and he remains a significant contributor to the field of cultural competence in health (Betancourt, 2006; Betancourt & Green, 2010; Betancourt, 2015).

The concept of cultural competence and its application in health care settings has also been closely examined by social scientists, who view narrow interpretations of culture as problematic. Descriptions that imply cultures are homogenous, static and divorced from the social, economic and political realities of people’s lives, run the risk of underestimating variations in beliefs and practices within cultural groups, and conflating culture with race and ethnicity (Carpenter-Song et al., 2007; Gregg & Saha, 2006; Kirmayer, 2012, Kleinman & Benson, 2006; Lo & Stacey, 2008). Furthermore, debate surrounds the role played by the “culture of medicine” in perpetuating inequities in health outcomes. Kleinman and Benson (2006) attributed the transmission of stigma and the presence of institutional racism in health care systems to the culture of biomedicine, which, as others have noted, is rarely interrogated (Good et al., 2003; Taylor, 2003). The dominance of biomedicine can produce a mismatch between professional socialisation, institutional practices and cultural competence strategies.

Other areas of debate concern the relationship between cultural competence and improved health outcomes, and the operationalisation of the concept. Prior to the work of Betancourt and colleagues, the unanswered question – can cultural competency reduce racial and ethnic health
disparities – was highlighted in a widely cited paper by Brach and Fraserirector (2000). The authors noted that “. . . while there is substantial research evidence to suggest that cultural competency should in fact work, health systems have little evidence about which cultural competency techniques are effective and less evidence on when and how to implement them properly” (Brach & Fraserirector, 2000, p. 181). Other writers have drawn attention to limited outcomes-based research that links cultural competence to better health, and to inadequate measures of the concept (Beach et al., 2005; Chun, 2010; Kumas-Tan, Beagan, Loppie, MacLeod & Frank, 2007; Lie, Lee-Rey, Gomez, Bereknyei & Braddock, 2011; Price et al., 2005). These issues, namely, narrow interpretations of culture, the culture of medicine and problems of measurement and limited outcomes-based research, remain the subject of debate, and are explored in the following article.
Refining the concept of cultural competence: building on decades of progress

The impact of culture in the clinical encounter is recognised as a contributing factor to patterns of health service utilisation and is a key focus of cultural competence training.1,2 While some studies have identified beneficial effects of cultural competence on health professionals’ knowledge, attitudes and skills, and on levels of patient satisfaction, few have explored its effects on health outcomes. This is unsurprising given that the factors affecting health outcomes are numerous and complex. The Commission on Social Determinants of Health has noted that health inequalities are largely related to the circumstances of people’s lives and to the services available to treat illness.3 In turn, people’s circumstances and the health care system are shaped by social, political and economic realities. Cultural knowledge is embedded in these circumstances and realities, and helps frame patients’ explanatory models of illness and clinicians’ decision making.2 It has been argued, however, that these two world views can collide in the clinical encounter.4 Cultural competence training aims to improve the quality of health care and reduce health disparities by focusing on communication and trust between patients and health care providers and enhancing provider knowledge about sociocultural factors linked to health beliefs, practices and utilisation of services.5

The idea of educating health professionals to be culturally competent began in earnest in the United States in the 1990s. The term “cultural competence” first emerged in the late 1980s and was defined as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations”.6 Cultural competence in health care was described as an emerging field in the US in 2002; however, over the past decade it has become firmly embedded in professional accreditation standards.7 In Australia, health professional competencies consistently make reference to cultural competence,8 and the concept has received legitimacy with its incorporation into significant health policy documents.10–13

While strategies associated with cultural competence aim to make services more accessible for patients from diverse cultural backgrounds, more recently they have focused on specific groups, particularly Indigenous Australians, where the failure of services to address large disparities in health outcomes is stark and confronting. Connecting Indigenous patients with the health system and communicating effectively can be challenging and has often not been done well (Box 1 and Box 2). Indigenous cultural competence has been identified as a desirable attribute of Australian health professionals.13–18 Perhaps as a result of the plethora of alternative concepts such as cultural safety, cultural awareness and sensitivity, cultural security and humility, and more recently cultural literacy, the use of an overarching term was inevitable, despite most concepts having different frames of reference.17,19 Cultural competence strategies usually target the health workforce with the aim of improving the interactions between the patient, the provider and the health care system, as the intermediate step to improving health care utilisation, service delivery and health outcomes. Many aspects of this concept remain the subject of debate.

Social science perspectives

Limitations of cultural competence highlighted by social scientists working in clinical and academic settings largely fall into three categories: lack of clarity around the concept of culture, inadequate recognition of the “culture of medicine” and the scarcity of outcomes-based research that provides evidence of efficacy of cultural competence strategies.

Cultural competence strategies aim to make health services more accessible for patients from diverse cultural backgrounds. Recently, such strategies have focused on specific groups, and particularly Indigenous Australians, where services have failed to address large disparities in health outcomes.

Limitations of cultural competence largely fall into three categories: lack of clarity around how the concept of culture is used in medicine, inadequate recognition of the “culture of medicine” and the scarcity of outcomes-based research that provides evidence of efficacy of cultural competence strategies.

Attention to cultural complexity, structural determinants of inequality and power differentials within health care settings not only provide a more expansive notion of cultural competence and a nuanced understanding of the role of culture in the clinic, but may assist in determining the contribution that cultural competence strategies can make to a reduction in health disparities.

For debate

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One of the Aboriginal doctors was doing a paediatric [paediatrics] trip and a patient had been driven overnight from Wiluna. And the doctors barely had time to see them [the family] and then they did not make them welcome, so this Aboriginal doctor was horrified. No wonder people don’t come back. It is the same with ordinary appointments. The reason why people miss appointments is because they can’t see the value of them. And I’ll ask them what happened at their outpatient appointment and they’ll say “They did what you do”. “What did they say?” “They said they will write you a letter”. “Did they examine you?” “Not really”. So there is a sense that these appointments are futile, especially the follow-up ones.

The young doctors that see the patients are afraid to discharge them from the clinic and so when they see them and everything is the same, they rebook them for another appointment for no good reason except they are too nervous to say “you don’t need to come back”.

It is a hassle to get a babysitter for your six kids, find transport, wait 4 hours … for nothing.

* Transcript notes from an interview with an experienced general practitioner who works at an Aboriginal Medical Service. The GP describes the lost time and opportunity costs for patients travelling great distances for appointments that may be very brief and perhaps not even necessary.

1 No wonder people don’t come back*

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Unpacking culture

While it is recognised that a patient’s cultural background may be significant in clinical encounters, lack of clarity about the concept of culture can distort its impact. Anthropology, the discipline from which the term “culture” originated, offers many definitions but most make reference to a system of shared meanings or guidelines that are inherited and provide a lens through which to view the world. Contemporary anthropologists stress variations that exist across cultures with respect to beliefs, practices, norms, behaviours and expectations. Helman, for example, notes that culture is “an increasingly fluid concept, which in most societies is undergoing a constant process of change and adaptation”. Social scientists stress that cultures are complex, heterogeneous and dynamic, and intricately connected to the social context of people’s lives.

So how does this understanding of culture differ from its usage in medical settings? Critics from social scientists suggest that culture is often conflated with race and ethnicity, resulting in reification of existing racial categories. Central to this criticism is the failure to recognise diversity within cultures and the concomitant reductionism whereby culture is identified as a variable associated with essential differences between groups. Culture is viewed as a “risk factor” and cultural attributes as potential sources of the problem. Kirmayer noted that culture has been framed in terms of “ethnoracial blocs” which “conflate language, geographic origin, ethnicity and race” and “do not capture the diversity of society and the rapidly growing numbers of people who define themselves in hybrid ways that cut across these categories or escape them entirely”.

Cultural competence literature tends to associate culture with group membership and shared beliefs and values that influence behaviour in health care settings. Not only does this approach underestimate cultural diversity within groups, but the process of “essentialising” culture removes individuals from their complex social worlds in which the structural and material determinants of inequality may be as powerful as cultural influences on health inequity. In an attempt to provide more conceptual clarity around cultural competence, Lo and Stacey coined the term “hybrid habitus” which interprets patients’ cultures as “the broad, less than fully conscious cultural orientations that shape a patient’s sense-making in clinical settings … [and] in turn, are shaped by surrounding, intersecting structural forces”. These forces may include socioeconomic status, gender, language and experiences of racism, all of which can interact with cultural orientations and influence the clinical encounter. This deeper understanding of culture in all its complexity has practical implications in health care settings. A patient’s culture is not reduced to stereotypical attributes, but rather understood as comprising layers of meaning that extend beyond values, beliefs and practices and are shaped by and in turn shape social structures.

However, any examination of the meaning and use of “culture” needs to consider the culture of medicine itself to assess its role in reproducing or addressing health inequities.

Culture of medicine

In the US, Good and colleagues questioned why disparities in health care continue to exist despite the introduction of cultural competence training in health professional programs. They suggested the need for a critical analysis of the culture of medicine where the “social processes within our complex medical institutions” are explored, including the presence of institutional racism, power imbalances and the role of professional socialisation. Taylor reinforces this, noting that cultural competence strategies have an over-emphasis on the patient’s culture with scant attention paid to the culture of biomedicine. Institutional and professional medical culture is characterised by expert language and efficiency in clinical decision making based on legitimate medical knowledge. Taylor suggests that “it is confidence in the truth of medical knowledge that underwrites physicians’ special power to alleviate suffering”. Medical knowledge is thus not seen as a cultural product but as “real” knowledge which leads her to describe medicine as “perceiving itself to be a ‘culture of no culture’”. While some may disagree with this, it has consequences for the development of cultural competence curricula that “go beyond focusing on ‘other’ cultural groups, and attend to cultural dimensions of medicine itself”. Central to this discussion is the potential mismatch between professional medical socialisation, institutional practices and cultural competence strategies. Indeed, clinicians sometimes can be at odds with institutional directives and feel constrained by administrative practices that may compromise patient care.

Despite cultural competence training becoming commonplace in medical programs in Australia and elsewhere, few studies have focused on the culture of medicine itself. As Good et al note “rarely do students have the time or the formal sanction to critically analyze the profession and institutions of care to examine how treatment choices, quality of care and research practices are shaped; or how medical culture may produce processes that evolve into
institutional racism … in clinical practice”.23 Kleinman and Benson go further, suggesting that the culture of biomedicine is “key to the transmission of stigma, the incorporation and maintenance of racial bias in institutions, and the development of health disparities across minority groups.”2 Implementing a more expansive notion of cultural competence that incorporates greater critical analysis of biomedicine has potential for less discordance between institutional culture and strategies aimed to improve culturally informed care.

Problems of measurement and limited outcomes-based research

Finally, critiques of cultural competence by social scientists and others have drawn attention to inadequate measures of the concept and the scarcity of outcomes-based research that links cultural competence strategies to better health.25–30 A study of quantitative measures of cultural competence found many hidden assumptions in survey questions designed to assess the impact of educational interventions, including the notion that frequent contact or immersion experiences necessarily enhance competence.29 Of course it’s hard in hospitals because doctors have so little time; but if they don’t explain things properly and patients don’t take their tablets because things aren’t clearly explained then they are wasting their time anyway.

Social science critiques of cultural competence highlight the lack of conceptual clarity around the use of the term “culture” in clinical encounters, inadequate recognition of the “culture of medicine” and a scarcity of outcomes-based research that provides evidence of efficacy in improving health. The value of training in cultural competence as an educational intervention will ultimately be validated by enhancing access to and achieving equity of health services and better health outcomes for culturally diverse groups. Given strong evidence that inequities in health arise from inequities in society, cultural competence strategies should not be divorced from addressing the material circumstances of people’s lives, an issue pertinent to the oldest and newest inhabitants of Australia. Perhaps there are unrealistic expectations about what culturally informed health care delivery can achieve in the absence of systematic attempts to break down barriers and address the material circumstances of people’s lives.

Conclusion

For debate

Social science critiques of cultural competence highlight the lack of conceptual clarity around the use of the term “culture” in clinical encounters, inadequate recognition of the “culture of medicine” and a scarcity of outcomes-based research that provides evidence of efficacy in improving health. The value of training in cultural competence as an educational intervention will ultimately be validated by enhancing access to and achieving equity of health services and better health outcomes for culturally diverse groups. Given strong evidence that inequities in health arise from inequities in society, cultural competence strategies should not be divorced from addressing the material circumstances of people’s lives, an issue pertinent to the oldest and newest inhabitants of Australia. Perhaps there are unrealistic expectations about what culturally informed health care delivery can achieve in the absence of systematic attempts to break down barriers and address the material circumstances of people’s lives.

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Further to the critique of cultural competence provided in this article, concerns have been raised about the application of the concept in diverse professional settings including social work, mental health and counselling. Pon (2009, p. 60) suggested that cultural competence “. . . bears striking similarities to new racism”, which is described as racial discrimination based not on biology, but on culture. This criticism extends the “essentialising culture” limitation previously identified, and refers to the “othering” of non-whites, albeit without racialist language. Pon (2009, p. 59) also lamented the fact that the concept of cultural competence views culture as “. . . neutral and devoid of power”. Sakamoto (2007) also grappled with the apolitical nature of the concept. Drawing on the Canadian experience and using “whiteness” as a lens, she suggested a re-visioning of cultural competence so that it is “. . . simultaneously framed by anti-oppressive principles while also being open to different ways of knowing” (Sakamoto, 2007, p. 109).

Analysis of structural oppression and power relations between service users and providers underpins anti-oppressive practice, whereas “whiteness” is viewed as a form of domination of one group over another based on the dynamics of power and the legacy of colonisation (Sakamoto, 2009). With reference to Native American populations, Weaver (2004, p. 21) also expressed the need for a stronger focus on “. . . social justice and confronting racism as important components of culturally competent care” and suggests that these had been obscured by a “. . . conceptualization of cultural competence that has been highly focused on individual interactions”.

Tyson (2007, p. 1341) posed another uncomfortable question: “can cultural competence be achieved without focusing specifically on racism and the related issue of white privilege?” Institutional racism is described as differential access to goods and services based on race, while white privilege refers to “. . . unearned assets that a person who is white can count on . . . (that is) the natural order of things” (Tyson, 2007, p. 1342). While Pon (2009) suggested jettisoning the concept of cultural competence altogether because it does not address these important issues, Sakamoto (2007, p. 112), like Tyson, believes the concept has utility, but only if we are prepared to “. . . identify, name, resist and reconstruct our assumptions and knowledge bases. . . .”

3.2.5 Cultural competence in health professional programs: international developments in pedagogical thinking

The incorporation of cultural competency training into health professional programs in the higher education sector in the United States occurred through the 1990s, especially in schools of medicine and nursing. At the same time, health professional programs in New Zealand integrated the concept of cultural safety into curricula and professional competencies, and attention turned to best practice teaching strategies for effecting attitude and behavioural change. The relationship between culture and health highlighted by the transcultural nursing movement
and medical anthropologists received more attention when it was linked to health inequities. It was recognised that health provider education in cultural competence must commence before practitioners entered the health care system. The first decade of the twenty-first century saw the publication of numerous reports on cultural competence in health professional training, and an extensive body of literature that addressed various pedagogical approaches to embedding this content into curricula, including evaluation strategies to assess the impact of teaching and learning.

With reference to medical education in the United States, Betancourt (2003) noted that cross-cultural education emerged for three main reasons: to prepare providers to meet the health care needs of an increasingly culturally diverse population; to improve provider-patient communication, thus reducing racial/ethnic health disparities; and to meet new professional accreditation standards that required the inclusion of cross-cultural education in curricula. He suggested that training in cross-cultural medicine can be categorised into three inter-related approaches which focus on attitudes, knowledge and skills.

Characteristics required of all health professionals such as humility, respect, empathy and sensitivity are viewed as essential in cross-cultural encounters. Thus, the focus of the “awareness/sensitivity approach” is upon self-reflection including on one’s own culture, and the goal is enhanced provider awareness of sociocultural factors that influence the health beliefs and practices of culturally diverse patients (Betancourt, 2003). The acquisition of specific cultural knowledge which Betancourt (2003) labelled the “multicultural/ categorical approach” is fraught with difficulty due to the risks of stereotyping groups and under-estimating the dynamic nature of cultures. However, Betancourt (2003) noted instances where this approach is beneficial, including within community settings and where the knowledge has an evidence-based impact on health care delivery. The third approach, called “the cross-cultural approach” teaches:

. . . skills, that meld those of medical interviewing with the ethnographic tools of medical anthropology that focus on . . . communication skills and train learners to be aware of certain cross-cutting cultural issues, social issues, and health beliefs while providing methods to deal with information clinically once it is obtained.

(Betancourt, 2003, p. 562)

This patient-focused approach aims to elicit patients’ explanatory models and to assess and understand their sociocultural context. It is a practical approach and considered more appropriate in the later clinical years of a program. With respect to evaluation of the impact of cross-cultural
education, Betancourt (2003) identified inherent difficulties including social desirability bias, where learners may respond with socially acceptable answers; limitations of fact-based assessments due to the diversity among and within cultural groups; and perceptions that cross-cultural content may be viewed as ‘soft science’ and hence not valued. He recommended the inclusion of both qualitative and quantitative assessment strategies that separately target attitudes, knowledge and skills. He also noted limited evidence linking cross-cultural curricula to improved health outcomes and suggested evaluation strategies to investigate the relationship. These include quantitative and qualitative methods to explore whether trainees learned and used what had been taught, and the extent to which cross-cultural content in the program had an impact on health outcomes and the quality of health care delivery (Betancourt, 2003).

A significant characteristic of Betancourt’s (2003) conceptual model for teaching cross-cultural content is vertical integration. The sequencing of content and its inclusion at carefully considered points in the learning journey is viewed as fundamental to shaping attitudes, enhancing knowledge and promoting skills to work with culturally diverse populations. It has been argued elsewhere that the educational process must also be accompanied by field experience, where students have an opportunity to simultaneously learn and apply cross-cultural knowledge in relevant settings (see Crampton, Dowell, Parkin & Thompson, 2003; Jong, 2011; Park et al., 2006; Sasnett, Royal & Ross, 2010; Shaya & Gbarayor, 2006). Such experiences, which take various forms from fieldwork excursions to in-depth cultural immersion experiences, are often included in the later years of health professional programs. In the context of pharmacy education, Shaya and Gbarayor (2006) noted that while students should be grounded in cultural awareness and sensitivity, they should also be exposed to cultural diversity. Opportunities for pharmacy students were provided by a “collaborative care model” which integrated education, research and clinical care and offered “. . . an alliance of parents, providers, researchers, educators, communities, and health care systems” (Shaya & Gbarayor, 2006, p. 126).

Crampton et al. (2003, p. 598), who described the impact of a cultural immersion program on third year medical students in New Zealand, pointed to its potential “. . . as a method of consciousness raising to counter the insidious effects of non-conscious inherited racism”. While cultural competence and its variants are widely reflected in undergraduate medical curricula in many settings including the United States and Canada, the authors noted that little attention is paid to the impact of racism in medical education and practice. This concurs with views expressed by others about limited attention paid to the “culture of medicine” in professional programs: how trainees are imbued with professional values and how these are implicated in disparate health outcomes (Good, et al., 2003; Kleinman & Benson, 2006; Taylor, 2003). Crampton et al., (2003, p. 596) described cultural immersion as “. . . an approach based on the
principle that immersion in a culture and language is an effective means of learning about oneself and about another culture”. Cultural immersion experiences were also thought to guard against racial stereotyping which can interfere with the health care provider-patient relationship (Crampton et al., 2003).

The week long immersion program at the University of Otago required medical students to accept the mantle of “guests” in the largely Maori populated, remote region of the East Cape. Students were formally welcomed and quickly acquainted with local tikanga (etiquette). They absorbed and adhered to local protocols while they conducted health assessments, and communities were recompensed for time and resources expended while hosting students. Evaluation of the experience by students was very positive, but the authors noted that while this reflected an enhanced understanding of cultural differences, an exercise such as this was not without risks, including negotiating the relationship with the host community and dealing with students who took on the role of “cultural tourist” (Crampton et al., 2003, p. 597). Other risks identified relate to potential conflict between the two aims of the exercise, namely, conducting health assessments and enhancing awareness of cultural differences, and the superficial nature of the educational experience due to limited time in the setting. Despite these risks, the capacity for cultural immersion experiences to actively engage students with issues of racism in health care and the opportunity to forge strong relationships with local communities and their health care organisations were considered invaluable.

The value of experiential learning was also highlighted by Jong (2011) in a study describing the Northern Family Medicine (NorFam) program at Memorial University in Canada. The program, which commenced in 1992 after extensive community consultation, was developed to address health disparities and staff shortages for the 15,000 mainly Indigenous inhabitants in the remote circumpolar region of Canada (Jong, 2011). It originally provided opportunities for a small number of resident physicians and medical students to spend up to two months in the region, however by 2011 it had expanded considerably, and immersion experiences of eight months in duration were common. Jong (2011, p. 45) noted that the program, which trains medical students and medical residents in rural and remote medicine, has as its main principles “…continuity of care, community based care and experiential learning”. The Indigenous health focus of the program lent itself to experiential learning through cultural immersion, and Jong described a typical day where local Innu Elders, students and staff set out on a day’s walk, under the supervision and guidance of the Elders. “During the walk, the trainees receive first-hand experience of the positive impact on health and wellbeing with the traditional way of living for Innu, and gain an appreciation of the importance of the land for our Indigenous people” (Jong, 2011, p. 47).
Experiential learning through cultural immersion has the capacity to shift the locus of power from medical staff and students, to Elders. In the Norfam program, students acknowledged how much they learned from the Elders, the custodians of knowledge and experience in their community. Students consistently evaluated the program highly, and Jong (2011) also noted an association between the program and a decline in infant mortality in the region, although recognised this as an observed association and not causal link. While limitations of the program were not explored, its longevity suggests that strong community relationships, positive learning experiences and reliable funding had contributed to its sustainability and success. It also highlights the benefits of learning through a cultural immersion experience, and the capacity for attitude and behavioural change among students, given the right conditions. Caution must be exercised however, when such programs are evaluated. As Kumas-Tan et al. (2007) noted, measures of cultural competence that assume enhanced knowledge, self-confidence and increased contact with culturally diverse groups, do not necessarily indicate greater insight. Furthermore,

... practitioners who have tolerant, non-discriminatory attitudes will not necessarily be culturally competent if they are not also trained to recognize when actions and inactions that support the status quo and business as usual unintentionally, but systematically, privilege some and marginalise others.

(Kumas-Tan et al., 2007, p. 554)

This section has provided an introduction to key international developments in cultural competence in health service delivery and higher education. It has highlighted the contested terrain surrounding cultural competence: the ongoing debates regarding the concept and its application; alternative approaches to culturally inclusive care; and models for teaching cross-cultural content in health professional programs, including their inherent challenges. Some issues raised, particularly in the area of pedagogy, are explored in greater depth in the following section which details developments in the Australian context. Many national initiatives have been influenced by the international thinking described, although subsequently coloured by uniquely Australian experiences.

### 3.3 Cultural competence in Australian health service delivery and higher education: approaches to working with Aboriginal populations

The development and application of the concept of cultural competence in health care settings and health professional programs in Australia has been strongly influenced by approaches to culturally inclusive care in the United States, Canada and New Zealand. As Australia’s population became increasingly diverse following post World War Two
immigration, the abolition of the White Australia Policy in 1973, and the development of stronger economic ties with Asia following the end of the Vietnam War, it was clear that health services were ill-equipped to provide culturally appropriate care to patients from non-English speaking backgrounds (Julian, 2013). The emergence of interpreter services, multicultural health centres, hospital liaison officers, and cultural awareness programs in health service delivery organisations and higher education institutions reflected a growing concern about barriers to access for culturally diverse populations.

Health service accessibility and delivery was also considered woefully inadequate for Aboriginal Australians, and those working in the field had publicised their concerns for a very long time (Hollows & Corris, 1991; Kamien, 1978; Perkins, 1975; Thomas, 2004). The rise of Aboriginal Medical Services, the first established in Redfern, Sydney in 1971, reflected discontent with traditional models of care and provided alternative community-based and controlled health service delivery for Aboriginal patients (Thomson, 2005). Unlike recently arrived migrants, whose health status tended to be better than locally born residents due to stringent health requirements prior to migration (Julian, 2013), Aboriginal health status was and remains markedly worse (AIHW, 2015). In fact, as noted in Chapter Two, it was not until after the 1967 referendum when Aboriginal people were counted in the census for the first time, that reliable data on Aboriginal health was gathered. The National Aboriginal Health Strategy (1989) highlighted the stark contrast in key health indicators, such as life expectancy, infant mortality and rates of hospitalisation between Aboriginal and non-Aboriginal populations, and also drew attention to inadequate coverage of the social determinants of Aboriginal health in health professional education (National Aboriginal Health Strategy Working Party, 1989).

In the 1990s two significant reports identified links between Aboriginal disadvantage, marginalisation and poor health outcomes. The Royal Commission into Aboriginal Deaths in Custody (1991) highlighted the over-representation of Aboriginal people in the criminal justice system, many of whom were detained for quite minor offences. High rates of incarceration were associated with powerlessness, low self-esteem and drug and alcohol misuse, and the duty of care to those detained was inadequate. Of the Aboriginal deaths in custody, a substantial proportion were due to suicide and in the decade following the Royal Commission this had risen to nearly 50% of all Aboriginal deaths in custody (Turale & Miller, 2006). A second report, Bringing them home: report of the National Inquiry into the Separation of Aboriginal Children from their Families provided further evidence of Aboriginal powerlessness in the face of policies that inflicted enormous social and emotional damage on families and communities, the legacy of which continues to be felt today (Human Rights and Equal Opportunity Commission, 1997).
3.3.1 Rethinking health service delivery: cultural security, respect, competence and anti-racism strategies

Reforms in health care services in Australia followed a similar trajectory to those in the United States, with the introduction of cultural awareness programs to address the knowledge deficit regarding Aboriginal cultures and health. As noted in Section 3.2.2, these programs focused upon self-reflection, personal biases, potential stereotyping, and the impact of these in the delivery of care (Grote, 2008; Smedley et al., 2002). Evaluation of programs revealed previously identified limitations, namely, that attitude change did not necessarily translate to behaviour change in clinical settings, and that systemic factors that exacerbated Aboriginal disadvantage were neglected. Unsurprisingly, despite the existence of cultural awareness programs, Aboriginal people continued to report dissatisfaction with health services, citing them as alienating and uncomfortable (Health Department of Western Australia, 2003; Thomson, 2005). Coffin (2007) argued that cultural awareness alone does not equate to better health care: it is a foundational concept only, and must be acquired before more sophisticated notions of safety and security are understood and implemented.

In 2003, the Health Department of Western Australia released a background paper titled *Aboriginal Cultural Security*. Cultural security was defined as:

\[\ldots\text{a commitment to the principle that the construct and provision of services offered by the health system will not compromise the legitimate cultural rights, values and expectations of Aboriginal people. It is a recognition, appreciation and response to the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health systems administration.}\]

(Health Department of Western Australia, 2003, p. 10)

Subsequently, Houston (2009, pp. 105-8) added that cultural security was an “an ethical commitment . . . with the crux of the move to cultural security being . . . a shift in emphasis from attitude to behaviour”. It was recognised that values underpinning cultural awareness programs were worthy but inadequate on their own. The concept of cultural security expanded and strengthened cultural awareness through its focus on practice, skills and behaviours. “It is about building the competence of practitioners and administrators to know, understand and incorporate Aboriginal cultural values in the design, delivery and evaluation of health services” (Health Department of Western Australia, 2003, p. 13). Coffin (2007) viewed cultural security as the highest level of attainment for health care providers delivering care to Aboriginal patients, and suggested cultural brokerage and protocols as essential elements required to sustain it. Brokerage developed with Aboriginal communities is about two-way communication and is
based on building faith and trust through the informal exchange of ideas: “one of the largest parts of brokerage is listening and yarning” (Coffin, 2007, p. 23). Protocols, on the other hand, relate to guidelines for appropriate community engagement, and recognise the important role played by Elders and other key community stakeholders in the development of partnerships. This process, which builds upon cultural awareness and cultural safety, is pivotal to the development of culturally secure health services for Aboriginal people (Coffin, 2007).

Thomson (2005) and Grote (2008) noted that the language of cultural security was not widely adopted in Australia, however it was further developed in a significant report prepared by the Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIIH) Working Party for the Australian Health Ministers’ Advisory Council (AHMAC, 2004). Titled the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004 -2009, it drew heavily upon the commitment and principles embodied in the concept of cultural security (Thomson, 2005), but embraced the language of cultural competence, promoting the need for cultural competence across all levels of health care delivery. Furthermore, it called for the development of national standards in the area of cultural competence.

The document highlighted inadequate mainstream services beset with problems related to provider attitudes, poor communication, a lack of cultural understanding, and instances of racism, although it acknowledged numerous interacting factors implicated in poor health outcomes for Aboriginal people. The identified factors were viewed as barriers to accessing health services, which, if addressed, would contribute to better health outcomes. The Framework was designed around the concept of cultural respect, defined as:

recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples . . . it is a commitment to the principle that the construct and provision of services will not wittingly compromise the legitimate cultural rights, practices, values and expectations of Aboriginal and Torres Strait Islander people.

(AHMAC, 2004, p. 7)

While the definitions of cultural respect and cultural security overlap and use the same phrases to explain the concepts, the Cultural Respect Framework went further by focusing on systematic action across a range of dimensions in health service delivery. It addressed the lack of integration across dimensions of health services, including knowledge and awareness, where the focus is upon attitude change to facilitate behaviour change; skilled practice and behaviour change; strong customer and community relationships within organisational settings; and finally,
equity of outcomes, which comprise the results dimension, subject to evaluation and quality improvement (AHMAC, 2004, pp. 10-11). It highlighted the need for stronger linkages between these dimensions where inputs (i.e. cultural awareness training), outputs (i.e. culturally appropriate behaviour and skilled practice) and outcomes (a more equitable health care system) provide a scaffold for a more integrated approach to the provision of care to Aboriginal and Torres Strait Islander peoples. Lastly, it recommended the adoption of cultural competence standards in accreditation, program planning and quality assurance across a number of sectors including primary care, mental health, aged and palliative care to improve access and levels of satisfaction (AHMAC, 2004, pp. 14-16).

The language of cultural respect was used in a recent study of primary health care services as, according to the authors, it draws attention to health systems, in additional to practitioner capabilities, and to the extent of racism experienced by Aboriginal people accessing care (Freeman et al., 2014). The authors found that a number of strategies, including the employment of Aboriginal staff, provision of transport, flexible appointments and home visits, could be employed at the organisational level to enhance cultural respect. They also identified the “... integration of cultural protocols, advocacy and action on social determinants” as strategies aligned with the concept of cultural respect and primary health care principles, which encourage responsiveness to local communities (Freeman et al., 2014, p.355).

By 2006, the concept of cultural competence appeared regularly in significant policy documents, and was embraced by the National Health and Medical Research Council (NHMRC, 2005) in its report *Cultural Competency in Health: A guide for policy, partnerships and participation.* While the focus of this report was upon culturally and linguistically diverse (CALD) populations, it acknowledged that many of the issues are relevant to Aboriginal and Torres Strait Islanders, but that these need to be considered separately, due to the complexity of the issues in these settings. Numerous policy documents followed and expanded on the work of the NHMRC report. Some focused on CALD populations (Ethnic Communities Council of Victoria, 2006; Queensland Health, 2009) while others proposed culturally competent services for Aboriginal families and children (Victorian Aboriginal Child Care Agency, 2008).

A more recent development in the discussion of culturally secure care for Australian Aboriginal populations is the naming of racism as a social determinant of health (Durey, 2010; Genet & Cripps, 2011; Larson, Gillies, Howard & Coffin, 2007; McDermott, 2012; Paradies, 2006, 2007; Ziersch, Gallaher, Baum & Bentley, 2011). Recognition of how structural factors impact on access to health services, the delivery of those services, and health outcomes was heightened in Australia as literature on the social determinants approach to health burgeoned.
internationally (see Chapter Two) Dr Lowitja O’Donoghue, a tireless advocate for improvements to the health of her people, had long argued for a model of Aboriginal health delivery that considered systemic racism, together with history and the impact of oppression and dispossession (Carson, Dunbar, Chenall & Bailie, 2007). In 2007 Carson et al. published the volume *Social determinants of Indigenous health*. It was based on a series of short courses run in Darwin, Northern Territory that brought together leaders in public health, including Aboriginal academics and health care professionals. Paradies’ (2007) contribution on racism as a determinant of health is particularly significant as he highlighted the extent of racism and its corrosive impact of health, especially mental health. He outlined the potential power of “anti-racism” policy approaches aimed at decreasing the presence and practice of racism. Drawing on Hollinsworth’s work in this area in the late 1990s, he noted that:

The most effective anti-racism training promotes an awareness of Indigenous history and culture, dispels false ideological beliefs and uses a liberal education approach that focuses on the complexities of racism and anti-racism, including the power relationships embedded in material and cultural structures.

(Paradies, 2007, p. 76)

Durey (2010) also promoted an anti-racist framework with an emphasis on reflective practice and cultural education in university programs and the health service delivery sectors. She called for long-term evaluation of these strategies. Durey views racism as a “...fundamental social determinant of health where interpersonal and institutional racist attitudes and behaviours are often embedded in social, structural and political contexts” (Durey, 2010, p. 87). She also noted how the experience of discriminatory practices can precipitate change, citing the rise of Aboriginal Community Controlled Health Organisations (ACCHO). A culturally appropriate model that integrates biomedicine with a holistic health approach, ACCHOs were successfully conceived and implemented, but they cannot, as separate services, directly address problems related to culturally inappropriate care in mainstream health services (Durey, 2010).

In a detailed analysis of diversity training, Kowal, Franklin & Paradies (2013) drew attention to some limitations of the anti-racism approach, namely the problems of “essentialism” and the potential for counter-productive, negative emotional reactions. They proposed a “reflexive antiracist” approach to address the risk of homogenising racial groups (essentialism) and findings that suggested racial prejudice increased among some participants following diversity training. The problem of essentialism is seen as relevant not only to the portrayal of different Aboriginal people, but also to white identity: “... antiracism training
risks reifying white racial identities as inherently racist and incapable of being antiracist . . . as generally deficient or even stigmatised” (Kowal et al., 2013, p. 322). Reference is also made to the emotional consequences of the ‘we and them’ perspective that can arise from anti-racist training and the management of negative emotions such as discomfort, anxiety and withdrawal. They noted that guilt associated with white privilege is linked to fear of perpetuating racism, which in turn gives rise to caution about interaction with those from other cultures (Kowal et al., 2013).

In their proposed framework, Kowal et al. employ reflexivity, with its focus upon one’s own background as a lens to address the limitations and risks identified in anti-racism training, and to interrogate race. The concept of “racialisation” which describes societal systems divided into races where power is unevenly distributed, and where actions can enhance or reduce the power imbalance, is a central component of this framework. The authors’ detailed analysis of race and racism recognises the inherent tensions and contradictions in identity formation, cognitive dissonance that can occur due to negative effects of guilt associated with white privilege, and the need to address these issues if racial oppression is to be countered (Kowal et al., 2013).

The development of these approaches in health care organisations and agencies, and the varying shifts in emphasis over the years are also reflected in higher education institutions, which have responded to the call for a culturally competent health care workforce (Indigenous Higher Education Council, 2007; INEWG, 2003; Kruske, Kildea & Barclay, 2006; Nash, Meiklejohn & Sacre, 2006; Paul, Carr & Milroy, 2006; Phillips, 2004; Rasmussen, 2001; Universities Australia, 2011). As in the United States and Canada, schools of medicine and nursing were leaders in curriculum initiatives in Australian universities, although schools of psychology have also been influential in curriculum development in Indigenous health and in the analysis of student responses to curriculum initiatives (McDermott & Gabb, 2010; McDermott, 2012; Ranzijn, Nolan & McConnochie, 2009).

3.3.2 Aboriginal content in higher education health professional programs: curriculum initiatives in medicine

The development of a more culturally inclusive medical curriculum was given a significant boost by the publication of the Committee of Deans of Australasian Medical Schools (CDAMS) *Indigenous Health Curriculum Framework* (2004). CDAMS partnered with the Office of Aboriginal and Torres Strait Islander Health (OATSIH) to develop and implement the framework, and the VicHealth Koori Health Research and Community Development Unit at the University of Melbourne hosted the project (Phillips, 2004).
Prior to reviewing the CDAMS report, it is important to note that the VicHealth Koori Unit, led by Dr Ian Anderson, had been active in the area of cross-cultural medical education for a number of years (VicHealth Koori Health Research and Community Development Unit, 2001; Rasmussen; 2001). In particular, the large project *Towards Reconciliation in Aboriginal Health: Initiatives for Teaching Medical Students about Aboriginal Issues* drew on experiences and research conducted at the University of Melbourne during 1994-1996 that had identified problems in the teaching of Aboriginal health (Rasmussen, 2001). Problems included limited time devoted to Aboriginal health, block teaching, few opportunities for direct contact with Aboriginal patients, and reluctance on the part of Aboriginal people to be involved in the teaching program due to large classes, the sporadic nature of their involvement and lack of control over content taught (Rasmussen, 2001).

The project team conducted a comprehensive literature review as part of a needs assessment, and subsequently explored in detail medical students’ understanding of Aboriginal health, Aboriginal issues more generally and student attitudes towards teaching in this area. The literature review revealed that “although the research findings on tertiary students’ attitudes towards Aboriginal people have been contradictory and, on occasion, problematic, the overall finding has been the prevalence of negative stereotypes and prejudicial views . . .” (Rasmussen, 2001, p. 38). They also noted gaps in our understanding of factors influencing attitudes and beliefs, and the impact of student attitudes on delivery of health care to Aboriginal people.

Following the needs assessment, a central focus of this project was the identification of barriers and facilitators to learning about Aboriginal health, knowledge of which was used to inform the development of a pilot program. Understanding students’ beliefs and attitudes and the factors that shape their formation is fundamental to any exploration of the learning process. While a range of perceptions about Aboriginal people and culture was discerned, patterns were identified, as were factors influencing responses, including degree of contact, the role of the media and prior knowledge (or lack of it) gained through secondary education. Rasmussen (2001) also identified a number of emotional responses that students brought to the learning experience, including feelings of powerlessness, guilt, anger and anxiety.

An outcome of this project was the development of an innovative pilot teaching program, which was subsequently evaluated. The intervention comprised a weekend immersion experience at an Aboriginal cultural centre in the country, followed by visits to Aboriginal community-controlled organisations in Melbourne. Students volunteered to be part of the pilot program and the overwhelming response to this intervention was positive. In conclusion, Rasmussen (2001, p. 145) argued for two types of teaching in Aboriginal health: “. . . an
improved, coordinated and integrated core curriculum and . . . elective processes for smaller groups of interested students”. Structural changes that were recommended included better integration and coordination of content, the development of partnerships with local Aboriginal communities, and consultation with Aboriginal people and students in the design, development and implementation of curriculum. Recommendations related to teaching methodologies included a focus on localised Aboriginal health teaching, acknowledgement and utilisation of Aboriginal medical students’ experiences, examination of students’ cultural backgrounds, immersion experiences and placements in community-controlled organisations. Lastly, with respect to teaching content, emphasis was placed on Aboriginal history, land rights, racism, health funding, social and cultural issues, demographics, notions of Aboriginality, and the relationship between health and self-determination (Rasmussen, 2001).

Rasmussen’s report on the teaching of Aboriginal health in medical education at the University of Melbourne appeared one year before the CDAMS initiative commenced. As both reports were by published by the VicHealth Koori Research and Community Development Unit at the University of Melbourne, it is likely that the earlier report was influential in the subsequent development of the CDAMS Indigenous Health Curriculum Framework. The objectives of the CDAMS initiative were to:

Audit existing Indigenous health content in core medical education; develop a nationally agreed curriculum framework for the inclusion of Indigenous health in core medical curricula; develop a network of Indigenous and non-Indigenous medical educators concerned with Indigenous health; and seek accreditation of the curriculum framework by the Australian Medical Council.

(Phillips, 2004, p.5)

The project was guided by a Steering Committee with Aboriginal members prominent in this group, and in the Drafting Reference Group. Members of the Australian Indigenous Doctors’ Association (AIDA), Indigenous community representatives, Deans, medical educators, and students all contributed to the final report.

The CDAMS curriculum framework presented a set of “underlying philosophical principles” to support effective teaching; identified subject areas and key student attributes and outcomes; presented ten key pedagogical principles underpinning successful design and delivery of Aboriginal content; provided recommendations on delivery, assessment and processes for curriculum development; outlined required resources; and offered suggestions on future workforce development issues (Phillips, 2004). The framework was expansive in
conception but key principles were reiterated throughout the document: diversity within and between communities; the validity of Aboriginal views on health and well-being; the importance of Aboriginal professionals’ and community members’ knowledge and expertise and their contribution to curriculum development; and the significant contribution that a culturally safe medical workforce can make to improving Aboriginal health outcomes. The Australian Medical Council subsequently included the framework in accreditation guidelines and this required regular reporting by all medical schools on the implementation process (Phillips, 2004). This process and a deeper understanding of curriculum initiatives are best viewed through the lens of specific examples identified in the literature.

In 2006, Paul, Carr and Milroy reported on the implementation of an integrated Aboriginal health curriculum at the University of Western Australia’s (UWA) medical school. They highlighted the impetus provided by the establishment of the Faculty’s Centre for Aboriginal Medical and Dental Health (CAMDH) in 1996. The CAMDH aimed to enhance the recruitment and retention of Aboriginal students in the health professions; develop Aboriginal health teaching; and “. . . provide health-related support and resources for Aboriginal communities and organisations” (Paul et al., 2006, p. 523). A new curriculum, approved by the Australian Medical Council and including course-long content in Aboriginal health, was offered to all students in 2005. These curriculum developments, which both preceded and overlapped the CDAMS framework, suggest there was much activity occurring in schools of medicine around the country, although not all initiatives were reported or evaluated.

At the UWA medical school, instruction in Aboriginal health varied from 37 hours of direct teaching to over 150 hours, dependent upon additional options chosen and whether or not students elected to spend a year in a rural community, an opportunity offered by the newly established Rural Clinical School in 2002 (Paul et al., 2006). Findings from student surveys on perceptions of their knowledge and abilities in Aboriginal health revealed that “. . . with a relatively small amount of targeted and structured teaching and learning in Aboriginal health, significant shifts in self-perceived levels of knowledge, skills and attitudes are possible . . . however, there is still room for improvement” (Paul et al., 2006, p. 524). The significant improvements in students’ recognition of Aboriginal health as a social priority and the need for culturally secure health services was tempered by limited open-ended feedback and self-rating of preparedness. The authors referenced the CDAMS report and drew similar conclusions about the keys to success in achieving learning outcomes, namely, “. . . integrating the material presented, involving Aboriginal people in planning and provision of teaching and learning, and drawing on the skill and experience of the teachers” (Paul et al., 2006, p. 525).
In another study at the UWA medical school, Paul, Allen and Edgill (2011) reported on the impact of an assessment completed by fourth year medical students on their engagement with the health of Aboriginal people. The assessment, a formal case history of an Aboriginal patient, required students to submit a detailed history including clinical examination, formulation, investigations suggested, and a management plan. A detailed discussion of an issue that arose out of interactions with the patient also formed part of the assessment. Importantly, students were required to comment on the learning experience, which introduced an element of reflective practice into the exercise (Paul et al., 2011).

The findings, which were presented in the context of a “. . . comprehensive vertically and horizontally integrated Aboriginal health curriculum across the six year MBBS program at the university” (Paul et al., 2011, p. 52) stressed the importance of the evaluation of curriculum initiatives that prepare students to work with Aboriginal people. Content analysis of 519 student reflections (largely from 2004-2009) indicated that “. . . significant learning . . . can occur from a structured learning task. Indeed, for some students this task appears to have provided a turning point in their understanding, interest and engagement in Aboriginal health” (Paul et al., 2011, p. 60). While some students found the experience confronting, reflections revealed an increased level of interest in working in Aboriginal settings. The authors stressed that a culturally competent health workforce is essential to reducing barriers to care for Aboriginal people, and that medical educators have a responsibility to contribute to improved health care by opening their students’ eyes and giving them opportunities to connect at a deeper level with Aboriginal patients. They did acknowledge, however, that educational initiatives such as those occurring in response to the CDAMS framework have yet to be linked in a systematic way to improved health outcomes for Aboriginal people, and that this work remains to be done (Paul et al., 2011).

In an attempt to address this issue, Ewen, Paul and Bloom (2012) conducted a systematic literature review to determine the impact of mandated Indigenous health curricula on health outcomes for Indigenous populations. In common with international literature in the field, they found that Indigenous health curricula was not patient outcome-focused, although claims that enhanced skills, knowledge and attitudes would lead to better health outcomes were widespread (Ewen et al., 2012). While the authors acknowledged other rationale for including Aboriginal content in curricula, they suggested that:
what is missing in health science education is a broad and foundational understanding of the contexts in which Indigenous people and health professionals meet and interact (with, in most cases, limited previous shared experience), and of the consequent impacts of these contexts on health and health outcomes.

(Ewen et al., 2012, p.52)

The authors urged medical educators to develop tools that evaluate the impact of curricula on patient outcomes, while concurrently measuring the impact on student learners (Ewen et al., 2012). In a subsequent paper Paul, Ewen and Jones (2014) reiterated that addressing health disparities should be the main rationale for the inclusion of culturally competent curricula in health professional programs. They applied Hafferty’s (1998) taxonomy of curricula (formal, informal and hidden dimensions) to cultural competence and identified potential areas of disconnect or incongruity. Formal curriculum comprises what is taught, whereas informal curriculum consists of those interactions between students, and between staff and students on topics under discussion in classes, and the influence of societal values on these conversations. Hidden curriculum is located in the language of institutions and in policies and resource allocation (Paul et al., 2014).

Paul and colleagues noted the under-representation of Aboriginal staff in medical schools and how this impacts on the informal and hidden curricula, and Aboriginal students’ experiences of discrimination. Compulsory training for all members of faculty was encouraged to increase the congruence between these dimensions of the curriculum and reinforce what is actually taught (Paul et al., 2014). The language of the hidden curriculum, particularly as it relates to the concept of cultural competence, was viewed as problematic and sometimes misleading. The term “competency” is defined as mastery of a “... finite body of knowledge, skills and attitudes”, but the notion of an endpoint to a learning outcome rather than a lifelong learning process is “anathema to professionalism” (Paul et al., 2014). They suggested re-naming the concept of cultural competence but acknowledged the minefield involvement in such a pursuit.

It is important to note that efforts to include Aboriginal health content in medical curricula are usually accompanied by recruitment and retention strategies to address the serious under-representation of Aboriginal students in the health sciences. When the CAMDH unit at UWA was established in 1996, only three Aboriginal students were studying medicine, and there had been only two Aboriginal graduates from the medical school (Paul, 2012). By 2011 this had risen to 26 students studying medicine, two students enrolled in dentistry, and another 12 in
health science degrees (Paul, 2012). Programs at the University of Newcastle, widely
recognised as a leader in the recruitment and retention of Aboriginal students in medicine
(Butler & Young, 2009) and UWA were characterised by pre-medicine programs, dedicated
places for Aboriginal students and extensive student support.

A rapid rise in the number of Aboriginal students enrolled in medicine occurred as a result
of initiatives at other universities too, and in 2015 there were approximately 204 Aboriginal
doctors and a further 310 Aboriginal medical students nationally (Australian Indigenous
Doctors’ Association, 2015). The formation of the Australian Indigenous Doctors’ Association
(AIDA) in 1998 and the Leaders in Indigenous Medical Education (LIME) Network in 2005 is
further testament to the success of capacity building strategies. In a paper outlining the history
of the LIME Network and the development of Indigenous health in medical education, Haynes
et al., (2013) noted how AIDA and LIME have been instrumental in the establishment of
Indigenous health as a discipline in its own right.

The LIME Network, which has operated as a bi-national program since 2008 (in
collaboration with medical schools in Aotearoa/New Zealand) has as its objectives: “... internal
quality review; professional development, capacity building and support; promoting best
practice and building an evidence base through research and evaluation; professionalising the
discipline; multidisciplinary and multi-sectorial networking; advocacy and reform; and hosting
the LIME Connection conferences” (Haynes et al., 2013, p. 67). In 2005, AIDA published
Healthy Futures: defining best practice in the recruitment and retention of Indigenous medical
students, which identified targets, principles and actions necessary to increase medical student
numbers. The report was revisited in 2012 as part of a national review of the implementation of
the Indigenous Health Curriculum Framework in medical schools (Medical Deans & AIDA,
2012).

An audit conducted as part of the national review revealed that by 2011 “... the vast
majority of Australian medical schools appear to implement significantly more Indigenous
health content than that of the medical schools audited in 2004” (Medical Deans & AIDA, 2012,
p. 12). However, considerable variability in the “comprehensiveness and effectiveness” of the
implementation was found to exist, despite improvements identified. Best practice
implementation was associated with the presence of Indigenous Health Units (IHU) and
Indigenous staff and while it was noted that 14 of the 19 medical schools had IHUs, the number
of full-time Indigenous staff and medical practitioners in particular, was found to be low
(Medical Deans & AIDA, 2012). Other factors associated with best practice included: the
establishment of effective, collaborative internal partnerships; experience-based learning
activities and opportunities; integration of clinical science/medicine and Indigenous content; cultural immersion and awareness programs and reflective learning activities (Medical Deans & AIDA, 2012.)

Issues identified as potential barriers to effective implementation of Indigenous content into medical curricula included: lack of technically specific and relevant content; broad content that was integrated superficially; time constraints; cultural sensitivities surrounding the content; lack of senior leadership positions among curriculum developers (lack of influence); content and assessment not embedded into the curriculum (not always compulsory or valued); and inadequate resourcing to enable effective implementation (Medical Deans & AIDA, 2012).

A review of the Healthy Futures targets, which aimed to increase the number of Indigenous students enrolled in medicine, revealed considerable shortfalls, as only six of the 19 medical schools had implemented any of the Report’s recruitment and retention strategies. Many schools identified staffing and financial constraints as factors that limited progress. It was noted however, that the number of newly enrolled Indigenous medical students in 2011 had reached 2.5% of the total intake, a percentage closely aligned to the proportion of Indigenous people in the population (Medical Deans & AIDA, 2012). This suggests that recruitment efforts, where adopted, have been successful, particularly with regard to alternative modes of entry and high school visits. Support provided to students upon entry however, remains variable. It is clear that organisations such as AIDA and LIME play important roles in providing students with a forum to develop networks and establish potential mentors. The LIME Network Good Practice Case Studies (2012; 2013; 2015), which disseminate information about curriculum initiatives, and recruitment and retention strategies in medical education, are excellent resources for all health professionals keen to develop capacity in this area.

In addition to curriculum developments and network opportunities provided by AIDA and LIME, the establishment of University Departments of Rural Health (UDRH) and Rural Clinical Schools (RCS) in the late 1990s/early 2000 resulted in increased opportunities for students to have rural clinical experiences (Department of Health & Ageing, 2009). Both programs were designed as “. . . workforce strategies to address the shortage of health practitioners within rural and remote Australia” and are based on the premise that “. . . students with a rural background, and /or students who are provided with a positive experience of rural practice . . . are more likely to choose to work in a rural area after graduation” (Department of Health & Ageing, 2009, pp. 9-16).
The recruitment and retention of health professionals in rural and regional areas of Australia remains an ongoing challenge for all rural communities but especially for Aboriginal people, who have poorer health status and are more likely to live in remote, under-serviced locations. Rural clinical placements, which are funded through UDRH and RCS, provide medical and other health science students with opportunities to experience rural life and interact with Aboriginal people who they may never have encountered before. These experiences have a positive impact on student learning about Aboriginal people and their cultures (Playford & Lines, 2013; Prout, Lin, Nattabi & Green, 2014; Rasmussen, 2001). Costs attached to rural clinical placements are defrayed by access to scholarships and students are encouraged to join rural health clubs, which hold regular conferences related to rural placements, rural health issues and employment opportunities.

3.3.3 Aboriginal content in higher education health professional programs: curriculum initiatives in nursing and midwifery

Adams (2010, p. 35) suggested that nurses and midwives have been “... at the forefront of developing and recognising the importance of culturally responsive health care”. The transcultural nursing movement established in the United States and the cultural safety framework developed in Aotearoa/New Zealand support this assertion. International developments in nursing and midwifery influenced local accreditation standards and curriculum initiatives, and during the 1990s many programs reflected the culturally diverse nature of Australian society, particularly with respect to CALD populations. However, content on Aboriginal cultures, history and health outcomes was not regularly incorporated into programs until much later, following the formation of the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) in 1997.

The arrival of AIDA and CATSIN on the national scene within a year of one another reflected the heightened awareness of Aboriginal health disparities and the under-representation of Aboriginal people in health professions at the time. CATSIN (which is now called CATSINaM to recognise Aboriginal midwives in their own right), under the leadership of Dr Sally Goold (until 2011) and founding patron Dr Lowitja O’Donoghue, highlighted inadequacies in nursing and midwifery curricula and barriers to enhanced Aboriginal student numbers (CATSINaM, 2015). The Report of the Indigenous Nursing Education Working Group (INEWG) “gettin em n keepin em” (2002) concluded that few nursing schools integrated Indigenous health into core curriculum, or provided cultural awareness programs for their academic staff. They also noted that Aboriginal nurses were under-represented in health care delivery and there was room for improvement in recruitment and retention strategies. The report
drew on international experiences that linked increased workforce participation of Indigenous health professionals with improvements in Indigenous health (INEWG, 2002).

The INEWG which was established by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) considered strategies to increase the number of Indigenous nurses and enhance culturally appropriate health care delivery in the nursing profession. The report recommended a national approach to these issues, underpinned by the following principles:

- an understanding of Indigenous cultural beliefs, history and practices is essential to culturally safe care;
- an increase in cultural capacity is related to social justice and issues of self-esteem;
- the holistic approach of primary health care should be utilised to explore Indigenous health;
- the National Aboriginal Health Strategy (1989) health model should be incorporated into nursing education;
- recognition of the cultural needs of Indigenous people will enhance recruitment and retention of students; and
- shared accountability for Indigenous health including from governments, Indigenous communities and health care sectors.

(INEWG, 2002, p. xi)

As noted in Chapter Two, the National Aboriginal Health Strategy Working Party (1989, p. x) adopted a definition of health that included “... the social, emotional and cultural well-being of the whole community”. An appreciation of this “whole of life” interpretation of health was regarded as essential, not only as a counter-balance to the dominance of biomedicine, but also as a means to establish respectful relationships with communities. The INEWG report presented 32 recommendations that addressed recruitment and retention, curriculum development and implementation, and advanced nursing practice and post-graduate education. Recommendations also made reference to articulation, particularly with Aboriginal Health Workers and Enrolled Nurses, partnerships and networks, and monitoring and accountability. Of particular significance was the call for compulsory content on Indigenous culture, history and health in all undergraduate nursing curricula and, for this to be defined by registration bodies and assessed using specific Indigenous cultural safety competencies (INEWG, 2002). This recommendation transformed many nursing and midwifery programs to the extent that inclusion of Aboriginal health content became widespread due to new registration competencies, and core units were included in many revised curriculum frameworks. These
reforms can best be observed through the lens of a specific example from Queensland University of Technology (QUT).

The *Yapunyah* project (Gunya word = eucalyptus trees that grow up from the river bank) was a Faculty of Health initiative at QUT that involved four schools and was informed by cultural competence and cultural safety models of health care (Nash, Meiklejohn & Sacre, 2006). It was partly a response to new regulatory requirements of the Royal College of Nursing Australia (RCNA, 2003) that curricula include Aboriginal history, and cultural security and safety as core content. The authors noted a dearth of Australian nursing literature on teaching and assessing cultural competence in Indigenous contexts at the time, but were guided by the CDAMS (2004) report and work conducted by the Royal Australian College of General Practitioners (RACGP) which assessed existing cultural training programs. The aim of the project was to “...enhance students’ appreciation and understanding of Aboriginal and Islander health and culture and facilitate the development of professional competencies that are fundamental to the provision of care that promotes optimal health outcomes...” (Nash et al., 2006, pp. 303-4). Aboriginal and Torres Strait Islander community participation and guidance was fundamental to the curriculum development process and enabled connections to be made with Indigenous community-controlled health services, thus enhancing placement opportunities.

Nash et al. (2006) described the curriculum audit, surveys and focus group discussions that preceded the implementation of any changes to the program. All units were re-designed to incorporate Indigenous content and the *Yapunyah* website was developed to provide additional resources for students. A parallel aspect of the project was the inclusion of staff development workshops, as it was recognised that many staff lacked experience and confidence working in this cultural environment. Pre and post-workshop evaluations revealed significant differences, particularly in the capacity of staff to facilitate student learning in the area of Indigenous health (Nash et al., 2006). The authors noted that at the beginning of the project staff expressed concern about the embedding process, in particular, a fear of offending Indigenous students or community members. The workshops were a vital component to address this tension. Ongoing student evaluation was anticipated, although the authors did not elaborate on student responses and potential attitude change (Nash et al., 2006).

While the *Yapunyah* project appeared to move beyond cultural awareness training, disquiet was expressed by some academics about the limitations of nursing curriculum reforms, the degree of commitment, and the need for anti-racism training. Fredericks (2006) recalled instances where she was invited to participate in nursing curriculum reviews as the Aboriginal representative, but considered the invitation an afterthought. She was confronted with the horns
of a dilemma: participate and ignore the late invitation, or not participate and be accused of disinterest. On other occasions, there were expectations that Aboriginal representatives on review teams would give:

... their time, skills, abilities and specific knowledge in Indigenous content for free (if we participated) and the non-Indigenous ‘Indigenous experts’ would have been paid for their time, skills, abilities and specific knowledge in Indigenous content.

(Fredericks, 2006, p. 95)

Fredericks (2006) concluded that an exploration of “white race privilege” was essential if the lens was to shift from “needy and problematic” Indigenous people to structural limitations of service delivery and providers. As discussed in Section 3.3.1, “white race privilege” is viewed as a contributing factor to Aboriginal disempowerment and is closely aligned with anti-racism strategies that challenge the presence of racism in all its forms.

Fredericks’ (2006) critique of cultural training in nursing and midwifery was not isolated. Downing and Kowal (2010) investigated the impact of Indigenous cultural training on nursing practice among a small group of nurses at the Royal Darwin Hospital in the Northern Territory. The study was prompted by limited information on the characteristics of effective cultural training and the tenuous link between cultural training and improved health outcomes for Aboriginal people. In-depth interviews conducted with six nurses elicited their perceptions of Indigenous cultural training, their experiences of how it influenced their professional practice, and how they saw the role of this training in their nursing practice (Downing & Kowal, 2010). While most of the participants received the training in their workplace, the findings also have relevance to teaching that occurs in higher education institutions. The study revealed that Indigenous cultural training has an integral role in educating nurses about colonial history and the presence of institutional racism. It highlighted specific cultural differences, provided skills to address these, and drew attention to limitations and barriers encountered when applying Indigenous cultural training in practice. The significance of both experience and pre-existing attitudes on responses to cultural training was also recognised (Downing & Kowal, 2010).

In a discussion of their findings, Downing and Kowal (2010) cautioned against objectification of Aboriginal people where diverse historical experiences and cultural beliefs and practices are minimised and a unified cultural identity portrayed. Drawing on post-colonial theory they suggested that:

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what is required is not so much the development of an ‘awareness’ of Aboriginal and Torres Strait Islander cultures, as an understanding of the processes that contribute to cultural identity formation, and the way in which discourses of culture and cultural knowledge are used by colonial systems to obtain and maintain the power of the dominant culture.

(Downing & Kowal, 2010, p.16)

Despite this concern, it was recognised that the nurses found it both relevant and satisfying to learn about specific cultural differences and tailor their care accordingly. The nurses also viewed individual personality characteristics and the desire to provide culturally safe care as significant in the translation of training into practice. They did suggest however, that organisational support would enhance this process (Downing & Kowal, 2010). In a subsequent paper, Downing, Kowal and Paradies (2011) noted that the culture of health care systems remains largely unexamined and yet power imbalances existing within these systems work against the provision of culturally safe care for Aboriginal people. Clearly, acknowledgement and exploration of the dominant structures and inherent assumptions contained within these systems are essential in cultural training, whether it occurs within universities or health care settings.

This section has reviewed literature that explores developments in culturally inclusive care for Aboriginal Australians in health service delivery and higher education institutions. The evolution of a language for culturally inclusive care, the application of terminology in policy documents, and the rise of anti-racist approaches to training in workplaces and educational settings have been outlined. Circumstances and policy initiatives that gave rise to the inclusion of compulsory Aboriginal content in medical and nursing programs, and efforts to increase the number of Aboriginal health professionals suggest this has been a dynamic area of reform over the last two decades. More recently allied health professions have been active in this area too, and were important contributors to the recently released *Aboriginal and Torres Strait Islander Health Curriculum Framework* developed to embed Aboriginal content in all health professional programs (Department of Health, 2016). The following section reviews literature that addresses initiatives in midwifery education and the provision of culturally inclusive care to pregnant and birthing Aboriginal women.
3.4 A closer look at midwifery education and practice: approaches to working with Aboriginal populations

It is important to note that in Australia the profession of midwifery was frequently subsumed under the “nursing” label. Only recently, as noted earlier, has midwifery been acknowledged by the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) as connected with but separate from nursing (CATSINaM). In part this is historical in origin and reflects the fact that following independent practice by midwives early last century in Australia, prospective midwives were later required to gain registration as nurses before they could complete a midwifery qualification (Hastie, 2006). As discussed in Chapter Two, the Australian Nursing Council established in 1992 changed its name to the Australian Nursing and Midwifery Council (ANMC) in 2004, coinciding with an expanded role, which included the development of codes of conduct and ethics, and national competency standards for nursing and midwifery (ANMC, 2007). Changes also occurred in universities, where many schools of nursing amended their titles to reflect not only the postgraduate diplomas offered in midwifery but also the introduction of direct entry, undergraduate midwifery degrees. Thus, curriculum initiatives that required compulsory Aboriginal content in nursing were generally mirrored in midwifery programs and monitored by the same regulatory framework.

3.4.1 Review of Aboriginal content in midwifery and nursing programs

In 2009 a review of Aboriginal content in Western Australian health education undergraduate curricula aimed to determine whether health professionals were equipped to provide culturally secure care to pregnant Aboriginal women (Reibel, 2009). It was noted that while midwifery programs “. . . always include Aboriginal content incorporating both general and antenatal specific cultural security indicators . . . as both stand alone and integrated components of curricular”, concern was expressed about the lack of content in nursing education related to pregnancy and childbirth practices in Aboriginal communities (Reibel, 2009, p. 3). This was identified as a significant issue given that in rural and remote regions nurses are frequently the only local health care providers with responsibility for antenatal care.

While undergraduate programs in nursing and midwifery are required by the Western Australian Board of the Nursing and Midwifery Board of Australia to include a discrete unit on Aboriginal health and culture, content on Aboriginal maternal and newborn care is not always included in these units in nursing programs. Midwifery programs reviewed by Reibel (2009) included: information on historical and contemporary issues related to Aboriginal health status; cultural awareness and /or cultural safety issues; variations in Aboriginal pregnancy and birth
practices; and methods for effective pregnancy and childbirth education and culturally appropriate care. However, the time devoted to these content areas varied considerably and was dependent, in large part, on whether the program was undergraduate or postgraduate, the former being allocated a greater number of hours (Reibel, 2009). The review recommended addressing these inconsistencies and supported the promotion of cultural competence continuous professional development (CPD) by relevant boards following registration for doctors, nurses and midwives. CPD was considered particularly important for doctors and midwives as principal providers of antenatal care for Aboriginal women (Reibel, 2009).

3.4.2 Culturally responsive service provision

Literature on cultural safety and/or security and maternity care for Aboriginal women in Australia is extensive, and includes contributions from Aboriginal academics and consumers. Research reports and discussion papers include: reference to cultural content in midwifery programs; the risks and benefits of birthing on country; the social and cultural dislocation experienced by women who leave their communities for confinement; inadequate responses by mainstream services to Aboriginal women’s cultural needs; lack of recognition of traditional Aboriginal birthing knowledge; partnership models for culturally secure care; and international developments in localised birthing, especially in the Canadian context (Birch, Ruttan, Muth & Baydala, 2009; Dietsch, Davies, Shackleton, Alton & MacLeod, 2008; Gherardi, 2002; Hancock, 2006; Health Council of Canada, 2011; Homer et al., 2012; Kildea, 2006; Kildea, Stapleton, Murphy, Low & Gibbons 2012; Kildea & Van Wagner, 2013; Kildea & Wardaguga, 2009; Kruske, Kildea & Barclay, 2006; Sainsbury, 2009; Stamp et al., 2008; Tracey, Barclay & Brodei, 2000; Van Wagner, Epoo, Nastapoka & Harney, 2007).

Discussion of culturally responsive maternity care for Aboriginal women is usually foregrounded by acknowledgement that maternal and child health statistics are considerably worse than for the wider population. These disparities, outlined in Chapter Two (Section 2.3), are one of the reasons for the rise of specialist antenatal clinics for Aboriginal women. In an evaluation of a specialist clinic, Kildea et al. (2012) drew attention to Aboriginal women’s dissatisfaction with some mainstream maternity care services, where negative staff attitudes, long waiting times, poor public transport, lack of Aboriginal staff and child care facilities and poor communication, were identified as problems. Similar concerns identified in Hancock’s (2006) review of Aboriginal women’s needs and experiences of maternity services, suggest that much more needs to be done to address the limitations of mainstream services, as many women do not have access to specialist, community-controlled clinics.
The Health Council of Canada’s (2011) report *Understanding and Improving Aboriginal Maternal and Child Health in Canada*, highlighted health disparities between Canada’s Aboriginal and non-Aboriginal populations, and provided a rationale for re-thinking the delivery of health services to Aboriginal women. In common with Aboriginal populations in Australia, Canadian Aboriginal women are characterised by a younger demographic and higher birth rates than their non-Aboriginal counterparts (Health Council of Canada, 2011; AIHW, 2015). There are striking similarities in terms of health disparities between Canadian and Australian Aboriginal infants and children including: higher infant mortality rates; higher rates of child injury, accidental death and ear infections; and higher levels of exposure to environmental contaminants, including tobacco smoke. These similarities, which also pertain to Indigenous populations in the United States and New Zealand, are associated with a number of social determinants of health including the impact of colonisation, poverty and sub-standard housing, and restricted access to appropriate health care and social resources (Health Council of Canada, 2011). While disparities in Australia are slowly narrowing, due to heightened awareness and resources associated with the *Closing the Gap* policy agenda, it remains the case that health and socio-economic disparities between Aboriginal and non-Aboriginal Australians are the starkest of all (Saggers et al., 2011).

Although midwifery programs in Australian universities include core content on Aboriginal cultures and health, there is little evidence to suggest that the knowledge gained and the shift in attitudes (where this actually occurs) is translated into culturally responsive care in practice settings. Health delivery research indicates that Aboriginal women continue to express dissatisfaction with service provision (Kildea et al., 2012). Kruske, Kildea and Barclay (2006, p.73) noted that the provision of culturally safe maternity care requires systemic reform of the health care system, including “. . . the individual practitioner response; the educational preparation of practitioners; the delivery of maternity services and the development of policy at local, state and national level”.

Consultations with Aboriginal women over many years have revealed that “. . . choice; cultural considerations around birth (e.g. being cared for [by] women and appropriate care of the placenta); having family members with them during birth and their children nearby. . .” are factors that are often absent from the birthing environment (Kruske et al., 2006, p. 75). The authors referred to the Aboriginal concept of *shame*, to highlight how cultural protocols can be breached through ignorance or inadequate resources. *Shame* is an emotion often misunderstood by health care providers and refers to “. . . feelings of guilt and can occur when an individual is singled out, or is involved in actions not sanctioned by the group, or in those that conflict with their cultural obligations” (Kruske et al., 2006, p.75). Aboriginal women attended by men
during childbirth may experience *shame*, and this combined with other anxieties such as isolation from family and community due to relocation, can place the health of mothers and babies at risk.

3.4.3 Relocation for birthing

It has been reported that many Aboriginal women desire to birth in their own community or *on country* where possible, and that such a model would improve maternal and infant health outcomes (Kildea & Van Wagner, 2012). Women in remote areas are routinely relocated to hospitals in regional areas when they are between 36 to 38 weeks gestation (Kildea, 2006). The emotional impact of separation from partners, children and extended family support networks, combined with cultural dislocation, is often a source of great stress (Gherardi, 2002; Kildea, 2006; Kildea & Van Wagner, 2013; Kruske et al., 2006). Kildea (2006, p. 389) noted that some women associated birthing in hospital with a “weakened spirit” in the baby, and prefer to have access to the knowledge and support of their Elders, even if *birthing on country* is “less safe”.

The 2012 report ‘*Birthing on County*’ maternity service delivery models: a rapid review addressed the National Maternity Services Plan (2011) Action 2.2.3 which required research into international evidence-based examples of *birthing on country* programs. The information gathered informed national developments in this area. *Birthing on country* was defined as:

> . . . maternity services designed and delivered for Indigenous women that encompass some or all of the following elements: are community based and governed; allow for incorporation of traditional practice; involve a connection with land and country; incorporate a holistic definition of health; value Indigenous and non-Indigenous ways of knowing and learning; risk assessment and service delivery; are culturally competent; and developed by or with Indigenous people.

(Kildea & Van Wagner, 2012, p. 5)

The review focused on programs in Australia, New Zealand, Canada and the United States. It explored the components of service delivery models, their effectiveness, and the barriers to, and facilitators of successful implementation and sustainability. Limited high quality research, small numbers and problems associated with combining data from studies with variable designs, combined to make the evaluation task complex. However, the international dimension of the review provided especially valuable information from the largest study conducted in the remote Inuit setting in Canada (Kildea & Van Wagner, 2012). The authors noted the striking similarities between Inuit and Aboriginal Australian communities, including: the vastness of the settings, the scattered nature of the populations, the impact of bad weather on transportation,
poor living conditions and low literacy and numeracy rates (Kildea & Van Wagner, 2012). Furthermore, both populations have a history of colonisation, loss of land and cultural identity. Due to these similarities, the Inuit birthing model has been closely observed by Australian midwives and policy makers (Kildea, 2006).

The Inuulitsivik *birthing on country* model adopted by the community in the Nunavut region of Quebec, Canada, is widely recognised as an exemplar in the field (Kildea, 2006; Kildea & Van Wagner, 2012). Originally conceived out of dissatisfaction with the requirement that all pregnant women be relocated to birth, the Inuit-led midwifery service combined local birth centres with training for local Inuit midwives. Following a pilot study in 1996, the efficacy of the centre was established and it was determined that women could deliver safely in their own communities (Gherardi, 2002; Kildea, 2006). Evaluation of maternal and child health outcomes revealed: a reduction in the perinatal mortality rate (based on 3,000 births), a halving of the rate of inductions, a drop in transfers from 91% to 9%, and a 2% caesarean section rate compared with 27% in Quebec (Kildea & Van Wagner, 2012). Additional data confirmed the sustainability and excellent outcomes of the midwifery service, where 86% of births were attended by midwives, 74% of whom were Inuit. Factors implicated in the success of the program included on-site midwifery training, and the integration of local Inuit knowledge with western knowledge. In addition, risk screening was viewed as a social, cultural, and community process, not purely a biomedical process (Kildea & Van Wagner, 2012).

In Australia too, some Aboriginal women have resisted relocation to regional hospitals, and believe that more localised birthing could improve maternal and perinatal health outcomes (Kildea & Van Wagner, 2012). The review found that “incorporation of traditional midwifery knowledge and skills . . .” was essential to the success of some community-based health services, and that Aboriginal staff were pivotal to service acceptability (Kildea & Van Wagner, 2012, p. 28). Potential benefits of community-based birthing services included:

- community ‘healing’
- Reduced family separation at critical times
- Reduced family violence
- Restoration of skills and pride
- Capacity building in the community
- Supporting community and family relationships
- Increased communication/liaison with other health professionals and service providers

Comprehensive, holistic, tailored care (Kildea & Van Wagner, 2012, p.28)
The review concluded that while a *birthing on country* model would most likely result in improved outcomes for Aboriginal women and their babies, serious workforce challenges existed with a critical shortage of doctors, nurses, and midwives in rural and remote regions. However, the authors did note the potential for employment of Aboriginal people in their own communities through capacity building, and the development of locally based education programs (Kildea & Van Wagner, 2012). Other studies have revealed that while many remote Aboriginal women acknowledge the benefits associated with western hospital care, family logistics, distance and loneliness are disincentives to relocate (Hancock, 2006; Simmonds et al., 2010; Simmonds et al., 2012). The provision of a support person to accompany a birthing mother is viewed as one way of tackling this problem.

Studies have also drawn attention to the involvement of Aboriginal Health Workers in pregnancy care and the organisation of services, cross-cultural education for all maternity care staff and the linking of health care providers with Aboriginal communities (Hunt, 2003 cited in Kildea & Van Wagner, 2012). Aboriginal Health Workers provide a range of primary health care services to Aboriginal and Torres Strait Islander communities including: screenings, immunisation, transportation and community health education. Their role usually requires certification in Aboriginal primary health care (Australian Indigenous health info.net, 2016b).

Numerous programs that aim to improve Aboriginal maternal and child health outcomes have been developed throughout Australia and undergo constant evaluation (Brown et al., 2015; d’Espaignet, Measey, Carnegie, & Mackerras, 2003; Kildea et al., 2012; Lowell, Kildea, & Esden, 2008; Panaretto et al., 2007; Stamp et al., 2008). When the issue of relocation for birthing is raised, however, Kildea (2006) has noted that risk assessment rarely considers Aboriginal authoritative knowledge. While this knowledge is socially constructed and dynamic, it represents the experience and voices of generations of Aboriginal women, who have been denied a role in decision-making concerning their birthing preferences, under the practice of the standard biomedical model (Kildea, 2006).

Education and practice issues in the midwifery profession that impact on service delivery to Aboriginal women have been presented in this last section of the literature review. Close professional links between nursing and midwifery have produced similar culturally inclusive approaches to health care delivery in training programs. However, there remains variability in the amount of Aboriginal content delivered in midwifery programs, especially in the postgraduate area. Issues pertinent to pregnant and birthing Aboriginal women, including: dissatisfaction with mainstream services, the rise of specialist antenatal clinics, problems associated with relocation for birthing, and the importance of Aboriginal authoritative
knowledge, have been outlined, with particular attention paid to the *Birthing on Country* review, its findings and recommendations.

### 3.5 Chapter summary

This chapter reviewed key international and local cultural competence literature that informs the principal research objective of this study: *exploring the concept of culturally secure practice in midwifery education and its application in service provision for Aboriginal women*. Contested terrain surrounding terminology and pedagogical approaches to the teaching of cross-cultural content in health science programs, were examined. In the Australian context, developments that led to the compulsory inclusion of Aboriginal content in professional programs, especially medicine, nursing and midwifery, were outlined.

While a consistent feature of programs that aim to improve Aboriginal health is recognition of the need for a culturally competent health care workforce, strong evidence of the link between improved outcomes, and cultural competence is yet to be established. Furthermore, little is known about the translation of students’ attitudes and knowledge about Aboriginal health into behavioural and practice change in health care settings. Despite this, it is recognised that culturally inclusive health care and secure practice enhances accessibility and reduces dissatisfaction with service provision. As a *Close the Gap* priority reform area, the development of a culturally competent health care workforce has never been more important. Closely associated with this aim, is an understanding of the educational processes involved in effecting attitudinal change among health care professionals. The next chapter outlines the methodology used to explore students’ responses to Aboriginal content in their program, and the extent to which this content enhanced knowledge and shifted attitudes towards Aboriginal Australians.
Chapter Four: Methodology

4.1 Introduction to the chapter

This chapter provides the rationale for and details of the mixed methods approach adopted in this study. The pragmatic paradigm commonly associated with mixed methods research, is discussed in the context of alternative worldviews, and the centrality of the research question in this underlying philosophical framework. The study design and the specific methods or tools used for the collection and analysis of data are described. Theoretical considerations as they relate to the development of the research problem, and the approach adopted to address the aims and objectives of the study, are also referred to in this chapter.

4.2 Approaches to research

Creswell (2014) describes the three main approaches to research as forming a continuum, with quantitative and qualitative approaches placed at different ends and mixed methods located in the middle. Like other authors (Newman & Benz, cited in Creswell, 2014; Onwuegbuzie & Leech, 2005), Creswell (2014) is quick to point out that quantitative and qualitative approaches do not represent distinct categories or bi-polar opposites, but rather tendencies on an interactive continuum. He defines quantitative research as “... an approach for testing objective theories by examining the relationship among variables” (Creswell, 2014, p.4). Typically, the measurement of variables renders numerical data which is statistically analysed. Deductive reasoning and generalisability are key characteristics of quantitative approaches. On the other hand, qualitative research is described as an approach “... for exploring and understanding the meaning individuals or groups ascribe to a social or human problem” (Creswell, 2014, p. 4). Inductive reasoning is central to qualitative research, and produces emerging questions and themes from rich data, usually generated in the participant’s setting. Data gathering varies between the two approaches, with questionnaires commonly associated with quantitative research, and in-depth interviews with qualitative research (Creswell, 2014). Historically, researchers often pledged allegiance to one of these two approaches and a bitter divide emerged (Onwuegbuzie & Leech, 2005), although more recently the value of mixed methods research has been actively promoted. Mixed methods research is defined as “an approach to inquiry involving collecting both quantitative and qualitative data, integrating the two forms of data, and using distinct designs that may involve philosophical assumptions and theoretical frameworks” (Creswell, 2014, p. 4). A central tenet of mixed methods research is that a combination of approaches provides a more comprehensive understanding of the research problem.
4.2.1 Philosophical assumptions in research approaches

The philosophical ideas or *worldview* that a researcher embraces informs the research problem and the approach adopted to investigate the problem. Creswell (2014, p. 6) defined the term worldview as “. . . a basic set of beliefs that guide action” and notes that the general philosophical orientation of a researcher, may be influenced by discipline perspectives and past research experiences. Some authors refer to a researcher’s worldview as a *paradigm*, and the terms *epistemologies*, *ontologies* and *theoretical frameworks* are also commonly used in the literature (Creswell, 2014). Mackenzie & Knipe (2006) suggested that a paradigm comprises logically connected assumptions that orient the research, and provide the philosophical intent or motivation for embarking upon it. This meaning aligns well with Creswell’s notion of worldview. While the researcher’s worldview or paradigm has a bearing on the approach adopted, and may be influenced by their discipline, an extensive systematic review of diffusion of innovations in health services revealed that different terminology used by various disciplines did not compromise research outcomes (Greenhalgh, Robert, Macfarlane, Bate & Kyriakidou, 2004). Four commonly identified worldviews are post-positivism; interpretative/constructivism; transformative and pragmatism (Creswell, 2014; Mackenzie & Knipe, 2006).

Post-positivism tends to be associated with quantitative research approaches, and is often referred to simply as the *scientific method*. It is characterised by a deterministic philosophy with respect to cause and effect; is reductionist; is based on empirical observation and measurement; and usually begins with a theory, which is supported or refuted (Creswell, 2014). Post-positivists challenge “the traditional notion of the absolute truth of knowledge” which characterises positivist thinking and believe that all knowledge is conjectural (Creswell, 2014, p.7).

An interpretive/constructivism worldview is associated with qualitative research approaches, and attempts to understand the subjective world of individuals’ experiences. The perspective of participants in the study and their interactions with others is paramount, and the positioning of the researcher in relation to the research conducted is recognised as a factor influencing the interpretation of data (Creswell, 2014; Mackenzie & Knipe, 2006). Unlike post-positivists, interpretive/constructivism researchers generate patterns of meaning or theories inductively from data gathered in the field.

The philosophical assumptions of a transformative worldview imply that “. . . research inquiry needs to be intertwined with politics and a political change agenda to confront social oppression at whatever levels it occurs” (Mertens, cited in Creswell, 2014, p. 9). The focus is
upon the needs of those in society who are marginalised or oppressed and transformative research attempts to provide a voice for participants, who often work collaboratively on research projects (Mackenzie & Knipe, 2006). Theoretical perspectives, such as those drawn from feminism, Marxism and critical theory, frequently provide a lens through which social issues are examined (Creswell, 2014). Transformative researchers may utilise quantitative, qualitative and/or mixed methods approaches to data collection.

The pragmatic worldview is the one adopted in this study. For pragmatists, attention focuses on the research problem, and any methods deemed appropriate to elucidate the problem are used. This liberates the researcher from the constraints associated with a single approach, and as such a pragmatic worldview is most commonly associated with mixed methods research (Creswell, 2014; Onwuegbuzie & Leech, 2005). The assumptions underlying pragmatism suggest that the world cannot be viewed as “an absolute unity”, that “truth is what works at the time”, and that research cannot be divorced from the various social, political and historical contexts in which it occurs (Creswell, 2014, p.11). “Subtle realism”, a variant of pragmatism, maintains that any knowledge is necessarily uncertain, and open to competing views of the social world, reinforcing the need for reflexivity with respect to methods adopted in research (O’Cathain, 2010).

The range of philosophical assumptions in these worldviews has sometimes caused tension, as proponents tend to focus on their differences rather than similarities. Purists suggest that quantitative and qualitative methods should not be mixed as they hold incompatible assumptions about the nature of research and how the world is viewed (Onwuegbuzie & Leech, 2005). Pragmatists, however, believe that a false dichotomy exists between these approaches. They do not insist on “epistemological purity” but rather suggest that our understanding of social phenomena is enhanced by the integration of quantitative and qualitative approaches, and utilisation of the strengths of each approach (Onwuegbuzie & Leech, 2005, p. 377).

Prior to describing mixed methods research, it is useful to clarify the difference between methodology and methods, as these terms are often used interchangeably. Methodology refers to the overall approach to research, the frame of reference which is linked to the researcher’s worldview or paradigm, whereas methods refer to the specific tools used for data collection, and for the analysis of data (Mackenzie & Knipe, 2006). Diverse data collection tools are frequently incorporated into mixed methods research designs in keeping with a pragmatic worldview, which argues that the research problem should determine the methods used for data collection and analysis (O’Cathain, 2010).
4.2.2 Mixed methods research designs

Mixed methods designs involve “combining or integration of qualitative and quantitative research and data in a research study” (Creswell, 2014, p. 14). While used by some psychologists in the 1950s, these designs became more widespread and refined in the 1990s where their value in neutralising the weakness of single approach research was recognised (Creswell, 2014). Early resistance to the combination of research approaches centred on incommensurability, the idea that quantitative methods are linked with positivism and qualitative methods with interpretivism, and it is not possible to combine worldviews or paradigms or the methods associated with them (O’Cathain, 2010). Over time the strength of this argument diminished and there is now general agreement that a mixed methods design within paradigms and even across paradigms is acceptable (Guba & Lincoln, cited in O’Cathain, 2010). Onwuegbuzie and Leech (2005, p. 383) promoted methodological pluralism and suggested that pragmatic researchers who used mixed methods are able to “combine empirical precision with descriptive precision . . . armed with a bi-focal lens (i.e. both quantitative and qualitative data), rather than with a single lens, (they) are able to zoom in to microscopic detail or to zoom out to infinite scope”. Drawing on the work of Greene, Caracelli and Graham (1989) they outlined the five broad purposes of mixed methods research:

1. triangulation (i.e. seeking convergence and corroboration of results from different methods studying the same phenomenon);
2. complementarity (i.e. seeking elaboration, enhancement, illustration and clarification of results from one method with results from the other method);
3. development (i.e. using the results from one method to help inform the other method);
4. initiation (i.e. discovering paradoxes and contradictions that lead to a re-framing of the research question); and
5. expansion (i.e. seeking to expand the breadth and range of inquiry by using different methods for different inquiry components) (Onwuegbuzie & Leech, 2005, p. 384).

Creswell (2014) described three principal mixed methods designs used in social science research, namely convergent parallel mixed methods; explanatory sequential mixed methods; and exploratory sequential mixed methods. These are differentiated by whether quantitative and qualitative data are collected simultaneously and merged (parallel) or sequentially with quantitative data first then qualitative (explanatory), or the reverse (exploratory). More sophisticated designs arise from these including multi-phased mixed methods, the design used in this study. The multi-phased design, which incorporates quantitative and qualitative strategies simultaneously and/or sequentially over a period of time, is most commonly used in evaluation studies and in the assessment of program interventions (Creswell, 2014).
In this study, the impact of an Aboriginal unit was explored across a semester and across an academic program. It required that various strategies be used at different points in the course of the study to provide the most comprehensive explanation of the research problem (see Section 4.4 for a detailed discussion of the study design). Four main justifications are cited for conducting mixed methods research (O’Cathain, 2010). To some extent these overlap with the purposes of mixed methods research identified above.

1. **Comprehensiveness**: this suggests that a combination of quantitative and qualitative methods allow for a more in-depth and complete study of the research problem, as the strengths of each method are utilised. Comprehensiveness is widely cited as a justification for the use of mixed methods in health research.

2. **Enhanced confidence in findings**: when the results from different methods are in agreement, the validity of the study is increased. The process of triangulation is frequently used in this context and may take a number of forms including data, theory and methodological triangulation. This process, which seeks corroboration of findings using different methods, is not without its critics, particularly with regard to the potential occurrence of shared bias in methods and how the value of different methods is assessed when findings do not converge.

3. **Development or facilitation**: where the findings of one method are used to assist the development of data collection or analysis based on another method. This justification is cited as a benefit of mixed methods research.

4. **Emancipation**: this proposition suggests that the voices of marginalised groups are more likely to be heard when a combination of methods is used in research (O’Cathain, 2010).

Mixed methods research designs are used for a range of reasons, justified on a number of grounds, and data are gathered concurrently or in sequence to illuminate the research problem. Despite the widespread use of this design, particularly in health research, there are limitations. These include the complexity associated with combining methods, the labour-intensive nature of the design and the need for researchers to be competent in both quantitative and qualitative data gathering collection methods and analysis (Whitehead & Elliott, 2007). It has also been noted that mixed methods designs have yet to be fully embraced by research communities, with suggestions that mixing methods and/or worldviews may taint individual methods and compromise rigour (Whitehead & Elliott, 2007). While these criticisms are rebutted by advocates of mixed methods designs, it is important to consider the specific research methods, including the data gathering techniques used and how they are combined to provide a more complete understanding of the research problem.
4.2.3 Research methods used in mixed methods designs

Creswell (2010) identifies the specific methods used in a study as the third component of a research framework in addition to philosophical assumptions or worldviews in research approaches, and research designs previously discussed. The methods include the tools used for data collection and the analysis and interpretation of the findings. The mixed methods research design used in this study incorporated a number of data gathering tools including a pre and post-intervention survey instrument, classroom observations and in-depth, semi-structured interviews. The choice of these tools was influenced by the nature of the research problem and the associated research objectives and questions. The following section will discuss the context of the research problem and describe how specific methods were used to explore the area under investigation.

4.3 The study context and research problem

While the study context has been described in Chapter Two, it is worth reiterating the justification for this study and how the research problem was formulated to address gaps in knowledge in this area. Interest in cultural competence in health service delivery has increased in the last two decades, even though there remains uncertainty about the extent to which a culturally competent workforce can improve health outcomes. In the Australian context, professional competencies in medicine, nursing and midwifery and most allied health professions require that programs address the complex relationship between culture and health, and in particular consider the implications of this relationship for Aboriginal communities.

While improved health is an aspirational outcome of a culturally competent workforce, it is recognised that culturally safe and secure health settings encourage utilisation and enhance satisfaction with service delivery.

The training of health professionals to become culturally competent practitioners varies according to the institution and discipline with recommendations by Universities Australia aimed at streamlining and strengthening content in all health professional programs (Universities Australia, 2011). A number of studies have explored student responses to compulsory Aboriginal content in their programs, with some medical schools particularly active in this area. It has been established that a spectrum of responses exist and that these may impact on whether students’ attitudes shift and whether their learnings are translated into practice (McDermott 2010; McDermott & Sjoberg, 2012). Little is known however, about midwifery students’ responses to Aboriginal content in their program, whether shifts in attitudes are maintained and whether cultural immersion experiences have value as a learning tool.
In midwifery practice, intimate and emotional times in women’s lives are shared with practitioners. The nature of the relationship forged with an Aboriginal woman and her family may influence her trust in and utilisation of future health services for herself and her children. Many pregnant and birthing Aboriginal women have culturally specific needs. Furthermore, they present in disproportionate numbers due higher levels of fertility and represent a younger demographic. Compared with other Australian women, they are more likely to be disadvantaged in terms of socio-economic status and geographical location. This combination of factors can influence attendance at antenatal clinics, progress of the pregnancy and desire to relocate for birthing. The education of midwifery students to provide culturally secure services is vital if they are to build trust, establish empathy and deliver services that are congruent with the expectations of Aboriginal women. This study arose from the recognition that little is known about the preparation of midwives to work with Aboriginal women, despite the fact that national competency standards require midwifery practice to be culturally safe. While the research objectives and questions were presented in Chapter One, it is worth re-stating them prior to describing the study design.

4.3.1 Research objectives and questions

The principal overarching research objective is: to explore the concept of culturally secure practice in midwifery education and its application in service provision for Aboriginal women. A number of specific objectives arise from this, namely to:

- critically analyse the concept of ‘cultural competence’ and related terminology, drawing upon national and international developments;
- review selected educational initiatives that prepare future health professionals to work with Aboriginal Australians;
- describe midwifery students’ engagement with Aboriginal content and compare findings with those from medical student studies;
- explore the impact of a compulsory, first year Aboriginal unit on student knowledge acquisition and attitude change;
- explore the impact of a compulsory, first year Aboriginal unit on the retention of knowledge and attitude change in subsequent years of a student’s program;
- determine the extent to which training for culturally secure practice is applied in clinical practice settings; and
• utilise this information to provide recommendations for the future development of Aboriginal content in midwifery and other health science programs.

Research questions were framed based upon these objectives. These include:

1. What constitutes culturally competent care in health service delivery and can it improve health outcomes for minority groups?
2. What approaches are used to prepare midwifery students to work with and care for pregnant and birthing Aboriginal women?
3. How do midwifery students respond to Aboriginal content in their program?
4. What factors influence student receptivity and resistance to Aboriginal content in their program?
5. Does experiential learning help students contextualise and apply content delivered in the classroom?
6. Do students perceive that they are adequately prepared to care for Aboriginal women and their babies at graduation?
7. How can this information be utilised to refine and improve programs to facilitate culturally informed health care delivery across the health sciences?

The following section describes the various data gathering techniques that were used to address the research objectives and questions posed. It also outlines the various stages of data gathering and the different student groups who participated in the study.

4.4 The study design

The nature of the research problem influenced the choice of the multi-phased mixed methods research design adopted in this study. Comprehensiveness and enhanced confidence in the findings, identified earlier as justifications for this design, were seen as important attributes that favoured a combination of quantitative and qualitative methods. As discussed in the literature review in Chapter Two, the theoretical orientation of this study rests on the premise that Indigenous cultural competence is an essential attribute of health professionals and content that is well designed and involves Aboriginal staff and community members in its development, has the potential to enhance knowledge and shift attitudes towards Aboriginal people.

4.4.1 The study population

Midwifery students in their first, second and third year of a university based, direct entry program and those in their final year (and semester) of a postgraduate diploma, comprised the study population. The first group is referred to as the undergraduate cohort and the second
group as the postgraduate cohort. A small number of practising midwives and midwifery academics were also consulted to provide information on clinical and pedagogical issues, and the impact of a remote area clinical placement completed by selected students in their final year. The annual undergraduate midwifery intake is limited to 20 students and most year groups comprise slightly fewer due to unit exemptions or recognition of prior learning. At the time of the study, the undergraduate cohort comprised 16 students in first year, 15 in second year and 13 in their final year; with $n$ equal to 44. The postgraduate cohort comprised 59 students across two final year groups.

The first year students in the undergraduate cohort were selected to facilitate investigation of key research objectives related to the impact of the Indigenous Cultures and Health unit on engagement with the content, knowledge acquisition, and attitude change. The second and third year students were included in the study population to provide insights into the longer term impact of the content and preparedness to work with Aboriginal women and their families. As the postgraduate cohort were qualified and practising nurses who were undertaking midwifery training, they already had diverse exposures to both formal Aboriginal content in undergraduate programs and clinical experience with Aboriginal patients. They were selected as part of the study population for these reasons and to ascertain their knowledge and attitudes towards Aboriginal health issues. It was anticipated that these findings might also provide a useful source of comparison with those from the undergraduate cohort.

4.4.2 Quantitative methods

Four survey instruments were designed in the study although many questions were identical. A pre and post-unit questionnaire was completed by first year midwifery students prior to the commencement of the Indigenous Cultures and Health unit and following completion of the unit. The post-unit questionnaire included additional items that assessed the impact of the unit on students. A third questionnaire was designed for second and third year students who completed the unit in the first year of their program. Finally, postgraduate midwifery students were provided with a questionnaire that was designed with their nursing experience in mind. The postgraduate diploma does not include a specific unit on Aboriginal health. Copies of all questionnaires are located in Appendix One.

Questionnaires gathered demographic information and data on students’ knowledge, attitudes and skills in the area of Aboriginal health. Information on factors that shaped student attitudes was also sought. The post-unit questionnaire completed by first year midwifery students included additional questions on students’ responses to the Indigenous Cultures and
Health unit. All other questions were identical in the pre- and post-unit questionnaires. Questionnaires for each year group included a set of statements on Aboriginal health that had been used in previous medical student studies. These statements were responded to using a Likert Scale. Third year students and postgraduate students who were about to graduate were also asked about their preparedness to work with pregnant and birthing Aboriginal women. Efforts were made to keep items as consistent as possible across the various questionnaires to ensure comparability of questions across time.

The statements from medical student studies and several attitude items were used in validated questionnaires developed at the universities of Western Australia and Melbourne, and Murdoch University. Approval for their inclusion was given and an acknowledgement recorded on the front page of each questionnaire. All items were pre-tested on midwifery students not involved in the study; minor amendments were made prior to distribution. Questionnaires were distributed to students in class by the researcher. This allowed time for the study to be explained and questions answered. It also facilitated a high response rate. Students were provided with a Participant Information Form (PIF), and a Participant Consent Form (PCF) which was signed prior to their involvement in the study. These forms are located in Appendix Two. No students declined the invitation to participate in the study.

Two difficulties arose during the distribution of questionnaires. The post-unit questionnaire was distributed to first year students during the last class of the semester. Some students missed this class as they were required to attend pre-arranged continuity of care appointments with pregnant women, and others skipped it because it was the last class and not deemed important. Questionnaires were sent to the absentees but not all responded. Of the original 16 students in the class, all of whom completed the pre-unit questionnaire, post-unit questionnaires were received from 12: one student withdrew in the first week and three students did not respond to email requests to complete and return the questionnaire. The second difficulty related to the postgraduate cohort. Many of these students lived in outer metropolitan or rural locations and did not regularly attend campus. Questionnaires were emailed to these students but the response rate was low. While electronic questionnaires are often characterised by low response rates, it should also be noted that many of these women were working and juggling family responsibilities. Of 59 postgraduate students across two final year groups, only 28 completed questionnaires were returned (48%). The majority of these were from students who completed them in class. While they provide useful information, it is less reliable than that obtained from the undergraduate cohort, where the overall response rate varied from 80-100% depending upon the year group.
4.4.3 Qualitative methods: classroom observations

Observations were conducted in weekly, two hour tutorials for midwifery students completing the *Indigenous Cultures and Health* unit. These were conducted by the researcher across a 12 week semester, although on one occasion the co-supervisor of the study conducted the observations on the researcher’s behalf due to work travel commitments. In total, 24 hours of observations were documented. Approval to conduct classroom observations was given by the unit coordinator and the tutor. The role of the observer in observation methods varies from that of “complete participant” in a setting, to that of “complete observer” where “…the researcher is confined to observations only and offers no interaction with participants” (Whitehead & Annells, 2007, p.131). In this study, the researcher assumed the role of “complete observer” and the research was undertaken with the full knowledge of the participants, as opposed to being covert.

The advantage of observation as a method relates to the capacity to capture interactions, behaviours and conversations of participants in a natural setting, and to document these in real time (Whitehead & Annells, 2007). In this study, interactions between students, and those between students and the tutor were carefully documented by the researcher, who was positioned at the back of the tutorial room. The intimate setting also enabled close observation of the participants’ body language. The observations, which took place throughout a semester, also enabled the researcher to document any changes in interactions and attitudes expressed as the semester progressed. This was essential to determine the impact of the unit on students.

Observation as a method also has limitations, the most commonly cited being the “Hawthorne effect” (Whitehead & Annells, 2007, p.132). This phenomenon arises from the fact that participants who know they are being observed may modify their behaviour to present themselves in a more positive light. While only complete concealment can eliminate potential reactivity of the part of participants, efforts can be made to mitigate its impact. In this study, the presence of the researcher lost its initial novelty effect due to the fact that it was a regular feature of every tutorial. There was an expectation of the researcher’s presence and over time the researcher was ignored. This was evidenced when chocolates were passed round the classroom, and only much later did a student notice that the researcher had been excluded. A second limitation of observational methods is the potential for greater subjectivity in the interpretation of the setting, although some suggest that researcher/participant subjectivity is a positive attribute of observation (Whitehead & Annells, 2007). In this study, detailed field notes were taken during each two hour tutorial. The researcher’s reflections were then immediately documented following the conclusion of the tutorial. While some degree of
subjectivity cannot be eliminated, and indeed may not be problematic, attempts were made to reduce its impact. An example of observation notes, including researcher reflections, is located in Appendix Two.

4.4.4 Qualitative methods: in-depth, semi-structured interviews

Twenty one in-depth semi-structured interviews were conducted as part of the research. Typically, semi-structured interviews use an interview guide or schedule, as was the case in this study. Numerous schedules were developed with the different groups of interviewees in mind, and the schedules contained many open-ended questions to stimulate discussion. The researcher, who is an experienced interviewer, took particular care to ensure the comfort and emotional safety of the participants. This was necessary, as the topics under discussion had potential to cause distress, especially for Aboriginal students.

Interviews were conducted in a private office at the university, or in the case of practising midwives, at the researcher’s or midwife’s home. Steps were taken to ensure interruptions were minimised: the telephone was taken off the hook, the mobile phone silenced, and a sign placed on the door. Efforts to minimise interviewee and interviewer fatigue were also made and one interview was conducted over two days for this reason (Whitehead & Annells, 2007). Drinks, food and tissues were readily available.

Given that in-depth interviews aim to elicit an emic or insider perspective on the area under investigation (Hennink, Hutter & Bailey, 2012; Liamputtong, 2011), a number of techniques were used to allow participants to speak freely and in-depth. Funnelling, probing and paraphrasing were employed to facilitate the interview process. Funnelling refers to the gradual shift in questioning from the general to the specific; probing is a technique which elicits additional information or clarification with targeted questioning; and paraphrasing requires the interviewer to repeat the participant’s answer using different words, but not changing the meaning, with the intention of seeking clarification and/or confirmation of a response (Whitehead & Annells, 2007). The breakdown of those who participated in interviews is as follows:

- Six interviews were conducted with students who had completed Indigenous Cultures and Health while the class was under observation;
- Seven interviews were conducted with final year students and midwives who completed the Ngaanyatjarra Lands remote clinical placement;
- Two interviews were conducted with a further two final year students;
• Three interviews were conducted with an Aboriginal midwifery student and two Aboriginal midwives, the total number of those who had enrolled in the program;
• Three interviews were conducted with staff: the undergraduate coordinator of the midwifery program; the Indigenous Cultures and Health tutor whose tutorial class was observed; and the midwifery clinical supervisor on the Ngaanyatjarra Lands.

Interviewees from the Indigenous Cultures and Health unit were purposively selected by the researcher to aid the interpretation of survey findings and classroom observations. Six students from the class of 15 (one withdrew from the original 16 after the first week) were invited to participate in an interview, and all accepted. Selected at the conclusion of the classroom observations, the researcher’s choice was influenced by the diversity of attitudes expressed towards the unit material. As the researcher had access to both pre-unit and post-unit survey results, and 24 hours of classroom observations at the time of interviews, they provided an opportunity to explore some issues in more depth, and triangulate data already gathered. The interviews, which lasted between 60 and 90 minutes, were all conducted face to face.

A second group of interviews was conducted with students who participated in the remote Ngaanyatjarra Lands clinical placement, which commenced in 2010. Invitations were extended to the first seven participants of the placement (the total number at the time of request). All accepted and were subsequently interviewed. At the time of interview, four students were in the final year of their program, and three were practising midwives. Details of the circumstances that gave rise to the clinical placement, and a description of the nature of the placement itself and its impact, are provided in Article 5 “‘Listening to the silence quietly’: investigating the value of cultural immersion and remote experiential learning in preparing midwifery students for clinical practice” in Chapter Five. Interviews lasted between 90 and 120 minutes, and were conducted face to face, with one exception, a phone interview with a country midwife. In addition to the remote clinical placement interviews, a further two interviews were conducted with students about to graduate, but who had not undertaken this placement. They were purposively selected to provide additional insights into final year classroom dynamics, and had identified themselves on the questionnaire as interested in being interviewed.

The third group of interviewees comprised Aboriginal women who were enrolled, or had previously been enrolled, in the direct entry midwifery program, since its inception in 2008 until 2013. Two Aboriginal women had completed the program and one was enrolled in her second year, but had deferred her studies. These small numbers reflect the fact that the direct entry midwifery program is relatively new and has a limited annual intake. Furthermore, Aboriginal women, who traditionally are under-represented in the health sciences, have been more inclined
to enrol in nursing as, until recently, midwifery was a postgraduate program. These interviews, which were conducted face to face, enabled the voices of Aboriginal women to be heard, not only from a student and professional perspective, but also from the vantage point of an Aboriginal women giving birth. Collectively, these women had 12 children between them, and as such had diverse experiences with the health care system in their own right. Their insights are referred to in Article 3 “‘Friendly racism and white guilt’: midwifery students’ engagement with Aboriginal content in their program” in Chapter Five.

The last group of interviews was conducted with three supervising staff, two employed by the university, and one employed by the Ngaanyatjarra Health Service in Alice Springs. Two interviews were conducted face to face and one by telephone. Input from the coordinator of the undergraduate program was considered essential, as in addition to overseeing curriculum development, she was closely involved in the establishment of the Ngaanyatjarra Lands clinical practice for final semester students. Equally, input from the midwifery clinical supervisor on the Lands provided an important perspective on students’ performance and capacity to work in very remote settings. The last staff interview, which was conducted with the tutor of the Indigenous Cultures and Health unit, was held at the conclusion of the teaching semester. This interview provided valuable information on the teaching process from the instructor’s point of view, and enabled triangulation of data gathered from students, and from the classroom observations.

Examples of interview schedules are located in Appendix Two. All interviewees completed a PCF and agreed to the recording of interviews. On several occasions, interviewees asked for the recorder to be paused while “off the record” comments were made. A small IC Sony recorder was used during each interview, and files were subsequently downloaded and transcribed. Interviewees were invited to listen to the recording prior to transcription, but all declined.

Despite the benefits of in-depth interviewing, which relate to the rich and extensive nature of data obtained, there are a number of limitations associated with using this research method. Interviews are time-consuming, resource-intensive, often difficult to arrange, and uncertainty exists around the number that should be conducted to provide a complete picture of the area under investigation (Whitehead & Annells, 2007). Furthermore, despite much time and effort, they may yield results that are not particularly useful. While these limitations are acknowledged, the benefits of incorporating in-depth interviews into this mixed methods study design far outweighed any disadvantages.
4.4.5 The multi-phased mixed methods research process

The multi-phased design used in this study required research methods to be used sequentially, and in tandem, over the period of data collection, that is, from July 2012 – March 2014. Figure 4.1 documents the various phases of the study. Ethics approvals, which were secured prior to the commencement of data collection, are described in Section 4.4.8.

**Figure 4.1 Multi-phased mixed methods research data collection process.**
While a multi-phased study extends the length of time of data collection, it has numerous advantages over conventional research designs. For example, in this study the researcher had access to both classroom observations and survey findings when student interviews commenced. Issues that required elaboration or clarification were followed up in interviews. This process is similar to an explanatory sequential mixed methods design, where quantitative findings are explored in more detail using in-depth interviews (Creswell, 2014). However, the inclusion of classroom observations over a period of time, and the use of before and after questionnaires, place the design more appropriately in the multi-phased mixed methods category. Regardless of the terminology, the design was chosen to best meet the research objectives.

4.4.6 Data integration and analysis

Multi-phased mixed methods designs frequently incorporate data analysis approaches used in convergent and sequential approaches. In a convergent approach, databases are analysed separately, compared side-by side, and merged or jointly displayed to confirm or disconfirm the findings (Creswell, 2014). The sequential nature of the design in this study resulted in corroboration of quantitative data, especially from open-ended items in questionnaires, and qualitative data acquired from classroom observations and in-depth interviews. Articles 2 and 3 in Chapter Five reflect this toing and froing between databases, however, the other papers rely more upon the data from the utilisation of a single method.

Coding and analysis of the survey data were performed using Statistical Packages for the Social Sciences (SPSS) software. Pre and post-unit questionnaires were matched and compared for evidence of enhanced knowledge and shifts in attitudes for individual students. Matching occurred using demographic characteristics and was possible due to the small number of students. Comparisons were also made across year groups. The small numbers due to capped enrolments in the midwifery program, limited statistical analysis. A non-parametric test, the Wilcoxon Signed Rank Test, was employed to test for evidence of shifts in knowledge and attitudes. Where appropriate, response categories were collapsed to increase numbers and aid analysis. Open-ended questionnaire responses were categorised and thematically analysed (Liamputtong, 2011). This process involved close scrutiny of each response to determine patterns and potential areas for follow-up in in-depth interviews. Article 4 in Chapter Five documents the quantitative process and the survey findings from the undergraduate cohort study.
Classroom observations and analysis were handled using standard qualitative procedures. The structure and organisation of the tutorials are described in Article 2 “Confronting uncomfortable truths: receptivity and resistance to Aboriginal content in midwifery education” in Chapter Five. An observational schedule was used to record information each week. Headings included:

- Tutorial theme/questions and readings
- Questions/comments in response to vodcasts
- Indications of receptivity/resistance in questions and comments
- Management of potential resistance (if any) by tutor and peers
- Degree of engagement based on tenor of student discussion
- Midwifery specific issues
- Sketch of classroom layout/comments on impact on student learning (if any)
- Group work, how many students in each, degree of participation
- Other comments, potential themes
- Notes, including impressions immediately after the tutorial and subsequent reflections

An example of a completed classroom observational schedule is located in Appendix Two. Initial codes were derived from weekly transcripts at the end of the teaching semester. Notations were made on the schedules to develop the codes and these were subsequently combined and categorised into key themes. Examples of initial codes developed from classroom observational schedules are provided in Table 4.1. Coding has been described as the starting point for qualitative analysis and involves labelling data to summarise and account for it (Liamputtong, 2011). Table 4.1 reveals that many initial codes were identified and sometimes repeated, but what they represent is the researcher’s distillation of meanings that participants attached to the unit content, and their responses to that content and the learning process: “. . . how people see their world and the symbols they use to understand their situation” (Liamputtong, 2011, p. 280).
Table 4.1. Coding sheets from classroom observations: Weeks 1, 6 and 11.

### Week 1 Introduction to unit

<table>
<thead>
<tr>
<th>‘kaya’ (affirmation)</th>
<th>representations</th>
<th>other cultures</th>
<th>engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting the scene</td>
<td>diversity</td>
<td>tutor’s role</td>
<td>respect</td>
</tr>
<tr>
<td>Conversation</td>
<td>safety in conversation</td>
<td>experiences</td>
<td>honesty</td>
</tr>
<tr>
<td>Reflexivity</td>
<td>friendly racism</td>
<td>reflective journaling</td>
<td>insecurity</td>
</tr>
<tr>
<td>Welcome to Country</td>
<td>stereotypes</td>
<td>terminology</td>
<td>safety</td>
</tr>
<tr>
<td>Acknowledgement</td>
<td>fear</td>
<td>resistance (gentle)</td>
<td>unpopular responses</td>
</tr>
<tr>
<td>Contradictions/ambiguities</td>
<td>soft option ‘lite’</td>
<td>kaya: power of words</td>
<td></td>
</tr>
</tbody>
</table>

### Week 6 Topic: Significance of Identity (observer’s reflection in bold)

<table>
<thead>
<tr>
<th>‘A very Aboriginal person’</th>
<th>Am I a racist?</th>
<th>Attitude formation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressures on Aboriginal kids</td>
<td>Code switching</td>
<td>Need for positive stories</td>
</tr>
<tr>
<td>‘Follow that dream’</td>
<td>Stereotypes</td>
<td>Being noticed</td>
</tr>
<tr>
<td>The third space</td>
<td>Assimilation policies</td>
<td>Professional practice</td>
</tr>
<tr>
<td>Kaya</td>
<td>Women disempowered</td>
<td>Aboriginal perspectives on</td>
</tr>
<tr>
<td>Skin colour</td>
<td>Mid students get it</td>
<td>birthing</td>
</tr>
<tr>
<td>Third space is safe</td>
<td>Reciprocity</td>
<td>Light skin, strong identity</td>
</tr>
<tr>
<td>Deficit model</td>
<td>Third space in midwifery care</td>
<td></td>
</tr>
<tr>
<td>Making assumptions</td>
<td>Scary behaviour on trains</td>
<td>Turning point tutorial?</td>
</tr>
<tr>
<td>Sometimes identifying is just too hard</td>
<td>Experiences</td>
<td></td>
</tr>
</tbody>
</table>
**Week 11 Topic: Health Story (observer’s reflection in bold)**

<table>
<thead>
<tr>
<th>Mission experience</th>
<th>Value of education</th>
<th>Embracing own history</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Returning home</td>
<td><strong>Fracturing in classroom?</strong></td>
</tr>
<tr>
<td>Resilience</td>
<td>Sense of authority</td>
<td>Connection with place</td>
</tr>
<tr>
<td>Stigma</td>
<td>Empowerment</td>
<td>Indigenous ‘exceptionalism’</td>
</tr>
<tr>
<td>Social determinants</td>
<td>Traditional medicines</td>
<td>Where are the Aboriginal</td>
</tr>
<tr>
<td>“us mission kids”</td>
<td>Collectivism vs individualism</td>
<td>midwives?</td>
</tr>
<tr>
<td>Lack of love</td>
<td>Positive discrimination</td>
<td>How circumstances shape</td>
</tr>
<tr>
<td>Positives</td>
<td></td>
<td>people differently</td>
</tr>
<tr>
<td>“Same can be said for non-Aboriginal person”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Capacity to cope within and outside institutions i.e. missions

Thematic analysis is a foundational method in qualitative studies (Liamputtong, 2011) and followed the initial coding process. This involved multiple readings of the classroom transcripts, reviews of initial codes, axial coding, where connections are made between initial codes, and categorisation of emerging themes. These themes were further refined as repeated patterns of meaning emerged from the data. While the NVivo computer package was initially used to organise data during the early coding process, this was eventually abandoned as the small number of transcripts did not warrant the time invested to master the software. Like Liamputtong (2011), spreadsheets, highlighters and Word cut and paste functions, combined with intimate knowledge and annotation of the transcripts, led to the development of final themes.

Data gathered from the in-depth interviews were also organised following thematic analysis procedures. Interview recordings were transcribed and these were annotated and coded to decipher emerging themes. As all interviews were over an hour in length, copious transcripts were produced. Manual organisation and analysis of the material was challenging, but the required thoroughness of the process resulted in the discernment of patterns and themes. Important quotations were identified, linked with themes, and subsequently used to give voice to the participants’ experiences and perspectives. Findings from the interviews were triangulated
with survey results and classroom observations to provide a more complete picture of the research problem, to tease out ambiguities, and highlight potential inconsistencies in the data.

### 4.4.7 Validity and reliability in quantitative and qualitative research

Approaches to reliability and validity vary according to the research methods adopted. In quantitative studies, validity refers to “. . . whether one can draw meaningful and useful inferences from scores on the instruments” (Creswell, 2014, p.160). Construct validity determines if items on a survey instrument measure hypothetical concepts and focuses on the usefulness of the scores, and their application in practice. Reliability refers to consistency across constructs and time, and in the administration of the survey (Creswell, 2014).

In this study, many questionnaire items were compiled from published research using validated instruments. As noted earlier, written approval was given for the inclusion of these items in the survey instrument. New items were discussed with the midwifery co-ordinator, and a modified instrument was pre-tested on midwifery students not involved in the study. This resulted in refinements to some items prior to the finalisation of the instrument. Previous studies had demonstrated reliability of the survey items with reference to internal consistency (Paul, Carr & Milroy, 2006; Rasmussen, 2001).

Efforts to enhance consistency in the administration of the survey included the use of a common PIF and PCF, and a standardised information session for all groups completing the questionnaire. The only exception to this was where some students in the postgraduate cohort were not on campus. Consistency was also prioritised in the development of various versions of the instrument: the same set of core items appeared in all versions with additional items only added to reflect the characteristics of the group and their level of training.

The accuracy and credibility of research findings is determined in different ways in qualitative studies. Strategies to enhance validity range from triangulation to rich, thick description, clarification of potential researcher bias and peer debriefing (Creswell, 2014). Multiple strategies are frequently employed with the aim of determining the accuracy or trustworthiness of the findings. In this study, examination of data from different sources (i.e. triangulation), and rich descriptions of settings and experiences were key strategies used to enhance the validity of the findings. In addition, the length of time spent observing classroom dynamics and conversations, lends credibility to the interpretation of those findings. The reliability or consistency of the qualitative methods adopted required careful documentation of the findings using standardised interview schedules and classroom observation sheets.
Transcripts were always checked for accuracy immediately following an interview or observation session and discussions with the supervisors of the study ensured that reflexivity was regularly employed.

4.4.8 Ethical issues

Within a research context, ethics has been defined as “. . . a set of moral principles that aim to prevent research participants from being harmed by the researcher and the research process” (Liamputtong, 2011, p. 32). Strict guidelines exist within institutions and organisations to guard against unethical research practices, and approvals must be sought prior to the commencement of data collection. In this study, the initial ethics approval was granted by the Western Australian Aboriginal Health Ethics Committee. Additional approvals were granted by Human Research Ethics Committees at Curtin University and the University of Western Australia.

Research must be conducted on the premise that participants will not be adversely affected by virtue of their involvement (Liamputtong, 2011; National Health & Medical Research Council, 2007; Universities Australia, 2011). In this study, student questionnaires were administered at the end of the teaching semester (with the exception of the pre-unit questionnaire) to minimise any potential misunderstanding that responses may influence students’ results. This was also clearly stated on PIFs given to all participants. Student names were not required on questionnaires and classroom observation notes did not identify students, rather they provided general information on their engagement with the content. Approaches to minimising risk and harm to Aboriginal participants are carefully documented in the National Health and Medical Research Council’s (2003) publication *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research* and in *Guidelines for Ethical Research in Australian Indigenous Studies* (Australian Institute of Aboriginal and Torres Strait Islander Studies [AIATSIS], 2012). These guidelines were followed to ensure that special responsibilities towards these participants were appropriately managed.

Informed consent and confidentiality are also important ethical considerations in research. A Participant Information Form (PIF), which outlined the research aims, methodology, anticipated benefits, and dissemination of the findings, was given to each participant prior to their involvement in this study. The voluntary nature of participation and the option to withdraw at any stage were outlined in the PIF, and reinforced verbally during information sessions. All of those involved in the research signed a Participant Consent Form and kept a copy of this document. An additional copy was kept by the researcher. As noted earlier, copies of these forms can be found in Appendix Two. Participants were reassured in the PIF as to the
confidential nature of the data gathered, and the checks and balances used to ensure their identity was not revealed. Practical measures included omitting names from questionnaires, using symbols or numbers for interviewees, safe storage of data in a locked cupboard and password-protected files. In addition, only the researcher and supervisors had access to survey and classroom data in its raw form throughout the study. Interview recordings sent for transcription were erased after 8 days by the providers of the transcription service, but were retained by the researcher for checking purposes.

4.4.9 Dissemination of research findings

An important part of the research process is the dissemination of findings amongst colleagues and those in the wider community who have a particular interest in the field. This has even more importance in Aboriginal research given its history in Australia, and Aboriginal people’s scepticism that they gain benefit from research, and necessarily influences the approach to research (Brands & Gooda, 2006; Davidson, 1980). Dissemination is advantageous to the researcher in terms of feedback and also allows those working in the field to be informed of current developments in research. On numerous occasions, various components of the research findings were presented at national and international conferences and forums. The findings were also disseminated at both local universities associated with the study. Aboriginal people were well represented at a number of presentations and used the opportunity to provide feedback and comments on the research findings. This exposure and the opportunity for cross-fertilisation of ideas was very beneficial and ensured reciprocity, a key ethical principle. Dissemination of the research findings also occurred through publications. Efforts were made to alert participants to new articles, and on numerous occasions these were forwarded to past and present students involved in the study, and health professional staff at the university and on the Ngaanyatjarra Lands. A full list of research presentations precedes Chapter One.

4.5 Chapter Summary

This chapter described the methodological approach adopted in the study, including the philosophical assumptions underlying the mixed methods research design. The research objectives and questions were presented in the context of the broader research problem, that is, the preparation of midwives to provide culturally secure care to Aboriginal women and their families. The study population and the various components of the study design, namely, surveys, classroom observations and in-depth interviews were described, together with the process of data collection and analysis. Procedures adopted to enhance the validity and reliability of the findings, and the ethical approvals granted prior to the commencement of data collection, were outlined. The study findings are presented in Chapter Five.
Chapter Five: The Study Findings.

5.1 Introduction to the chapter

This chapter presents the study findings from the undergraduate and postgraduate midwifery cohorts. The focus of the study was on the undergraduate cohort: exploring the impact of the Indigenous Cultures and Health unit on first year students, its longer term impact on students in subsequent years, and the value of experiential learning acquired through cultural immersion. Five articles address these areas and are presented in their published format. Postgraduate data were collected as a potential source of comparison with the undergraduate findings, and to explore students’ knowledge and attitudes, and their preparation for providing care to pregnant and birthing Aboriginal women. As the postgraduate survey response rate was quite low (48%), these findings are presented with more cautious interpretation.

5.2 The undergraduate cohort findings

The undergraduate cohort findings are presented in three sections. The first two articles are based on classroom observations conducted to explore the impact of the Indigenous Cultures and Health unit on first year midwifery students. They also draw upon selected survey findings and interview responses. These articles are titled Confronting uncomfortable truths: receptivity and resistance to Aboriginal content in midwifery education (Article 2), and ‘Friendly racism and white guilt’: midwifery students’ engagement with Aboriginal content in their program (Article 3).

In the second section, cross-sectional survey data collected from each of the undergraduate year groups is presented in Article 4: Exploring undergraduate midwifery students’ readiness to deliver culturally secure care for pregnant and birthing Aboriginal women. Articles 5 and 6, which are presented in the third section, explore students’ experiences and learning derived from a remote clinical placement on the Ngaanyatjarra Lands in Western Australia. These articles are titled ‘Listening to the silence quietly’: investigating the value of cultural immersion and remote experiential learning in preparing midwifery students for clinical practice, and Promoting women’s health in remote Aboriginal settings: Midwifery students’ insights for practice.
Confronting uncomfortable truths: Receptivity and resistance to Aboriginal content in midwifery education

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Abstract: Objectives: The emotional responses of students undertaking a new, compulsory unit on Indigenous cultures and health were investigated as part of a broader study looking at culturally secure practice in midwifery education and service provision for Aboriginal women. Methods: Classroom observations were conducted on a first year midwifery cohort from July to October 2012 and students completed ‘before and after’ questionnaires. Results: A spectrum of emotional responses was identified and found to be consistent with studies of medical student exposure to Aboriginal content. While stereotypes were challenged and perceptions altered as a result of the content, issues surrounding racism remained unresolved, with some students expressing dismay at the attitudes of their peers. Conclusion: This study confirmed the need for content on Aboriginal health and cultures to extend beyond one unit in a course. Learning and knowledge must be carefully integrated and developed to maximise understanding and ensure that unresolved issues are addressed.

Keywords: nursing and midwifery, Aboriginal health, cultural security, teaching and learning

The inclusion of compulsory content on Aboriginal health and cultures in health science programmes in Australia is now widespread and is a response to the recognition that a culturally informed health care workforce can contribute towards reducing health inequities. Despite progress in recent years, there remains a 10–12 year gap in life expectancy between Aboriginal and non-Aboriginal Australians. An Aboriginal child is twice as likely to die before their fifth birthday as a non-Aboriginal child, school retention rates are much lower for Aboriginal students and unsurprisingly, unemployment is considerably higher than in the wider community (Department of Families, Housing, Community Services and Indigenous Affairs, 2013). While many factors are implicated in these poor outcomes, a recent Universities Australia report highlighted the contribution that culturally competent graduates can make to a reduction in health and socio-economic disparities. In the context of Australian higher education, the report defines cultural competence as ‘student and staff 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, p. 3). Critiques of cultural competence make reference to limited evidence linking the concept to improved health outcomes for disadvantaged groups (Ewen, Paul, & Bloom, 2012; Lie, Lee-Rey, Gomez, Bereknyei, & Braddock, 2010). Despite this, it is recognised that culturally safe environments encourage Indigenous Australians to utilise health services.

The inclusion of Aboriginal content in health professional programmes has been accompanied by an expansion in the body of knowledge about student responses to this content, particularly in medicine. Studies have revealed that significant changes in students’ self-perceived levels of knowledge, skills and attitudes are possible if content is integrated, when Aboriginal people are involved in the planning and teaching of the material, and if experienced teachers are familiar with and comfortable working in inter-cultural contexts (Paul, 2012; Paul, Carr, & Milroy, 2006; Rasmussen, 2001). Although teaching and learning strategies vary, programmes that provide increased opportunities for interactions with Aboriginal people, including clinical encounters and community immersion experiences, have been shown to shift attitudes, with both the nature of interactions and the quality of the experiences of importance (Crampton, Dowell, Parkin, & Thompson, 2003; Huria, 2012; Jong, 2011; Kumash-Tan, Beagan, Loppie, Macleod, & Frank, 2007; Rasmussen, 2001).
The design of assessments, particularly those that require interaction with Aboriginal patients, also play a crucial role in challenging student assumptions and stereotypes, and provide profound learning experiences not readily acquired from textbooks (Paul, Allen, & Edgill, 2011). Despite these encouraging findings, the value attached to Aboriginal content in programmes is affected by perceptions of ‘soft science’ as opposed to evidence-based ‘real science’, with some students categorising this content as irrelevant (Betancourt, 2003; McDermott & Sjoberg, 2012). Perhaps due to the fact that compulsory Aboriginal content is fairly recent in health science programmes in Australia, few studies apart from those with medical students have explored responses to this content and evaluated the effectiveness of educational interventions. Given that nurses and midwives care for Aboriginal patients in urban, rural and remote settings and have, through their work, the opportunity to forge strong relationships with clients and their families, it is timely to explore the impact of Aboriginal content in curricula. As universities move towards embedding Indigenous cultural competency in all programmes, it is imperative that the academy evaluates the process and health outcomes of these initiatives for Aboriginal people, as well as how educational interventions impact on attitudes and behaviour in professional practice settings (Ewen et al., 2012; Nash, Meiklejohn, & Sacre, 2006; Universities Australia, 2011). This paper, which presents findings on first year midwifery students’ responses to a compulsory Aboriginal health unit, contributes to knowledge and understanding of teaching and learning processes in this intercultural space.

**Study Population and Methodology**

The study utilises the opportunity afforded by the introduction of core Aboriginal content into health sciences curricula at a Western Australian university. In 2011, an inter-professional common first year was introduced that included a compulsory Aboriginal health unit. The unit was developed and is taught by a team of Aboriginal and non-Aboriginal academics. The concepts of cultural safety with its focus upon the recipients of care and cultural security which maintains that health service delivery should not compromise Aboriginal cultural values (Thomson, 2005) provided a paedagogical framework for the unit development (J. Hoffman, personal communication, June 17, 2013). All health professional programmes at the university, including midwifery, required students to undertake this unit in the first year of their enrolment. The midwifery student cohort was selected as the study population reflecting the National Competency Standards for the Midwife (Australian Nursing and Midwifery Council, 2006) that require midwifery practice to be culturally safe and given that studies have highlighted the importance of midwifery students’ preparedness to work with Aboriginal women.

Additional factors informing the need for such a study included the unsatisfactory nature of maternity services for Aboriginal women especially those living in rural and remote regions, the higher fertility and maternal morbidity rates of Aboriginal compared with non-Aboriginal women, and the poorer health of Aboriginal infants (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2008; D’Antoine & Bessarab, 2011; Dunbar & Ford, 2011; Hirst, 2005; Kildea, 2006). In an overview of cultural competence in nursing and midwifery practice, Adams (2010) suggested that improved cultural responsiveness is necessary if health professionals are to play a significant role in improving Aboriginal health outcomes. Indeed, the nature of the relationship between a midwife and an Aboriginal woman has been linked to accessibility and satisfaction with health services, both of which may impact upon regular health care utilisation (Gherardi, 2002; Kildea, Kuske, Barclay, & Tracey, 2010).

The lead researcher, an anthropologist and long term Faculty member at this university, had taught health science students for over 20 years, including midwifery students since the inception of the undergraduate programme in 2008. Prior to the commencement of this in-depth study in 2012, the researcher ceased teaching midwifery students, although students were aware of the researcher’s longstanding role in the Faculty.

A mixed methods research design which included classroom observations, ‘before and after’ questionnaires, and interviews was chosen.
to gather data on student receptivity and engagement with Aboriginal content in their programme. Mixed method designs have been recommended as appropriate for this type of inquiry as they not only afford opportunities for triangulation of data but also avoid some of the pitfalls of narrow approaches (Betancourt, 2003; Kumash Tan et al., 2007). The ‘before and after’ questionnaires, which were pre-tested, were developed using validated questions from medical student studies (Paul et al., 2006; Rasmussen, 2001) and new, specifically designed questions relevant to the cohort. An ‘attitude thermometer’ which gauges the range of favourable to unfavourable attitudes towards Aboriginal people and has previously been used in a cultural psychology unit was included to assess changes that could be attributed to the unit content. Ethics approval for the study was granted by the Western Australian Aboriginal Health Ethics Committee and reciprocal approval received from Human Research Ethics Committees at the relevant universities.

This paper draws primarily from classroom observations and relevant sections of the survey data, in particular, open-ended responses. The ‘complete observer’ approach, where no interaction with the participants occurs, was adopted (Whitehead & Annells, 2007, p. 131). One tutorial group comprising 15 non-Aboriginal students (the total number of new midwifery students) was observed every week of the teaching period, from July to October 2012. This produced data from 12 two-hour tutorial sessions, that is, 24 hours of classroom observations. Permission was granted from the midwifery course coordinator, the unit co-coordinators, the tutor (non-Aboriginal) and all students prior to the commencement of the study. Information was provided on the observer’s role at an orientation session prior to the commencement of semester when consent was obtained and the pre-unit questionnaire completed. Thereafter, the observer was quite literally ‘a fly on the wall’; a person regarded as familiar and safe but to be ignored.

The tutorial format was tightly structured and included the viewing of a vodcast (prepared specifically for the unit and featuring Aboriginal speakers), discussion of issues arising, case studies, and periodic presentations by students. Topics ranged from diversity within communities, international comparisons, family structure, past policies and practices, cultural beliefs in health contexts and specific professional practice issues. Observational field notes recorded questions asked and comments made by students in response to podcast viewing, tenor of student discussion, indicators of receptivity and resistance as reflected in questions and discussions, quality of presentations and responses of peers, and observer perceptions of the learning process. Assessment in the unit comprised a number of computer-based e-tests that focussed on factual content from the text, a group presentation and a reflective journal. Full units in health science programmes in the Faculty attract 25 points; this unit attracts 12.5 points, so is categorised as a half unit with two contact hours a week.

Classroom observations facilitated the recording of developments in the teaching and learning process across a specific time frame, the identification of areas of resistance and a capacity to observe how these were managed. The main limitations of observational methods relate to the presence of the observer and the impact they have on the group being studied (Liamputtong, 2009; Whitehead & Annells, 2007). This impact was minimised by the lead researcher attending every tutorial (except one) thus minimising the novelty effect, and by remaining as discreet and unobtrusive as possible. As the semester progressed it became obvious that the researcher had successfully become almost invisible, evidenced when chocolates were shared amongst the class and tutor, with the observer completely overlooked without a glance or comment.

Sixteen students completed the pre-unit questionnaire (one student withdrew in the first week). Four students were aged between 17 and 20 years; six were in the 21–30 year age category, and the remaining six students were between 31 and 50 years. Almost 70% of the students were born in Australia, with other birthplaces including England (three students) and Papua New Guinea and South Africa (one student each). Nearly 40% of the cohort had a tertiary qualification prior to enrolment in this programme. In the pre-unit questionnaire, no one acknowledged descent or identified as an Aboriginal or Torres Strait Islander, although in the post-unit questionnaire one student acknowledged their descent
but noted that they did not identify. Attendance at tutorials was consistent throughout most of the semester however, as midwifery students are required to be on-call to ensure continuity of care for pregnant women, some students did miss classes. The last tutorial which was poorly attended made completion of the post-unit questionnaire difficult. Follow-up emails eventually produced an 80% response rate, with 12 of the 15 students completing questionnaires.

**Results**

**Creating a safe learning environment**

At the commencement of semester, agreement was established by the tutor and students on how challenging conversations would be conducted. Guidelines developed by students included respect for people’s rights to express a different opinion, not devaluing that opinion, keeping an open mind, remaining friends despite differences expressed, and refraining from labelling someone as ‘racist’. It was suggested that one ‘should not judge others too harshly’ and that consideration be given to experiences and background that may influence attitudes expressed. The tutor’s role in encouraging students to establish appropriate protocols and supporting the notion of ‘courageous conversations’ was pivotal to the creation of a safe learning environment where honesty was valued and experiences respected. It was noted however, in the course of observations, that this arrangement gave some students the imprimatur to discuss issues in a way that was offensive to others. For example, the honesty of one student’s account of her mother’s efforts to avoid any contact with Aboriginal people visibly shocked her peers and led another student to comment ‘it’s hard to hear someone talk about their background when the family is so prejudiced towards Aboriginals’.

Early on, it became clear that the creation of a safe learning environment involves not only giving students permission to speak honestly, without fear or favour, but recognising and responding to the impact of opinions expressed, especially when they have the potential to cause distress. The experience, sensitivity and skill of the tutor were essential to diffusing situations that arose, including in this example. Focus was redirected to attitude formation, and the reflexivity that was demanded enabled students to appreciate the multiple influences that impact on their worldviews.

**Emotional responses and indicators of receptivity and resistance**

The capacity to bring Aboriginal voices into the classroom using pre-recorded vodcasts was a successful teaching and learning strategy. Most students had minimal contact with Aboriginal people, and for some who had contact, it had not always been a positive experience. Students were greeted using the Noongar term *kaya* (language group from South-West of Western Australia), welcomed to country in Noongar, and throughout the semester ‘virtually’ introduced to many Aboriginal people from diverse backgrounds. Some clips contained individuals who fitted their preconceived notion of an Aboriginal person and others did not. This process of exposure to different Aboriginal people and scenarios was accompanied by a range of emotional responses, many of which were deeply felt. Shame, shock, disbelief, sorrow, sadness, anger, confusion, guilt and frustration were some of the responses identified and verbalised.

As asked about emotional responses to the content in the post-unit questionnaire one student commented ‘land rights, Stolen Generation, 1967 vote, 1905 Act – all these really shocked and upset me, a little teary in some classes, felt very frustrated and helpless’. Another student noted ‘I feel very sad about the issues facing Aboriginal people, not just in the past but still today. I have felt a strong sense of injustice on behalf of Aboriginal people, but I also hope that I can use what I have learned in my practice once qualified’.

Others felt conflicted when portrayals of Aboriginal people did not coincide with their experiences. For example, one student commented ‘I sometimes felt confused… Aboriginal culture and community can be portrayed in an idealistic way and yet my experience is different’ and another noted ‘at first I was very frustrated, a little offended, but as I learnt more I realised that there is truth in what we learnt’.

Some students were strongly affected by stories about the removal of children as told by Aboriginal mothers. Classroom discussions revealed that for those who were mothers, the ability to identify and empathise with Aboriginal women having
Receptivity and resistance to Aboriginal content in midwifery education

their children taken away was particularly powerful. Shame, guilt and anger were strong emotional responses to past policies and practices and the impact of these on the everyday lives of many Aboriginal people today. Few students were unmove by the power of stories told by those who had ‘lived experience’ and for some these were identified as the most useful aspect of the unit.

‘The real life stories in vodcasts giving accounts of life including good and bad aspects of situations makes it much more real/relevant when words are coming from a person as opposed to a textbook. Putting a face to a story gives deeper impact to what is being said, also shows us how people can look very different and still identify as Aboriginal’.

Indicators of receptivity and resistance to Aboriginal content were drawn from students’ questions and comments but also from more subtle responses including body language and classroom dynamics. Receptivity to the content based on questions and comments was overwhelmingly positive and the survey responses support this finding. In the post-unit survey, more than half of the students indicated that they were very receptive and would like more content on Aboriginal health and cultures in their midwifery programme. Many expressed surprise that they had not encountered this material earlier in their education, considering it a failing of the education system. Some who indicated that they had been resistant to the content at first commented that they had changed their minds over the course of the semester. No students reported being ‘resistant for most of the semester, couldn’t see the point’. Receptivity was particularly evident when students began applying the content to their professional practice. In one presentation, students identified Noongar terms for midwifery care that highlighted their understanding of the close relationship between language and cultural identity. They acknowledged that traditional languages are still used and have the potential to bridge divides between Aboriginal women and health care providers.

Signs of resistance in some students were observed, particularly early in the teaching sessions. This was evident in the comment that ‘it’s the same for all of us’ which was repeated on numerous occasions, including at the end of semester. Its expression took slightly different forms: ‘common issues for all, not just Aboriginal people’ and ‘the same can be said for a non-Aboriginal person’. The context was usually socio-economic circumstances, family issues or identification with country but it was a view expressed by a minority. This view was also reflected in the post-unit survey with one student commenting ‘sometimes I found that issues were made to be Aboriginal issues when they could also be applied to anyone’. These comments drew attention to elements of disadvantage that exist for many people. However, they failed to acknowledge the profound multiple disadvantages that many Aboriginal people endure. Others questioned the need for a unit only on Aboriginal people, commenting on the general nature of the content and that it could be offered in high schools, wondering out loud ‘will we all pass? Is it one of those units that everyone passes?’ While not indicative of resistance as such, these comments reflect the notion that students consider some units ‘soft’ and easy to pass (whether they are or not). Their attention to the content may be devalued as a result.

Resistance (if that’s what I’m detecting) can take many shapes and forms: quietness, facial expressions, raising the refrain ‘but it’s like that for everyone’, texting, switching off. I see it occasionally. (Observational field notes, 25/09/2012)

Observations of classroom dynamics revealed subtle tensions including the dominance of several group members. This was a source of irritation for some students and although skilfully handled by the tutor, it remained throughout the teaching period and was also commented upon in post-unit questionnaires. One student noted ‘some discussions were always dominated by the same people’, and another, ‘the discussion moves slowly because most people don’t contribute and a small number of people keep going over the same ground’. The tutor focussed the spotlight on the issue when she asked for anyone other than xx to respond to a question. It was taken light-heartedly, but did change the classroom dynamics with quieter students being drawn into the discussion. It was only a short term solution, however. Other sources of tension included opinions expressed that were not supported by the literature, and a controversial discussion around
definitions of Aboriginality, benefits and identity. While many stereotypes were exposed and student discussions were conducted within their guidelines, there remained unresolved issues around ‘race’ and what constitutes racist attitudes and behaviours. The group appeared to fracture over these issues, with some clearly offended by the attitudes of others. One student commented in the post-unit questionnaire that the most useful aspect of the unit was ‘seeing that people really don’t get it. I think I must spend my time with open minded people because I was disturbed by their narrow-mindedness’.

Finally, students’ attitudes towards Aboriginal people, as measured by the attitude thermometer increased from 63.3% in the pre-unit survey to 75.4% in the post-unit survey, where 100% represented ‘extremely favourable’ attitudes. Although the class size was small, this suggests that teaching and learning in this unit had the capacity to change attitudes. A stronger indication of this capacity for change was evident from post-unit survey comments in response to the question ‘If there has been any change in your perceptions (about Aboriginal communities and their health) can you outline this in more detail?’ While one student commented that there had been no change, ‘I have always respected the Indigenous population, I just have more understanding of health issues’, there were common themes reported by those whose perceptions had changed: less judgemental, greater understanding of the impact of past policies on health, less resentful, more compassion and open-mindedness.

(I have) a greater understanding of the underlying reasons and contributing factors to many of the problems we are aware of. I no longer judge behaviours/attitudes/problems as I have previously – the way this race has been treated makes me sick and any judgement has been replaced by compassion and empathy. Also much more frustration and anger towards past/current policies – didn’t think about this much before.

I have become more open minded and less judgemental towards Aboriginals. I feel slightly more comfortable if I was to care for an Aboriginal woman today as I’m more aware of how to communicate with them – yet I would still feel intimidated.

It is apparent from the last comment that positive changes in perceptions are not necessarily accompanied by increased confidence working with Aboriginal people in health care settings. A unit on Aboriginal health may have the capacity to change attitudes but preparedness for professional practice requires on-going development in this area and real life experiences where what has been learned can be applied. All students with only one exception reported wanting more clinical exposure to Aboriginal settings in their training.

**Development of critical thinking**

One advantage of observing teaching and learning processes longitudinally is the potential to record the development of more sophisticated thinking and students’ capacity to contextualise content in professional practice settings. By the middle of the teaching period clear evidence emerged that students were thinking at a deeper level. When the notion of the ‘third space’, a shared space where traditional power structures are broken down and people come together on equal terms, was under discussion, students were ready to embrace the idea but also critically analyse its application.

A really useful discussion of the ‘third space’ and some sound critical thinking is emerging, e.g. ‘flexibility is all very well but we are working in an inflexible health care system. So how do we deal with that?’ Students are contextualising and are more inclined to relate issues to professional practice. Also, there was very interesting discussion about ‘light skin’ and strong identity. Stereotypes are being dismantled. (Observational field notes, 21/08/2012)

The development in student thinking was also observed in discussions that centred on the Northern Territory Intervention and past policies of removing children from their families. The Intervention is the Australian Government’s response to the Northern Territory’s inquiry into the protection of Aboriginal children from sexual abuse (Wild & Anderson, 2007) and included a legislative component widely regarded as undermining the collective and individual rights, native title, and self-determination among Australia’s first people (Brown & Brown, 2007). The complexity of the issues involved, the way in which circumstances can shape people differently and the range of views expressed within the Aboriginal community, particularly with respect
to the Intervention, were recognised as significant considerations. Students also were alert to the lack of balance in reporting and some connected with the content at a deeper level as they developed greater empathy. Critical thinking emerged in students’ capacity for reflexivity, particularly with respect to their own backgrounds, socialisation, and experiences all of which shape values, attitudes and behaviour. When a young Aboriginal man, an actor and musician, and his girlfriend’s mother (a university teacher) visited the class to discuss Aboriginal family structure and the upcoming birth of his first child, stereotypes were challenged at the most profound level. For some students, this was the only interaction that had had with an Aboriginal person. That it was such a positive experience and that the visitors were talented, creative and successful individuals, helped dispel the misconceptions that some students harboured.

Finally, by the end of the teaching sessions it was evident that students were in a much better position to know what they didn’t know. For example, as content was contextualised and issues related to professional practice were considered from the perspective of what had been learned, many students commented on the desire to know more about issues that were specific to Aboriginal women and their families. These included birthing on country, traditional beliefs and practices surrounding birthing, the role of the father, mother and grandmother during delivery and the difficulties encountered by women who had to be sent away from their communities to birth. When students were asked what sorts of topics they would like to see covered in additional teaching on Aboriginal health, comments centred around more application of the content to midwifery, for example ‘how to specifically communicate with pregnant Aboriginal women – learning specifically about issues surrounding Aboriginal women who are pregnant’ and ‘I would love to know more about Aboriginal birthing traditions – I want to work with them’. Some students had already experienced practicums at Boodjari Yorgas (Noongar for ‘pregnant women’), a Family Care Program at Armadale Hospital in Western Australia, and were clearly eager to provide a culturally safe service to Aboriginal women. Discussion of their experiences suggested the practicum was a valuable learning experience although it was not clear how it influenced their attitudes towards Aboriginal women or whether they had an opportunity to apply what they had learned in the unit.

**DISCUSSION**

The creation of a safe learning space for students to discuss uncomfortable material is essential if teaching and learning is to be effective. McDermott and Gabb (2010) note the importance of clear guidelines for mutually respectful discussions as a means to facilitate ‘manageable disquiet’ when Aboriginal content is raised in the classroom. Disquiet manifests as unease or anxiety that is exhibited when students confront material that may shock or disturb. Other successful strategies identified include team teaching with Indigenous and non-Indigenous facilitators, an inclusive attitude encompassing the concept of partnerships, small group discussions, personalised material and practical application of learning. Confronting uncomfortable truths about our shared history can produce defensive responses and disquiet requires skilful management.

The strategies recommended by McDermott and Gabb (2010) were, to varying degrees, in place in this classroom setting. Clear guidelines developed by the students and endorsed and monitored by the tutor, ensured that differences of opinion were respected and honesty valued. Team teaching did not occur, however, and discussions with both Indigenous and non-Indigenous staff suggest it is the preferred teaching method. It was clear that when students had the opportunity to interact with Aboriginal people in a classroom environment, pre-existing stereotypes were challenged in a way that was different to that achieved by watching excerpts on film. An inclusive attitude prevailed throughout the semester and was reinforced by the introduction of Aboriginal voices into the classroom via vodcasts and by the tutor who constantly referred to ‘partnerships’, a concept that resonated with midwifery students. Small group discussions occurred each week, content was personalised through ‘lived experience’ stories, and as the semester progressed, applications to professional practice were discussed. However, facilitating ‘manageable disquiet’ was clearly more complex than simply applying a checklist of successful strategies.
Classroom dynamics are influenced by students’ personalities and experiences, demographic characteristics, the programme they are undertaking and, of course the skills and experience of the facilitator. The presence of Aboriginal students or an Aboriginal facilitator, for example, may not only change the dynamics considerably, but necessitate a rethink of what constitutes a safe learning environment from an Aboriginal student’s perspective.

Disquiet for most students is part of the learning experience and if managed carefully can be a key to attitude transformation. In this classroom setting, disquiet was observed when students were confronted with personal stories and factual information with which they were either unfamiliar or that conflicted with their preconceived notions of reality. It was also observed when judgemental attitudes were expressed. As discussed earlier, one student commented that the most useful aspect of the unit was the realisation that others simply did not understand the issues involved. She was genuinely shocked by this, rather than by any of the content in the unit.

Emotional responses of students to Aboriginal content in their programmes have been explored in a number of studies (McDermott & Gabb, 2010; McDermott & Sjoberg, 2012; Paul et al., 2006, 2011; Rasmussen, 2001). A recent study by Paul et al. (2011) focussed on student reflections following the completion of a formal case history of an Aboriginal or Torres Strait Islander patient conducted as an assessment by fourth year medical students at the University of Western Australia. A review of student reflections revealed a range of responses, including fear and apprehension, concerns about causing offence, the challenging of stereotypes, and the impact of confronting racism in the health sector. For some students, this was their ‘first in-depth interaction with an Indigenous patient’ (Paul et al., 2011, p. 58). The assessment proved to be a rich learning experience for students and for some, heightened their interest in working in Aboriginal health.

Midwifery students in this study exhibited a similar range of emotional responses with some expressing fear about causing offence and how this may interfere with their interactions with Aboriginal women. Students’ values also were challenged when confronted with examples of racism in the health care system as portrayed by Aboriginal people in the vodcasts. For some this was deeply shocking and lead to introspection, including asking themselves ‘am I a racist?’ Feelings of guilt and shame identified by McDermott and Gabb (2010) were also present, although denial of personal responsibility for the past was often incorporated into this complex emotion. Students’ receptivity to the content may be associated with their chosen vocation. One student commented that ‘we are midwives, we get it; we work with women’. The implication was that women are often disempowered during the birthing process and hence midwives have a better insight into difficulties confronting Aboriginal patients. Too little is known about midwives’ interactions with Aboriginal women to support this notion.

Many cross-cultural training programmes commence by asking participants to reflect on their own cultural background and their life experiences including the development of values and attitudes that have shaped their thinking and behaviours. Garvey (2007, p. 6) has described reflection as ‘… an active process of witnessing one’s own experience in order to take a closer look at it, sometimes to briefly direct attention to it, but often to explore it in greater depth’. The process of critical thinking often arises out of such self-reflection and is essential to understanding how others live their lives, how experiences affect us and how our values and attitudes may change when confronted with different realities. Browne and Varcoe (2006, p. 161) comment on the need to be ‘… consciously self-reflective about how we construct others; to be aware of the language we use to refer to others; to be conscious of the assumptions that underlie our constructions …’ They favour a critical cultural perspective that requires examination of ‘… how each individual is enmeshed within historical, social, economic and political relationships and processes’ and draws attention to the impact of these processes in the lives of others (Browne & Varcoe, 2006, p. 163).

Assumptions and stereotypes held by the students about Aboriginal people were readily acknowledged and brought into sharp relief when vodcast participants and invited visitors to the classroom did not meet preconceived notions.
of Aboriginality. As their thinking developed, the impact of such misconceptions in clinical settings became more apparent. Critical thinking which forms part of the reflective practice process requires looking inward but also to be outward looking ‘… to think critically about the dynamics of the organisation in which we work and our relationships with others, and to consider the broader social and political environments within which decisions are made’ (Thackrah & Scott, 2011, p. xxvii). Findings from this study suggest that students were cognisant of organisational barriers they are likely to encounter in clinical practice, but lacked confidence in their capacity to respond to these challenges.

**CONCLUSION**

For many midwifery students in this cohort, preparation for culturally informed practice with Aboriginal people began when they enrolled in this unit. While the teaching and learning process has been shown to have some capacity to change attitudes and to develop critical thinking among students, its impact will be limited if Aboriginal content is not carefully integrated and developed throughout the programme and particularly in clinical settings, to ensure that these early gains are maximised. Unresolved issues surrounding race, what constitutes and contributes to racist attitudes and behaviours and the presence of institutional racism in health care, all require a more sophisticated understanding of how health care delivery impacts on Aboriginal people and must be addressed before students enter the workforce. Furthermore, careful consideration should be given to team teaching where all students have the opportunity to be taught by Aboriginal and non-Aboriginal staff in partnership, even though this clearly has resourcing implications. In this study, vodcasts proved to be a powerful approach to challenging stereotypes and stimulating discussions, although the presence of an Aboriginal academic and visitor in the classroom had even greater impact.

Despite recommendations by Universities Australia (2011) to embed Indigenous cultural competency into all university programmes, the question remains as to whether information learned by health science students and attitudes challenged, will be reflected in interactions with Aboriginal patients and contribute to improved health outcomes. Studies on attitude change in response to Aboriginal content in the health sciences must be accompanied by research that explores whether these attitudes are translated into culturally secure practice in clinical settings. The real assessment of whether students’ learning translates in circumstances that matter will be their ability to challenge aspects of the prevailing culture within health services that impede the provision of culturally secure care for pregnant and birthing Aboriginal women.

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**REFERENCES**


Abstract

Since 2011, all first year students in a health sciences faculty at a university in Western Australia complete a compulsory (half) Unit titled Indigenous Cultures and Health. The Unit introduces students to Aboriginal and Torres Strait Islander history, diversity, cultural protocols, social structures, patterns of communication, contemporary policies and their implications for health professionals. It also invites students to reflect on their own social and cultural backgrounds and consider factors that shape their worldviews. The broader intent of the Unit is for students to commence the journey towards ‘Indigenous cultural competency’. This paper focuses upon findings from 12 weeks (24 hours) of classroom observations conducted in July-October 2012 with midwifery students enrolled in this Unit. It also explores data from comprehensive pre-and post-Unit questionnaires, together with findings from student and staff interviews. Observations, survey and interview data form part of a larger, mixed method study investigating culturally secure practice in midwifery education and ultimately service provision for Aboriginal women. Findings draw attention to strategies employed by teaching staff and students to create a safe learning environment, emotional responses and indicators of receptivity and resistance by students to Aboriginal content, the development of sophisticated critical thinking, and the uneasy, unnamed tension that hovered in the classroom and remained unresolved throughout the semester.

Introduction

On February 13th 2008 the Prime Minister of Australia, Kevin Rudd apologised to Aboriginal and Torres Strait Islander peoples for the damage inflicted by past policies and practices, in particular, the forced removal of children from their families, a practice that continued until the early 1970’s (Australian Parliament 2008). ‘The Apology’ as it is now known, acknowledged the impact of history on Aboriginal people’s health but also recognised the potential for healing that is inherent in a public display of remorse. Ewen and McCoy (2011, 213) note that the word ‘sorry’ has particular resonance for Aboriginal people and the rituals of sorry, known as ‘sorry business’ when translated to English, serve to “…gather people together to mourn, to make their grief public and to be healed”. The notion of sorry seeks to “…acknowledge those forces that have caused hurt, sickness, and death in the past and also express individual and group commitments to support the life and wellbeing of people into the future” (Ewen and McCoy 2011, 213)

One important initiative that arose from this symbolic gesture was a government policy called ‘Closing the Gap’ (Australian Government 2009). The gap refers to the enormous disparities that exist between Aboriginal and non-Aboriginal Australians in health, education and
employment. The difference in life expectancy between Aboriginal and non-Aboriginal Australians is more than 10 years, mortality rates for Aboriginal infants and young children are twice those of their non-Aboriginal counterparts, school retention rates are much lower for Aboriginal students, and unemployment is considerably higher than in the wider community (Department of Families, Housing, Community Services and Indigenous Affairs 2013; Saggers, Walter and Gray 2011). It has been suggested that the ‘Closing the Gap’ policy framework acknowledges, perhaps for the first time, that the social determinants of poor Aboriginal health outcomes must be tackled if significant improvements are to be achieved (Saggers et al. 2011). It is also widely recognised that enhancing access to health services is fundamental to improving health outcomes and that health professionals play a pivotal role in this process by creating culturally safe and secure environments for Aboriginal patients. Cultural safety had its origins in New Zealand in the late 1980s and is defined as:

The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice compromises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual (Te Kaunihera Tapuhi o Aotearoe: Nursing Council of New Zealand 2011, 7).

In the Australian context, the concept of cultural safety is used widely in nursing and midwifery literature together with the closely connected concept of cultural security where the focus is upon maintaining the integrity of Aboriginal cultural values in clinical settings. The application of cultural safety and security is associated with cultural competence strategies that also include the concepts of cultural awareness, humility and literacy (Ewen 2011; Thompson 2006).

Since the mid-1990s, the curricula of many health science programs in Australian universities have reflected the importance of preparing health professionals to work in diverse cultural settings. Developments in cultural competence in the United States had some bearing on curriculum initiatives in Australia but of equal importance was the recognition that cultural background was related to service accessibility and health outcomes among Australia’s culturally diverse populations. The term ‘cultural competence’ was defined by Cross et al (1989, iv) as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross–cultural situations”. In light of the enormous health disparities between Aboriginal and non-Aboriginal Australians, a particular focus on Australia’s First Peoples gained momentum.

It was less than a decade ago, in 2004 that an Indigenous Health Curriculum Framework was designed for implementation in medical schools at Australian universities (Phillips 2004). The framework was a response to consistent recommendations to strengthen Indigenous
content in medical curricula with the ultimate aim of improving health outcomes. Guiding principles for the development and delivery of Indigenous health in medical curricula made reference to cultural and geographical diversity, Indigenous perspectives on health, historical and social determinants of health, partnerships and Aboriginal Community Controlled Health Services (Phillips 2004). Other health professional programs soon followed suit and in the ‘Guiding Principles for Developing Indigenous Cultural Competency in Australian Universities’ published in 2011 by the peak body representing all national universities, Indigenous cultural competence was seen as a desirable attribute of all graduates (Universities Australia 2011, 3)

The momentum provided by ‘The Apology’ and the ‘Closing the Gap’ policy framework ensured that disparities in health between Aboriginal and non-Aboriginal Australians were firmly on the agenda and no longer able to be ignored. This is especially apparent in the academy where health professional programs incorporate content on Aboriginal cultures and history with the aim of developing cultural competence as a strategy to reduce health inequities. It needs to be noted that given the geographical distribution of Aboriginal people in areas of lower socioeconomic status, including outer urban, rural and remote areas, most students who enter Australian universities have limited knowledge of Aboriginal communities and cultures and the ongoing consequences of colonial settlement. This also reflects failings in the delivery of Australian history and social studies within Australia’s primary and secondary education systems.

Apart from some studies in medicine, little is known about how students respond to Aboriginal-related content and whether changes in attitudes and improved levels of knowledge and skills acquired in university programs translate to behaviour change in clinical settings. Furthermore, there is limited evidence to suggest that cultural competence in the workplace reduces health disparities in the community, although the few studies conducted indicate that where there is an association, it is in a positive direction (Lie et al. 2010). This paper which presents findings on midwifery students’ responses to Aboriginal content in their program addresses the existing knowledge gap in this area and is a necessary first step to determine whether sustained attitude and behaviour change is possible in the health care system. Entry into the undergraduate midwifery program in Western Australia that is the focus of this study is highly competitive and there are many applicants for the 20 places available each year. An additional two places are quarantined for Aboriginal students in addition to those accepted in the standard round of applications, however rarely are these filled. Only one Aboriginal student has graduated from the program since it began in 2008 and another is currently enrolled.

**The study population and methodology**

Midwifery students enrolled in the Unit ‘Indigenous Cultures and Health’ were chosen as the study population for reasons which included research findings that show poorer maternal and child health outcomes in Aboriginal communities compared with the non-Aboriginal population (Australian Bureau of Statistics and Australian Institute of Health and Welfare 2008) and the relatively recent requirement that midwifery practice is culturally safe
Also, Aboriginal women are more than twice as likely to give birth to babies below the optimal birth weight (<2500 grams) and are much younger than non-Aboriginal women at the birth of their first child (D’Antoine and Bessarab 2011). Many Aboriginal women have compromised health prior to pregnancy and are less likely to utilise antenatal care for a range of reasons including distrust of service providers (Bar-Zeev et al. 2013; Kildea et al. 2012; Panaretto et al. 2011; Reibel and Walker 2010). Permission to conduct the study was obtained from the relevant teaching staff, the students and the appropriate ethics committees, including the Western Australian Aboriginal Health Ethics Committee.

Fifteen midwifery students (the total number of new students) were observed in two hour tutorials across the twelve teaching weeks of a semester from July to October 2012, producing 24 hours of data. The mixed methods research design required students to complete a ‘before’ and ‘after’ questionnaire, and five students were purposively selected together with the tutor, to participate in an in-depth interview at the completion of the unit. Student selection for interviews was based on classroom observations which suggested receptivity or resistance to the content. Only one student approached declined to be interviewed. Within the tutorials the lead researcher utilised the ‘complete observer’ approach (Whitehead and Annells 2007, 131) where no interaction occurred between the observer and the classroom participants. This approach facilitated a longitudinal record of the teaching and learning processes and an analysis of student engagement across the semester.

The tutorial program was carefully designed to ensure that Aboriginal voices were heard in the classroom. Pre-recorded vodcasts that featured interviews with a diverse group of Aboriginal people formed a focal point for discussion and reflection. Topics covered included Aboriginal and Torres Strait Islander history, diversity, cultural protocols, social structures, patterns of communication, contemporary policies and their implications for health professionals. Reflective practice exercises required students to consider their own experiences, attitudes and behaviours with respect to Aboriginal people and acknowledge any impediments to the provision of culturally secure health care. Assessments included a group presentation, a series of short e-tests and a reflective journal.

Forty per cent of students in this cohort had a tertiary qualification prior to their enrolment in midwifery which is considerably higher than for other health science students in the Faculty where the figure was 15 per cent (Office of Strategy and Planning, Curtin University 2013). All students were female, with four students aged between 17-20 years and the remaining twelve students were evenly divided in the 21-30 and 31-50 age categories (one student subsequently withdrew after the first week of classes). Two thirds of the students were Australian-born, other birthplaces were England (3 students) and Papua New Guinea and South Africa (one student each). No students acknowledged descent or identified as an Aboriginal or Torres Strait Islander in the pre-Unit questionnaire, although one acknowledged descent in the post-Unit questionnaire, noting that they did not identify. The tutor was a non-Aboriginal Australian, although almost 50% of the tutors teaching in the unit were Aboriginal Australians.
As part of a broader investigation into culturally secure practice in midwifery education, indepth interviews were also undertaken with two Aboriginal women – one a practicing midwife who was the first Aboriginal graduate from the program and the second with a currently enrolled student in her second year of training. The aim of these interviews was to obtain Aboriginal perspectives on the education of midwifery students and gain insights into their experiences of being the only Aboriginal student in the class.

**Findings**

*‘Friendly racism’*

If a safe learning environment exists, students can speak honestly about complex and potentially divisive topics without fear or favour. Pre-conditions for the creation of a safe learning environment were negotiated between the tutor and students at the beginning of the semester. Honesty, respect and open-mindedness were prioritised by the students and endorsed by the tutor. Strong emphasis was placed upon being non-judgemental and listening to others, and students were asked to consider the context of attitudes expressed and experiences encountered. The importance of discussing uncomfortable material was reflected in the use of the term ‘courageous conversations’ to describe the nature of classroom discussions. In the post-Unit survey some students commented on the relaxed atmosphere in the class and the encouragement given to speak honestly about contentious issues. One student noted ‘xx is great, I think it’s really good to have a non-Indigenous person teaching the class to give people the comfortability (sic) to be open and honest’. The non-Aboriginal tutor had a very positive impact on the students with all stating in an online evaluation that they were satisfied with their learning experience in this unit.

There were students however, who disclosed in interviews that they did not feel that the environment was safe due to the classroom dynamics. ‘I didn’t think it was a safe environment to say what you think because some strong personalities dominated the discussion. There was definitely something there, pervading the whole atmosphere, just beneath the surface ... no-one wanted to put up their hand and say “I believe this” in case someone shot them down.’ This student explained how she was shocked by the ‘little racist judgements’ that were made and not contested by others, including herself, because, for her part, the emotional energy invested would be wasted.

The presence of racism in Australian society and hence potentially in oneself, was the most complex and divisive topic than recurred throughout the semester. In the first class, a student described herself as a ‘friendly racist’. ‘I cross the road if I see an Aboriginal person. I often do this with people from other cultures too. This is how I was raised and now I’ll have to deal with it’. The use of the descriptor ‘friendly’ has the effect of neutralising the power and offensive nature of racism and highlights how normalised this behaviour had become due to socialisation. Another student noted that her first reflective journal entry was titled ‘Am I a racist?’ which arose from the unsettling experience of questioning her own attitudes in the first class. Honesty about beliefs and practices was common as the semester progressed, although overall the use of the terms ‘racist’ or ‘racism’ was rare. Instead the complexities around such labels remained as a tension which was unnamed but evident in the post-Unit
questionnaires and interviews, and perhaps in student discussions outside the classroom to which the researcher did not have access. When students had an opportunity to reflect on the Unit in the post-Unit questionnaire, it became clear that some were shocked by the attitudes of others.

An incident that occurred part way through the semester and was raised by the tutor and a number of students in interviews, revealed just how fractured the group had become. All students in the cohort corresponded via a closed Facebook page. Communications related to assessments, readings and other issues concerning the Unit. It was considered a useful forum until there were postings about a young, handsome Aboriginal man who visited the class which were considered to be disrespectful by some in the group. In the online forum some students expressed surprise that he was so handsome and talented (he played the didgeridoo) but also Aboriginal as if these characteristics were in opposition to one another. Another noted that she didn’t think he was Aboriginal because he was “so nice”. Other more explicit comments led a group of mature-aged students to withdraw from the Facebook site altogether, angry about the attitudes expressed and not wanting any further association with the site. In an interview, one of these students suggested that the comments on the site indicated that students were uncomfortable with dismantling their pre-conceived ideas of Aboriginality, so deflected the conversation to sex. Certainly the dismantling of stereotypes was an unsettling experience for many and was evident in the classroom in the week following the visit. One mature-aged student reflected ‘I wonder if he was more acceptable to me because he talks like me, dresses well, does he represent the values that I hold dear too? ... he displays white, middle class values ... he dispelled the stereotype of an Aboriginal man that we often hold’.

Aboriginal students’ classroom experiences also were explored as part of this study, although, as noted earlier this cohort comprised only non-Aboriginal students. In interviews, Aboriginal women who had been through this program in the past were asked if they had ever encountered racism in a classroom setting. One responded,

‘No, I think it is because if you put an Aboriginal person like me, I look Aboriginal, in a classroom, you are not going to get it. If they can’t see an Aboriginal face, then they feel safe to say stuff. It restricts people’s tongues when they see you are Aboriginal. Of course there was that first week, and I could have hit him in the head, but no, I can honestly say a lot of stereotypical statements were made but I would challenge them and say, well that’s not right. In a smaller setting, it was a discussion, everyone was entitled to express their opinion, and it was safe. Some awful things were said though about people from other cultures, which surprised me.

The incident below occurred in this student’s first week at university and refers to an offensive comment written by a student in a lecture.
When the lecturer mentioned Aboriginal health, a young lad sitting in front of me wrote ‘Koon health’ and I couldn’t believe it. It really upset me. He looked bored, perhaps it is me projecting a little bit because it is important to me, but that was a shock. I went and saw the tutor, and she said this is going to happen but hopefully by the end of semester their attitudes will turn around. He was very young, but why do health if that’s your attitude?

It is interesting to note that while this student was not subjected to racism in the small classroom setting, she was surprised by the comments made about those from other cultures. Furthermore, large lecture theatres usually give students a certain amount of anonymity although in this case the comments did not go unobserved.

The second Aboriginal woman interviewed did not encounter racism in the classroom and provided similar explanations for its absence. ‘When they knew I was in the class, that stopped it, and I’m not someone to let it go. I’ve been fighting for my Aboriginality for many years so I’m quite happy to jump down people’s throats if I need to and people know that about me’. Given this, it is not surprising that when Aboriginal students are in the classroom, non-Aboriginal students are more guarded in their comments, perhaps in the same way that they would be with an Aboriginal tutor.

White guilt
As the semester progressed, students were introduced to a number of past policies and practices that continue to impact on Aboriginal families and communities today. These included the breaking up of families by the removal of children, the loss of land and cultural identity, employment with minimal or no wages, segregation from the wider society through the imposition of permits and passes, limited voting rights and exclusion from the national census until a referendum in 1967. As students became familiar with the policies and practices and their impact on contemporary Aboriginal health status, some were moved to tears and expressed a sense of shame about our shared history. Aboriginal voices telling these stories were powerful, and few were unmoved by the visual representation in vodcasts. In particular, stories about the removal of children from families resonated with these students, many of whom had children of their own. ‘Researching the ‘stolen generation’ presentation upset me greatly – the stories I read were so sad. I also felt angry that Australia has perpetrated such horrific acts against Aboriginal people’. A sense of outrage was frequently aired in the classroom however, there were some students who considered this counterproductive.

During certain conversations I withdrew because it was boring … the constant outrage was repetitive and the conversation, even when the tutor tried to nudge it in a different direction, would get back to the cycle of outrage … the meat was there but we kept chewing the same bit of fat and we didn’t explore the issues to the extent that we could have’.

It was evident from student interviews that those who were frustrated with this response from members of the class were already familiar with the historical context of Australian colonial settlement and were keen for a more sophisticated analysis of the implications of disadvantage and lack of trust on health outcomes and the delivery of services. The majority of students,
however, had little awareness of Aboriginal history, so the shock of what they encountered was profound. Guilt about the past can be disabling, even paralysing to the extent that students can feel anxious about interacting with Aboriginal people and causing offence. This was a view expressed by one student who referred to ‘being intimidated’ at the thought of working with Aboriginal women, in part because she now knew so much more and had a better understanding of an Aboriginal person’s perspective. There was an element of ‘guilt by association’ in this reaction.

Discussion of the Northern Territory Intervention, the Australian government’s response to a report on the protection of Aboriginal children from sexual abuse (Wild and Anderson 2007) drew some parallels with past policies and practices. Students recognised that contentious policies with respect to Aboriginal people did not only occur in the past and that the Intervention remained a source of much bitterness within communities in the Northern Territory. The Intervention (now termed by the Government the Stronger Futures Policy), resulted in the temporary suspension of the Racial Discrimination Act and the compulsory acquisition of land, and was responsible for the dilution of individual and community rights (Brown and Brown 2007). While some students expressed outrage at the consequences of The Intervention, the reaction was tempered by a range of views expressed in Aboriginal communities and portrayed in the vodcasts about the benefits and limitations of the legislation. This framing of the discussion resulted in the emergence of critical thinking among students: ‘What was portrayed in the media was very different. Were they telling lies? When you hear the facts, you realise how biased the media was. This would never have happened to white people’. Another student noted ‘well if sexual and physical abuse is occurring, then it’s not on. A line must be drawn, whether you are Indigenous or non-Indigenous. If a child is at risk they need to be helped regardless’. The researcher’s classroom observational notes from this tutorial recorded:

McDermott categorises students’ responses to Aboriginal content and one of these is ‘white guilt’. This was evident today, and with respect to the tutor as well as the students. This is interesting and probably quite common among non-Aboriginal tutors teaching Aboriginal content (myself included). As an observer though, you realise the importance of playing the ‘devil’s advocate’ as a means to elicit and debate other perspectives. They can be dismantled where necessary but should be referred to as this ultimately adds strength to the position taken. Observational field notes, 14/08/2012.

It became clear by the end of the semester that students’ receptivity and/or resistance to Aboriginal content in this Unit could not be accurately interpreted using only one means of data collection. Findings from classroom observations alone did not tell the full story, although there were glimpses of fracturing in the group based upon the content to which they were exposed. Survey data and in-depth interviews were required to tease out the complexity of many of the student responses observed.

Discussion

The facilitation of teaching and learning processes that include cross-cultural content places many demands on academic staff. Tutors are expected to be comfortable teaching this
content, knowledgeable about the subject matter and sufficiently experienced to deal with diverse student responses, some of which may be offensive to other students. In this study, the non-Aboriginal tutor was highly competent and brought a love of teaching and passion for the subject matter to the classroom. Despite these strengths, interviews with students suggested that the open and honest discussions that were encouraged resulted in some students ‘shutting down’ and withdrawing from conversations. Students who were most likely to withdraw from participating in classroom discussions were those who considered that the discussions had become repetitive and dominated by a few for who this content was very new. Consequently, teaching strategies aimed at creating a safe learning space resulted in some offensive attitudes not being challenged by other students, although they were by the tutor. It transpired in interviews that the students who made a decision during the semester not to debate contentious comments were more likely to have had prior knowledge of Aboriginal issues and positive interactions with Aboriginal people. These students were mindful of the need to remain a cohesive group but expressed dismay at comments made.

In a study investigating emotional responses of students to Aboriginal mental health issues, McDermott and Gabb (2010) identified a number of categories of responses. These included being positive, supportive and open to new information; moved, sorrowful, ashamed of our nation but not feeling personally blamed; uncertain, distressed, resentful, betrayed; and angry, rejecting. Thematic analysis of students’ receptivity to content in this Unit based on classroom observations revealed a similar spectrum of reactions although none were overtly resistant to the content delivered and this was later confirmed in questionnaire responses. However, signs of subtle resistance were observed and centred on persistent comments by some students that many issues confronted by Aboriginal people were the ‘same for all of us’.

McDermott (2012, 15) notes how easy it is for the presence of racism to bypass consciousness.

Although living in the same country, many non-Indigenous Australians would have difficulty recognising the world of corrosive attitudes that many Indigenous Australians report. If you’re neither target, nor witness, you miss racist events. The more invisible the racism, the harder it is to comprehend its pervasiveness and potency as a social determinant of health. The Australian self-image of a tolerant, multicultural success story leaves little room for a counter-discourse of a more complex reality…

The challenge of overcoming deeply ingrained stereotypes of Indigenous people in Australia is illustrated by a recent incident in the Australian sporting world which revealed how easy it is for racist comments to be ‘casually’ inserted into conversations, and in this case, on live radio. In May 2013, a high profile broadcaster and an Australian Football League club president suggested that an Aboriginal footballer, whom he named, would be the perfect person to promote the new King Kong musical about to commence in Melbourne. Ironically, the broadcaster had been congratulated just days earlier for his swift response to a racist comment directed at the same footballer by a young female spectator. Called to account, contrite and emotional, the broadcaster could not explain his racist comment apart from saying it was ‘a slip of the tongue’, he was ‘fatigued’ and that he was profoundly sorry. He subsequently apologised unreservedly to the footballer. (The Australian, May 29, 2013).
Australian Football League’s Racial and Religious Vilification Policy required the broadcaster to undergo cross-cultural educational sessions and meet personally with the footballer to whom the comment was directed. There were calls for his resignation, but he retained his high profile positions. Public commentary around this incident varied, but of particular note was the argument proffered prior to the incident that the silent, pervasive racism in Australia is of greater concern that the occasional outbursts that receive media attention. As Waleed Ali, a (Muslim) broadcaster and academic noted “... our real problem is the subterranean racism that goes largely unremarked upon and that we seem unable even to detect ... The most insidious racism is just so ingrained it's involuntary ... self-examination is crucial” (The Age, April 5, 2013).

Reflexivity and self-examination were encouraged in this classroom setting. Students did confront uncomfortable truths about Australia’s colonial history and about their own attitudes towards Aboriginal people. Members of the class, however, did not all enter the learning experience at the same point, and came with a range of attitudes towards Aboriginal people informed by a number of factors - including the media, personal exposure and for some, arts and literature. Those students with little or no knowledge of Aboriginal culture were more likely to experience outrage, or ‘white guilt’ when they learned about past policies and practices. Some of these students also commenced the process of ‘transformative unlearning’ of their own attitudes, values and behaviours. Ryder, Yarnold and Prideaux (2011, 781) described transformative unlearning as “…a process that requires time for students to become immersed in specific material such as to facilitate change at their own pace in a safe and informed environment”. They suggested that the ‘unlearning’ of preconceptions, stereotypes and behaviours is as important as the learning of new knowledge and skills when preparing to work and communicate effectively with diverse cultural groups. In this study, classroom observations, interviews and survey findings (not reported here) revealed that most students in the cohort were receptive to Aboriginal content in the Unit and they expressed surprise that they had not learned about Aboriginal history and cultures in secondary school. Despite these positive findings, it was clear that some students were offended by the underlying racist comments and attitudes of others and felt constrained by the classroom dynamics to challenge these attitudes and responses, many of which were framed in a way that suggested these were normal within their family and social circle.

Conclusion

This study revealed some of the challenges that confronted staff and students when a compulsory unit on Aboriginal cultures and health was introduced into an undergraduate midwifery program. The importance of this content is undeniable given that many Aboriginal women have compromised health prior to pregnancy, are younger than non-Aboriginal women at the birth of their first child and are more likely to deliver a low birth weight baby. Midwives are uniquely placed to develop strong and trusting relationships with Aboriginal women that potentially enhance the utilisation of antenatal care and provide opportunities for on-going health care utilisation. This in-depth, small scale study revealed that while midwifery students were largely receptive to Aboriginal content in their program and
acknowledged its importance to clinical practice, a wide range of attitudes and experiences created tensions within a group classroom situation where historical and contemporary issues were explored. Unresolved issues surrounding race and racism hovered and were rarely challenged due to classroom dynamics.

The question remains as to whether Aboriginal content learned in this unit is retained and applied in clinical settings. Integration of content throughout the program and enhanced opportunities for clinical practice with Aboriginal women will assist this process. In workplace settings, as in the classroom, students will encounter a range of attitudes and behaviours towards Aboriginal people. One gauge of the success of this Unit will be how successfully students respond to the presence of racism in health care settings and the extent to which they can create culturally secure environments for pregnant and birthing Aboriginal women.

References


Exploring undergraduate midwifery students’ readiness to deliver culturally secure care for pregnant and birthing Aboriginal women

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Abstract

Background: Culturally secure health care settings enhance accessibility by Aboriginal Australians and improve their satisfaction with service delivery. A culturally secure health service recognises and responds to the legitimate cultural rights of the recipients of care. Focus is upon the health care system as well as the practice and behaviours of the individuals within it. In an attempt to produce culturally secure practitioners, the inclusion of Aboriginal content in health professional programs at Australian universities is now widespread. Studies of medical students have identified the positive impact of this content on knowledge and attitudes towards Aboriginal people but relatively little is known about the responses of students in other health professional education programs. This study explored undergraduate midwifery students’ knowledge and attitudes towards Aboriginal people, and the impact of Aboriginal content in their program.

Methods: The study surveyed 44 students who were in their first, second and third years of a direct entry, undergraduate midwifery program at a Western Australian (WA) university. The first year students were surveyed before and after completion of a compulsory Aboriginal health unit. Second and third year students who had already completed the unit were surveyed at the end of their academic year.

Results: Pre- and post-unit responses revealed a positive shift in first year students’ knowledge and attitudes towards Aboriginal people and evidence that teaching in the unit was largely responsible for this shift. A comparison of post-unit responses with those from students in subsequent years of their program revealed a significant decline in knowledge about Aboriginal issues, attitudes towards Aboriginal people and the influence of the unit on their views. Despite this, all students indicated a strong interest in more clinical exposure to Aboriginal settings.

Conclusions: The inclusion of a unit on Aboriginal health in an undergraduate midwifery program has been shown to enhance knowledge and shift attitudes towards Aboriginal people in a positive direction. These gains may not be sustained, however, without vertical integration of content and reinforcement throughout the program. Additional midwifery-specific Aboriginal content related to pregnancy and birthing, and recognition of strong student interest in clinical placements in Aboriginal settings provide opportunities for future curriculum development.

Keywords: Midwifery education, Aboriginal health, Culturally secure practice

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Background

Professional accreditation standards in medicine and the health sciences increasingly require that practitioners be 'culturally competent' although there remains uncertainty about how best to measure this attribute, and if acquired, the extent to which it is translated into clinical practice. Debate also surrounds the concept itself with other terms such as cultural respect and cultural security often used interchangeably with cultural competence. However, following the 2011 recommendations from Universities Australia [1], the peak body representing all national universities, the notion of 'Indigenous cultural competency' as a graduate attribute has gained momentum in the higher education sector (see Endnote\textsuperscript{\textregistered} for an explanation of terminology). In their report outlining the guiding principles for the development of 'Indigenous cultural competency', the authors defined the concept as 'student and staff 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' [1].

Developments within universities and regulatory bodies paralleled changes in Australia's social and political climate where reconciliation with Aboriginal people, the National Apology to the Stolen Generations and the 'Closing the Gap' campaign created heightened awareness of socio-economic and health disparities between Aboriginal and non-Aboriginal Australians [2]. Increased utilisation of health care services and ultimately improved health status are anticipated outcomes of a culturally competent health care workforce, although there is limited evidence linking cultural competence to improved health outcomes and a reduction in health disparities [3-5].

Even prior to Universities Australia's report, efforts to develop more culturally inclusive curricula were proceeding in medicine, nursing, midwifery and allied health programs, albeit at different rates. In 2004 the Committee of Deans of Australasian Medical Schools (CDAMS) 'Indigenous Health Curriculum Framework' [6] identified key principles with respect to core Aboriginal content. These included diversity within and between communities; the validity of Aboriginal views on health and wellbeing; the importance of Aboriginal professionals' and community members' knowledge and expertise in curriculum development; and the contribution that a culturally safe medical workforce can make to improving Aboriginal health outcomes [6]. Furthermore, a positive strengths-based model was encouraged together with vertical and horizontal integration of Aboriginal content. The CDAMS framework was subsequently included in accreditation guidelines and a 2012 audit revealed a significant increase in the amount of Aboriginal content in medical schools over an eight year period, despite variability in 'comprehensiveness and effectiveness' [7].

Curriculum initiatives and national competencies in nursing, midwifery and the allied health professions mirrored developments in medicine although were implemented later. The Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) lobbied strongly for the inclusion of compulsory Aboriginal content in nursing curricula. The 'gettin em n keepin em' report which confirmed that few nursing schools integrated core content into programs, made numerous recommendations with respect to revising curriculum frameworks in nursing and midwifery [8]. The profession of midwifery was, until quite recently, subsumed under the 'nursing' label; however, nursing councils, boards and academic schools now commonly identify midwifery as a profession in its own right. CATSIN too, has recently changed its title to CATSINaM (aM = and Midwifery) reflecting this trend. This is significant as both professions are now required by regulatory bodies to include core Aboriginal content in their programs although their focus differs, and this is not necessarily reflected in the generic Aboriginal units offered. Programs in psychology, physiotherapy and occupational therapy have incorporated Aboriginal content in their curricula for some time but attempts are now being made to streamline offerings following completion of the national 'Aboriginal and Torres Strait Islander Health Curriculum Framework' in early 2015 [9].

Evaluation of Aboriginal health curriculum initiatives in medical school programs has been conducted although according to the National Medical Education Review [7] reporting has been inconsistent. Early findings from an on-going evaluation at the University of Western Australia found that '... significant shifts in self-perceived levels of knowledge, skills and attitudes ...' could be achieved from carefully structured and targeted teaching and learning in the area of Aboriginal health [10]. Integration of material presented, involvement of Aboriginal people in the design of the content and teaching, and the experience of staff were identified as key factors in the achievement of learning outcomes [10]. Subsequent studies investigated the role of reflective practice in the assessment process, particularly as it applied to the preparation of case histories with Aboriginal patients. Ewen, Paul and Bloom suggested that an understanding of the context of interactions between Aboriginal patients and health professionals and the consequent impact on health outcomes is a serious omission from many health science programs [4]. Other studies have explored medical student responses to Aboriginal content, their interactions with Aboriginal patients, and the benefits of cultural immersion experiences [11-13].

Limited evaluation of the impact of Aboriginal content in nursing, midwifery and allied health programs has
been reported but is expected to increase when the ‘Aboriginal and Torres Strait Islander Health Curriculum Framework’ is implemented [14-18]. Substantial variations exist in the degree of integration of Aboriginal content in programs, the involvement of Aboriginal people in its development and delivery, and the number of hours dedicated to Aboriginal health over the course of a program [1]. Furthermore, little is known about the extent to which student learnings are reinforced throughout programs and transferred into clinical practice upon entry to the workforce. Such knowledge is fundamental to understanding the potential relationship between cultural competency and improved health outcomes for Aboriginal patients.

In this study, a core undergraduate Aboriginal health unit designed and taught by a team of Aboriginal and non-Aboriginal academics, was introduced into an interprofessional common first year in a health science faculty at a Western Australian university. Unit development drew upon an earlier iteration that was introduced into nursing and midwifery programs in 2006 and 2008 respectively. It was well received and recognised with an Australian Learning and Teaching Council Award in 2010. The new unit, upon which this study is based, was introduced in 2011 and is now undertaken by over 2000 interprofessional first year students. In 2014 this unit also received national recognition. Both units used as their frame of reference the concepts of cultural safety and cultural security (J. Hoffman, personal communication, June 2013). These concepts, with their emphasis on the recipients of care and the importance of Aboriginal cultural values in health service delivery, were reinforced throughout 12 two-hour tutorial sessions across the semester. The new unit utilised specially prepared vodcasts featuring Aboriginal speakers and adhered to a tightly structured format of discussion and presentations. Content included diversity within Aboriginal communities and international comparisons, past policies and practices, social determinants of health, family structures and responsibilities, cultural health beliefs and professional practice issues. For the first year midwifery students, an experienced non-Aboriginal tutor taught the unit; second year students who participated in this study had also been taught by this tutor. Assessment was based on student presentations, online quizzes and submission of a reflective journal.

Given that Aboriginal women have higher fertility and morbidity rates than non-Aboriginal women, their infants have poorer health outcomes, and there is reluctance by some women to use mainstream services [19,20], it is timely to investigate the preparation of midwifery students to provide culturally secure care in clinical practice. This paper presents research that explored midwifery students' knowledge and attitudes towards Aboriginal people, and the impact of the Aboriginal unit in their program. The findings form part of a larger study which utilised classroom observations and in-depth interviews with students to investigate culturally secure practice in midwifery education and service provision for Aboriginal women. Together, the findings add to the limited research on attitude change and students' perceptions of their knowledge and readiness to work in Aboriginal contexts.

**Methods**

Information was gathered from students using pre-tested questionnaires that included validated items from past medical student and psychology studies [10,13,21] and newly designed questions relevant to midwifery students. (The corresponding author can be contacted for copies of the questionnaires). Permission was granted to include previously validated items in the midwifery student survey. Approval for the study was granted by the Western Australian Aboriginal Health Ethics Committee and the Human Research Ethics Committees at the University of Western Australia and Curtin University.

The lead researcher, with the permission and support of academic midwifery staff, spoke to students about the study, obtained written consent and distributed and collected the questionnaires. A personal approach was utilised reflecting the researcher's desire to provide a context for the study and address any questions raised, although questionnaires were e-mailed when students were absent from class. The first year students were surveyed before and after completion of a compulsory Aboriginal health unit. Second and third year students who had already completed the unit were surveyed at the end of their academic year. The researcher, a longstanding staff member, had previously taught midwifery students but excluded herself from teaching in the program at the time of the study.

Students responded to a series of statements about perceptions of their knowledge regarding Aboriginal issues; recorded their attitudes towards Aboriginal Australians using an attitude thermometer; identified factors that shaped their attitudes; and indicated their expected involvement with Aboriginal patients in the future. They also responded to 16 statements about Aboriginal health used in previous medical student studies [10]. Survey data were coded and analysed using the Statistical Package for the Social Sciences (SPSS). Due to small numbers, analysis was largely descriptive, although statistical testing (Wilcoxon Signed Rank Test) that compared matched pre- and post-unit responses and post-unit responses with the combined second and third year responses was undertaken. Open-ended questions were categorised and thematically analysed [22].

**Results**

The undergraduate cohort comprised 47 students, 44 of whom completed questionnaires. The three-year undergraduate direct entry program accepted a maximum of
only 20 students annually. Four students were exempt from the unit due to recognition of prior learning in Aboriginal health and were not included in the study population. The first year students (n = 16) were surveyed immediately before the commencement of the unit and then upon completion following 12 weeks of instruction. The post-unit questionnaire was completed by 12 of the initial 16 students. The second and third year students (n = 31) completed the unit in the first year of their program. Twenty-eight of the 31 students completed the questionnaire and recalled the impact of the unit retrospectively.

Undergraduate student demographic characteristics
The undergraduate age distribution reflected the tendency for fewer ‘straight from school’ students to enrol in the direct entry midwifery program compared with nursing and allied health programs. Only 7 students (16%) were aged 17–20 years and 9 (20%) were aged over 40 years. Forty per cent of students (18) had a prior tertiary qualification. Eighty per cent of students were Australian-born, and three acknowledged Aboriginal descent although only one identified as Aboriginal. All overseas-born students were from English-speaking countries, most commonly, England and Ireland. The majority of Australian-born students were raised in large cities and only 4 (10%) spent their childhood in small country towns or remote communities. This urban focus was also reflected in students’ desire to practice in the metropolitan area of Perth or in large regional centres in their first five years following graduation, with only 2 students indicating interest in small, remote settings. The majority identified public hospital services as their preferred employment setting with community-based midwifery the second most favoured option. One student identified Aboriginal-focused practice as a first preference and three as a second preference for employment.

First year pre- and post-unit survey responses
Despite small numbers, students’ knowledge about issues facing Aboriginal people, Aboriginal history and culture, and Aboriginal health was significantly greater after completion of the unit. Relative to pre-unit responses, no students considered their knowledge ‘less than adequate’ after completion of the unit and those who considered their knowledge ‘more than adequate’ increased. Pre-unit and post-unit self-reported knowledge about Aboriginal issues is presented in Table 1.

Attitudes towards Aboriginal people were self-reported on an attitude thermometer which provided 10° intervals ranging from 0° (extremely unfavourable) to 100° (extremely favourable), with the mid-point of 50° representing neither favourable nor unfavourable attitudes. Individual pre- and post-unit responses are presented in Table 2.

Students’ attitudes as measured by the attitude thermometer were significantly more positive after completion of the unit (z = −2.61; p = .009). Relative to pre-unit rankings, 9 students rated their attitude towards Aboriginal Australians more highly with only one dropping (from 100 to 90) and one remained unchanged. When students reported factors that shaped their attitudes towards Aboriginal people and understanding of Aboriginal issues, ‘lived experience’, ‘family’ and ‘media’ were identified as the most influential factors in the pre-unit responses. Post-unit responses identified ‘teaching in midwifery course’, closely followed by ‘lived experience’

<table>
<thead>
<tr>
<th>Knowledge statements</th>
<th>First year pre-unit student responses (A=Adequate)</th>
<th>First year post-unit student responses (A=Adequate)</th>
<th>Change in score from baseline</th>
<th>Wilcoxon signed rank test results</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do you rate your knowledge of issues facing Aboriginal people?</td>
<td>9 Less than adequate</td>
<td>5 Adequate</td>
<td>2 Adequate</td>
<td>16</td>
</tr>
<tr>
<td>How do you rate your knowledge of Aboriginal history and culture?</td>
<td>9 Less than adequate</td>
<td>4 Adequate</td>
<td>3 Adequate</td>
<td>16</td>
</tr>
<tr>
<td>How do you rate your knowledge of Aboriginal health?</td>
<td>9 Less than adequate</td>
<td>6 Adequate</td>
<td>1 Adequate</td>
<td>16</td>
</tr>
</tbody>
</table>

Key: T = sum of ranks; z = +/-1.96 or greater to reach statistical significance (p = .05); N = number of participants.
and ‘family’. These differences did not reach statistical significance. With respect to expected involvement with Aboriginal patients upon graduation, pre- and post-unit responses remained the same with just over 40 per cent of students expecting involvement to be ‘quite often’ or ‘frequent’.

Responses to a series of 16 statements on Aboriginal health provided further evidence of the positive impact of the unit on students. Pre- and post-unit changes were observed with respect to students’ perceptions of their capacity to communicate with Aboriginal women (\( z = -2.81; p = .005 \)) and to encourage adherence to advice offered (\( z = -2.48; p = .013 \)). Students were also more likely to agree with the statement ‘The state of Aboriginal health is mainly due to a lack of funding for health services’ following completion of the unit (\( z = -2.23; p = .025 \)) which suggested acknowledgement of structural factors at play in health status. Responses to other statements did not reach statistical significance however, upon completion of the unit all but two students indicated that the content had changed their views on Aboriginal issues (most expected it would). With only one exception all agreed that an Aboriginal health unit should be compulsory in all health science courses; they would work towards improvements in Aboriginal health as a personal priority; and they had a social responsibility to work towards changes in Aboriginal health. Pre-unit responses indicated that the majority of students held these views before they commenced the Aboriginal health unit so little change was observed.

Upon completion of the unit, students were asked to comment on their receptivity to the content, the extent to which it influenced their perceptions of Aboriginal communities and their health, the adequacy of the amount of teaching in the area, and interest in more clinical exposure to Aboriginal settings in their training.

### Combined undergraduate post-unit survey responses

Undergraduate responses were combined to determine the overall impact of the Aboriginal health unit on students and to compare responses of students immediately upon completion with those who completed the unit in preceding years. Significant differences were observed between post-unit first year students and the combined group with respect to knowledge about issues facing Aboriginal people. Although the second and third year students had previously completed a unit on Aboriginal health, they were less likely than the first years to rate their knowledge as adequate or more than adequate (\( z = -2.542; p = 0.011 \)). This pattern was repeated with respect to their knowledge of Aboriginal history, culture and health although did not reach statistical significance. Twenty-five per cent of the second and third year students (7) considered their knowledge about Aboriginal health to be inadequate, compared with no post-unit first year students. A breakdown by year group reveals a gradual drop off in confidence, although the small numbers prevented further analysis.

Self-reported attitudes towards Aboriginal people for the three undergraduate groups produced a mean of 68° based on raw scores. A break down by year group and categories (Table 3) shows that while 83% of students
who had just completed the Aboriginal unit reported ‘highly favourable’ or ‘favourable’ attitudes, this dropped to 64% for second year students (9/14) and was only 36% for third year students (4/11). Differences also were observed in ‘unfavourable’ and non-committal responses, especially among final year students. Means calculated from raw scores equalled 78° for first year post-unit students, but were lower at 69° for second year students and 55.5° for final year students.

Differences in raw scores between first year students and combined second and third year students were statistically significant (z = −1.95, p = .051). When second and third students ranked factors which shaped their attitudes towards Aboriginal people and understanding of Aboriginal issues, they identified ‘lived experience’ as the most influential factor, followed by ‘teaching in midwifery program’. First year post-unit students reversed the order of these factors and were more likely to be influenced by teaching in the Aboriginal health unit. This difference was statistically significant (z = −2.412, p = .016).

Responses to the 16 statements on Aboriginal health did not vary greatly across groups. Almost all students recognised Aboriginal health as a social priority, trust as an essential attribute of culturally secure care, and intimidation as a barrier. When first year post-unit student responses were compared with the combined second and third year groups, only two statements differentiated them statistically: ‘The state of Aboriginal health is mainly due to lack of funding for health services’ (z = −1.95, p = .051) and ‘The information I learned in this unit has changed my views on Aboriginal issues’ (z = −2.465, p = .014) with first year post-unit students more likely to agree with these statements. Undergraduate student responses to Aboriginal-related statements combined for the three year groups are presented in Table 4.

When all undergraduate students were asked to comment on their responses to Aboriginal health content delivered in the midwifery program, the majority (80%) indicated they were either ‘generally receptive’ (44%) or ‘very receptive, want more content in program’ (36%). Just over half of the students (22) indicated that their perceptions about Aboriginal communities and health had been ‘reasonably or considerably influenced’ by teaching in the area. When first year responses were compared with the combined second and third years, the differences were statistically significant (z = −2.875; p = .004) with teaching having more influence upon perceptions among those who had just completed the unit.

With respect to the adequacy of the amount of teaching received in Aboriginal health for their level of training, 75 per cent of students (30) indicated that it was ‘adequate’ or ‘more than adequate’. Differences were not

<table>
<thead>
<tr>
<th>Social priority statements</th>
<th>Undergrad responses % N = 40</th>
</tr>
</thead>
<tbody>
<tr>
<td>The state of Aboriginal health is a social priority.</td>
<td>Agree</td>
</tr>
<tr>
<td>Trust is a key for culturally secure health care.</td>
<td>97.5</td>
</tr>
<tr>
<td>Feeling intimidated is a barrier to culturally secure health care.</td>
<td>95.0</td>
</tr>
<tr>
<td>Health service delivery statements</td>
<td>Agree</td>
</tr>
<tr>
<td>The Western medical model suits the health needs of Aboriginal peoples.</td>
<td>7.5</td>
</tr>
<tr>
<td>The state of Aboriginal health is mainly due to a lack of funding for</td>
<td>22.5</td>
</tr>
<tr>
<td>health services.</td>
<td>20.0</td>
</tr>
<tr>
<td>Aboriginal people have the same level of access to health services as</td>
<td>75.0</td>
</tr>
<tr>
<td>all other Australians.</td>
<td>20.0</td>
</tr>
<tr>
<td>Community control in Aboriginal health care services is fundamental</td>
<td>80.0</td>
</tr>
<tr>
<td>to the improvement of health for Aboriginal people.</td>
<td>80.0</td>
</tr>
<tr>
<td>Preparedness and ability statements</td>
<td>Agree</td>
</tr>
<tr>
<td>I think it will be difficult to get Aboriginal women to adhere to</td>
<td>62.5</td>
</tr>
<tr>
<td>advice from health professionals.</td>
<td>62.5</td>
</tr>
<tr>
<td>I need to think beyond the individual when considering Aboriginal</td>
<td>92.5</td>
</tr>
<tr>
<td>health issues.</td>
<td>65.0</td>
</tr>
<tr>
<td>The information I learned in the Indigenous Cultures and Health unit</td>
<td>90.0</td>
</tr>
<tr>
<td>changed my views on Aboriginal issues.</td>
<td>90.0</td>
</tr>
<tr>
<td>Future commitment statements</td>
<td>Agree</td>
</tr>
<tr>
<td>I will work for improvements in Aboriginal health as a personal priority</td>
<td>7.0</td>
</tr>
<tr>
<td>in my health practice.</td>
<td>90.0</td>
</tr>
</tbody>
</table>

Table 4 Undergraduate midwifery student responses to statements about Aboriginal-related issues (adapted from Paul, Carr and Milroy [10])
observed between first years and the combined second and third year group. In addition, 85 per cent of third year students (13) considered they were ‘adequately’ or ‘more than adequately’ prepared to work with Aboriginal women and their babies, a question asked only of this group who were about to graduate. There was a consistent desire among all students for more clinical exposure in Aboriginal settings, with over 80 per cent (32) indicating interest.

Lastly, when students were asked to comment in an open-ended question about topics they would like covered in additional teaching on Aboriginal health the most frequently cited suggestion was for more information on Aboriginal cultural protocols surrounding pregnancy, birth and the post-partum period. Students wanted to learn about midwifery-specific issues including birthing on lands, women’s business, birthing beliefs and practices and grandmothers’ law. Reference also was made to communication skills, which many students considered were undeveloped.

**Discussion**

Australian National Competency Standards for the Midwife [23] require that midwifery practice be ‘culturally safe’, a concept developed in New Zealand in the late 1980s. Central to the concept of cultural safety and the associated term cultural security, is recognition of and respect for cultural values in clinical settings. The presence and effectiveness of culturally safe health care is determined by the recipients of care, with unsafe cultural practice viewed as ‘...any action which diminishes, demeans, or disempowers the cultural identity and well-being of an individual’ [24,25]. Similarly, the concept of cultural security developed in the Australian context requires that health services ‘...not compromise the legitimate cultural rights, values and expectations of Aboriginal people . . . ’ [26] and as Houston noted, the crux of cultural security is ‘...a shift in emphasis from attitude to behaviour’ [27].

In an effort to prepare culturally safe practitioners, Australian undergraduate midwifery programs are required to include a compulsory unit on Aboriginal health. Competency standards make reference to content including historical background, variations in cultural meanings and responses to health and maternity care, specific health needs of Aboriginal women and recognition and respect for customary law [23]. In this study, students completed an Aboriginal health unit in the second semester of the first year of their program. This unit was the principal source of information on Aboriginal health and cultural issues as there was little integration of content throughout the three year program.

**Enhancing knowledge and shifting attitudes: immediate impact of the Aboriginal unit**

Findings from the first year student surveys conducted immediately before and after completion of the Aboriginal unit revealed a positive shift in knowledge and attitudes towards Aboriginal people and evidence that teaching in the unit was largely responsible for this shift. Receptivity to unit content was high, and all students acknowledged its influence on their perceptions about Aboriginal communities and their health. Given that prior to the unit the majority of students had little contact with or knowledge about Aboriginal people and the impact of colonisation on their communities, it is unsurprising that they responded emotionally to the content delivered. Some revealed a deep sense of sadness and shame about our shared history [18] and similar responses to Aboriginal content in health science and medical programs have been reported elsewhere [12,16].

Enhanced knowledge about the causes of disadvantage has been linked with more positive attitudes towards Aboriginal people and their communities [10,12,13,28] and the findings from the pre- and post-unit surveys reinforced this observation. While the small class size was a limitation and the findings require cautious interpretation, individual shifts in knowledge and attitudes did prove statistically significant. On completion of the unit students rated their knowledge of issues facing Aboriginal people, including history, culture and health, more highly than before they commenced the unit and self-reported attitudes towards Aboriginal people were more positive. So what does this tell us? While the survey findings suggest that the Aboriginal unit successfully enhanced students’ knowledge and shifted attitudes towards Aboriginal people, for many it was an unsettling learning experience. Findings reported elsewhere reveal that students grappled with their own pre-existing attitudes, the various factors that shaped them and the responses of their peers to the content [18]. Open-ended questionnaire responses, interviews and classroom observations identified the presence of underlying tensions and unresolved issues, especially related to racism, despite the positive impact of the unit [18].

McDermott has identified the challenges involved in responding to the health consequences of racism in classroom settings, including resistance on the part of students [29]. An evaluation of the impact of integrated Aboriginal health curriculum initiatives on medical students at the University of Western Australia, also found that while changes in self-perceived levels of knowledge, skills and attitudes were possible, the process of building a culturally secure health care workforce remained a challenging and complex endeavour [10]. When interpreting the findings from survey data in this study it is important to recognise this complexity and the discomfort many students encountered during the process of knowledge acquisition and attitude transformation.

**Maximising gains and preparation for practice**

Few studies have investigated the longer term impact of Aboriginal content in medical and health science programs
although a number have explored student responses to content and perceptions of their abilities to work with Aboriginal patients [10,12,13,16]. Evaluation of the impact of educational interventions on attitudes and behaviours in professional practice settings has been identified as essential to determine whether cultural competence strategies section to work with Aboriginal women.

While there remain unanswered questions that require further investigation in a larger study, it is clear that more attention should be given to maximising the positive gains in students’ knowledge and attitudes observed following exposure to the Aboriginal unit. This might be achieved through better vertical integration of content or the location of unit content in a later year of the program. The provision of more clinical practice opportunities with Aboriginal women, an idea supported by the overwhelming majority of students, seems likely to strengthen preparation to deliver culturally secure care. While further research is required to investigate the transferability of student learnings into professional practice and to determine whether culturally secure practice is associated with better Aboriginal health outcomes, responses to the teaching of such content remain vitally important as part of the process and warrant closer scrutiny. It is in the academy where future health professionals are trained and this setting provides an excellent opportunity to influence the development of a culturally secure workforce.

Conclusions
Although Aboriginal content in medical and health sciences programs in Australian universities is widespread, the amount of content, its placement in a program and the degree of vertical integration differs widely and may impact on the effectiveness of learnings and the extent to which they are sustained and translated into clinical practice. This study, which investigated the impact of a first year Aboriginal health unit on midwifery students’ knowledge and attitudes, found significant pre- and post-unit differences, but also observed a steady decline in the impact of the content in subsequent years. While a number of factors might be implicated, the pattern of findings suggests that if an Aboriginal health unit is located in the first year of a program, vertical integration is necessary to consolidate knowledge acquired and the positive shift in attitudes observed. Suggestions for additional midwifery-specific Aboriginal content and strong student interest in more interaction with Aboriginal women in clinical and community settings provide opportunities for future curriculum development. If harnessed, this interest would enhance students’ preparation to deliver culturally secure care to Aboriginal women and maximise the early gains observed in this study.

Endnotes
*In the Australian context the term ‘Indigenous’ refers to Aboriginal and Torres Strait Islanders and appears in
this paper when it is included in the title of reports or referred to in citations. The term ‘Aboriginal and Torres Strait Islander’ is frequently abbreviated to ‘Aboriginal’ and that is the usage in this paper, except where the full term is used in reports or citations. These terms are often used interchangeably by government bodies, the academy and by Aboriginal people themselves and hence it is not possible to impose consistency.

One of the authors (RDT) developed and taught the original unit, together with Aboriginal colleagues.

‘Grandmothers’ law relates to intergenerational knowledge and skills concerning women’s business including birthing, pregnancy and the care of children [31].

Competing interests
The authors declare they have no competing interests.

Authors’ contributions
RDT contributed to the study design, developed and distributed the questionnaires, analysed the data and prepared the manuscript for publication. SRT supervised the study and provided critical feedback during the data collection and analysis phases and throughout the drafting and revision of the manuscript. AD provided critical feedback on the larger study and reviewed the manuscript prior to submission. All authors read and approved the final manuscript.

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References
“Listening to the silence quietly”: investigating the value of cultural immersion and remote experiential learning in preparing midwifery students for clinical practice

Rosalie D Thackrah1,2*, Sandra C Thompson1 and Angela Durey2,3

Abstract

Background: Cultural immersion programs are increasingly offered to medical and health science students in an effort to provide experiential learning opportunities that focus on ‘the self’ as well as ‘the other’. Immersion programs encourage self-reflection on attitudes towards cultural differences, provide opportunities to build relationships and work with community members, and allow students to apply knowledge and skills learned in training programs in a supervised practice setting. The aim of this paper is to describe midwifery students’ reflections on a remote Aboriginal clinical placement that has been offered at a Western Australian university since 2010.

Methods: Interviews were conducted over a period of 15 months with the first seven participants who completed the program. At the time of interview, four participants were in the final year of their undergraduate degree and three were practicing midwives. In addition, access was given to a detailed journal kept by one participant during the placement. Interviews also were conducted with midwifery staff at the university and practice setting, although the focus of this paper is upon the student experience.

Results: Student selection, preparation and learning experiences as well as implications of the placement for midwifery practice are described. The remote clinical placement was highly valued by all students and recommended to others as a profound learning experience. Highlights centred on connections made with community members and cultural knowledge learned experientially, while challenges included geographic and professional isolation and the complexities of health care delivery in remote settings, especially to pregnant and birthing Aboriginal women. All students recognised the transferability of the knowledge and skills acquired to urban settings, and some had already incorporated these learnings into clinical practice.

Conclusions: Cultural immersion programs have the potential to provide students with rich learning experiences that cannot be acquired in classroom settings. In Aboriginal communities on the Ngaanyatjarra Lands students gained valuable insights into the impact of isolation on health service delivery, the extent and strength of cultural traditions in the region, and a heightened awareness of the difficulties encountered by pregnant and birthing Aboriginal women in remote locations.

Keywords: Midwifery education, Aboriginal health, Cultural immersion, Cultural competency

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Background

Mandatory inclusion of Aboriginal and Torres Strait Islander content in medicine, nursing and midwifery programs in Australian universities and the recommendation of Universities Australia that ‘Indigenous knowledges and perspectives’ are embedded in all university curricula [1], have focused attention on the concept of Indigenous cultural competency. However, issues of how it is reliably acquired, assessed and effectively translated into practice still need attention. The ‘Guiding Principles for Developing Indigenous Cultural Competency in Australian Universities’ report defines cultural competence in Indigenous Australian contexts as ‘student and staff 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’ [1]. In the health care context, enhanced accessibility to and improved satisfaction with services, and ultimately better health outcomes for Aboriginal Australians are desirable outcomes associated with a culturally competent workforce.

Community engagement is identified as one of the five guiding principles of a best practice framework for embedding Indigenous cultural competencies into university programs [1]. Community engagement takes many forms including Aboriginal representation on university advisory committees, invitations to deliver a ‘Welcome to Country’ at significant functions, and involvement of students in Aboriginal community-based organisations. Partnerships with local communities are recognised as the ‘primary foundation for building Indigenous cultural competency in university governance, teaching and learning, research and human resources’ [1].

Cultural immersion programs: aims and outcomes

Cultural immersion programs have the potential to provide opportunities for community engagement and deliver rich learning experiences for students, while simultaneously offering valuable services to communities [2-6]. Rasmussen [2] described an immersion-style pilot project for 32 volunteer medical students that involved a weekend at an Aboriginal cultural centre in the Grampians in Victoria followed by a tour of Aboriginal community-controlled organisations in Melbourne. The aims of the pilot project focused upon providing opportunities for students to build relationships with a diverse group of Aboriginal people and developing a sense that these relationships ‘are both possible and potentially positive and rewarding’ [2]. At the same time, students were encouraged to reflect on their own cultural backgrounds, consider the influence of past practices on contemporary Aboriginal health status, and recognise the diversity and strength within Aboriginal communities. Evaluation of the pilot project which occurred immediately after the intervention suggested that it was a ‘positive and constructive experience’ for students with many describing it as ‘. . . ‘life-changing’. . . with respect to their attitudes towards Aboriginal people and their culture, and towards their own cultural origins and sense of self’ [2].

Another medical student cultural immersion program had the specific aim of reducing racism in medicine. Crampton et al. [3] described a program for third year students in the rural and remote East Cape region of New Zealand. A week in length and designed in collaboration with a Maori based health care provider, the aim was to provide an immersion experience for students and offer health needs assessments for communities. The program was informed by the principles of cultural safety where the focus was upon ‘. . . potential differences between health providers and patients that have an impact on care’ and aimed ‘. . . to minimize any assault on the patient’s cultural identity’ [3]. The authors noted that ‘. . . students are “inducted” into the Maori world of the East Cape according to a protracted and clear entry protocol; they slept and ate in marae (traditional Maori meeting places) and were cared for by kaiawhina (local health care workers). Local communities were compensated for time and costs incurred while hosting their guests [3].

Students’ evaluations of the immersion experience were very positive and reflected a heightened awareness of cultural differences. Nevertheless, the authors drew attention to potential risks associated with immersion programs including the need for delicate management of the relationship with communities in rare cases of inappropriate student behaviour. They recommended that programs provide adequate preparation in advance of such experiences and ensure that learnings are systematically reinforced and built upon. They also noted the superficial nature of the exposure due to the limited time frame [3].

While limited exposure is usually identified as a weakness of immersion programs, Playford and Lines [4] reported that a single week of immersion in a rural community practice made a significant contribution to students’ understanding of primary health care principles. Final year students from a diverse range of health disciplines worked in teams in a small, remote town in Western Australia, and were matched with various ‘at risk’ populations, including Aboriginal people. The immersion exercise which formed part of a ‘Country Week’ practice ‘. . . gave students an idea of how to interact with populations and communities unlike their own’ and ‘. . . embedded students’ understanding and appreciation of the community being a significant partner.
in healthcare’ [4]. Marked shifts in students’ attitudes towards rural communities were observed, and it was recommended that opportunities for immersion experiences be more readily available to students. Others too have confirmed the value of similar immersion experiences [5].

An innovative immersion program that provided opportunities for medical students’ experiential learning while at the same time addressed a physician human resource need has been operating in remote Indigenous communities in north eastern Canada for over 20 years [6]. The Northern Family Medicine (Norfam) program at Memorial University in Canada was developed after consultation with a range of stakeholders including community leaders and Elders, and aimed to address health disparities and a shortage of physicians in the region. The program began with six month rotations for medical residents and later included medical students who stayed in the region for up to two months at a time. As the program grew and the relationship with communities developed the Elders wish ‘. . . to pass on their knowledge and values to new physicians . . . ’ resulted in an invitation to students from Innu Elders to join them on a traditional walk where the students slept in tents with their hosts [6]. It was noted that opportunities for experiential learning occurred while they walked, rested, and prepared and ate food together. ‘During the walk, the trainees received first-hand experience of the positive impact on health and wellbeing with the traditional way of living for Innu, and gain an appreciation of the importance of the land for our Indigenous people’ [6].

This experience in a bitterly cold environment was rated highly by students, as were placements in remote Indigenous communities. The principles of ‘two ways’ learning, a combination of scientific and Indigenous traditional thinking, were enacted in this setting where the locus of power shifted from medical staff and students to the Elders. This role reversal gave students a new appreciation and respect for Innu culture and enhanced sensitivity in their interactions with community members [6,7].

The importance of experiential learning is emphasised in Kolb’s [8] conceptualisation of the learning cycle where experience, observation and reflection, the formulation of abstract concepts and the testing of these concepts in new situations are viewed as integral to every learning process. Rasmussen [2] noted that immersion-style programs attempt to engage students at the point of ‘experience’, however, care must be taken to ensure that they feel safe and are strongly supported to prepare for this type of learning activity.

**Aboriginal maternal and infant health and maternity service provision**

Despite improvements over the last decade, Aboriginal women in Australia continue to have higher maternal mortality rates and twice as many low birth weight babies and perinatal deaths compared with their non-Aboriginal counterparts [9]. Council of Australian Government (COAG) funding provided through the ‘Close the Gap’ policy framework has focused on target areas including to ‘halve the gap in mortality rates for Indigenous children under five within a decade’ [10]. In the area of Maternal and Infant Health, the National Strategic Framework for Aboriginal and Torres Strait Islander Health (2009) identified ‘. . . improved antenatal care provision, alcohol and smoking reduction in pregnancy, reducing the rate of low birth weight babies, reducing the rate of teenage pregnancies and birth, and addressing the causes of maternal mortality and early childhood hospitalisations’ as key indicators for improving the health outcomes for Aboriginal mothers and their babies [11].

While socio-economic factors are clearly implicated in risk factors for Aboriginal women, it has been noted that a lack of culturally appropriate maternity services may also be responsible for adverse pregnancy outcomes [7]. With particular reference to the Ngaanyatjarra women of Western Australia, Simmonds and colleagues (including four local grandmothers) suggested that mainstream services which do not incorporate or recognise traditional beliefs and practices surrounding pregnancy and childbirth fail to meet the needs of many women and may breach cultural norms [7]. The National Maternity Services Plan (2011) recognised the limitations of maternity service provision and had as one of its aims ‘(to) . . . deliver and expand culturally competent maternity care for Aboriginal and Torres Strait Islander people’ [11]. Implicit in this aim is that maternity services should allow for the incorporation of traditional practices and that this is particularly significant in remote communities.

The National Competency Standards for the Midwife require that midwifery practice is culturally safe. This involves incorporating knowledge of cross-cultural and historical factors into practice, respect for differences in cultural meanings and responses to health and maternity care, recognition of the specific needs of Aboriginal and Torres Strait Islander women and their communities, and recognition and respect for customary law [12]. The inclusion of compulsory content on Aboriginal cultures and history in midwifery programs addresses this competency. However, additional opportunities for experiential learning in community settings can reinforce classroom based learning and enhance cross-cultural understandings.

**The setting: Ngaanyatjarra Lands, Western Australia**

In this study, final year undergraduate midwifery students and more recently, postgraduate students were invited to apply for a one week clinical practice placement (excluding travel) on the Ngaanyatjarra Lands in Western Australia.
The opportunity, which first arose in 2010, resulted from keen interest expressed by a student in a remote placement and subsequent collaboration between midwifery academics and a practicing midwife who had taken up a position at an Aboriginal Community Controlled Health Service on the Lands. A Memorandum of Understanding set out the practice arrangements and scholarships to cover costs incurred by students were accessed through the Australian College of Nursing (ACN). The ACN also paid a supervision payment to the Ngaanyatjarra Health Service, the host organisation. Reserve entry permit applications administered by the Ngaanyatjarra Council were obtained by students prior to the commencement of the clinical placement [13,14].

The aim of the placement was to provide an opportunity for students to deliver supervised health care in remote, traditionally orientated Aboriginal communities. Learning outcomes related to the enhancement of student knowledge and understanding of Aboriginal health and cultures in the region with particular reference to Aboriginal women’s health issues, development of communication skills, and recognition of the challenges associated with health care delivery in remote settings, including the difficulties women faced upon relocation to large metropolitan and regional hospitals. The clinical placement did not form part of an assessment (it is planned to be in the future), however, students were required to give a presentation on the experience and include their reflections in a submitted portfolio of work. The presentation formed part of an informal debriefing and dissemination exercise [Personal communications, Academic co-ordinator, midwifery program].

Ngaanyatjarra Lands comprise 250,000 square kilometres in Western Australia and support approximately 2,300 people living in twelve autonomous communities (see Figure 1). Glass and Newberry [15] noted that the Ngaanyatjarra dialect is spoken by around 1,000 people across the region. The communities are ‘dry’ due to local laws prohibiting alcohol, and despite huge changes in lifestyle since the establishment of settled communities Simmonds et al. [7] noted that ‘... traditional belief systems and maintenance of the Law remain central to their health and well-being’.

The Ngaanyatjarra Health Service (NHS) is an Aboriginal Community-Controlled Health Service which has its administrative office based in Alice Springs, Northern Territory. Eleven clinics provide primary and preventive health care to people living in widely scattered communities throughout the Lands. The Service employs a multidisciplinary team of health care providers including

Figure 1 Ngaanyatjarra communities. The map of the Ngaanyatjarra Lands identifies the small communities in the region [16]. Permission to use the map has been given by the Ngaanyatjarra Council.
Aboriginal health workers, registered nurses and midwives [13]. Due to remoteness, pregnant women attend the nearest regional town (Kalgoorlie or Alice Springs) for an ultrasound at 18 weeks and for normal pregnancies are then transferred at around 38 weeks to await the birth of their baby. Antenatal care is provided by a midwife and only occasionally is a baby delivered in the community [7].

This paper, which presents findings on the remote clinical placement offered to midwifery students at a university in Western Australia, adds to our knowledge about the strengths, limitations and risks associated with experiential learning from the perspectives of the student participants.

Methods

The study population comprised the first seven students who were selected to undertake the Ngaanyatjarra Lands clinical placement between 2010 and 2013. Selection for the placement was based upon a written submission in which students outlined the reasons for their application. Student grades and their capacity to work effectively in a challenging environment, as judged by staff, were also taken into account. The lead researcher, who had previously taught midwifery students (but excluded herself from teaching for the duration of the study), contacted those in the study population by email and telephone. All agreed to participate in a research interview to explore their remote clinical practice experiences. Interviews also were conducted with supervising staff however the focus of this paper is upon the student experience.

One student visited the Ngaanyatjarra Lands in 2010 (the only applicant) and two in each subsequent year, although none visited at the same time. Applications from 2011 always exceeded the placements available. Students were in the final year of their undergraduate program with the exception of one, who applied when the program was opened up to postgraduate diploma students in 2013. All were female, mature-aged students (that is, not straight from school) and three of the seven women had children of their own to make arrangements for while away for up to two weeks.

In-depth, semi-structured, face to face interviews were conducted between November 2012 and February 2014 with six study participants and a phone interview was arranged with one participant who lived in a rural community. Data gathering that utilised in-depth interviews was deemed appropriate for this small-scale, descriptive study which aimed to elicit students’ responses to the experience of delivering health care to Aboriginal women living in remote communities. Participant information and consent forms were provided and written consent obtained prior to the commencement of interviews. Issues related to confidentiality and anonymity were emphasised in the consent form and discussed with all students. All gave permission for conversations to be recorded. Interviews, which were conducted by the lead researcher, lasted between 1.5 and 2.5 hours and the recordings were subsequently transcribed. An example of questions used in the interview guide is presented in Additional file 1. Additional probing questions were asked when further information was sought. Although not a requirement, one student kept a journal of the clinical practice experience and made this available to the researcher. Four participants were students at the time of interview and had recently returned from the Lands. Three, who were practicing midwives, recalled the experience retrospectively and were able to comment on the value of the placement to their professional practice.

Patterns of meaning across participant interviews were discerned using standard thematic analysis techniques. Thematic analysis has been described as ‘a method for identifying, analysing and reporting patterns (themes) within the data’ [17]. In this study, transcripts were reviewed multiple times to generate key words and codes were allocated to emerging themes. Marginal notes on the transcripts aided the coding process and provided an audit trail for open scrutiny. Multiple transcript reviews also facilitated the identification of quotations which highlighted emerging patterns of meaning. Early thematic analysis was conducted in the context of existing literature on cultural immersion experiences, and meanings associated with the codes were explored. This process led to further refinement as links between the themes were established and a thematic map was formulated. The interpretative approach described produced the key themes which frame the discussion.

This study which explored the value of cultural immersion and remote experiential learning is part of a broader investigation into culturally secure practice in midwifery education and service provision for Aboriginal women. Ethics approvals were received from the Western Australian Aboriginal Health Ethics Committee and from the Human Research Ethics Committees at the University of Western Australia and Curtin University.

Results

Initial themes presented in the results include: motivations and preparation; getting there and responding to the setting; encounters: giving and receiving; highlights and challenges; and application to midwifery practice. Three themes emerged from these categories and form the framework for the discussion.

Motivations and preparation

When asked about motivations to become a midwife, students primarily made reference to a desire to work
with women and support them through the journey to motherhood. For some this was a long-standing passion, and all were influenced by a range of factors including past experiences (both personal and work-related), encounters with midwives, insights from literature on early midwifery practice [18,19] and dissatisfaction with past employment (‘it was not satisfying my soul’). The fact that the undergraduate midwifery program could be studied independently of nursing was a strong incentive for those keen to work predominantly with women and their families.

Motivations to undertake the remote clinical placement were varied. Several students were strongly influenced by involvement in constant arguments about Aboriginal issues in social settings.

This was a really good opportunity for me to go out and . . . have a look and make my own decisions based on what I experienced out there and the people I come into contact with. It was also a perfect opportunity to consolidate what we had actually learnt in our Indigenous studies.

Another student put it this way:

I suppose the biggest reason was that I wanted to see it for myself. I wanted to see how an Aboriginal community is, what it looks like, what it feels like, what resources are there, to see the way they live, rather than go by the Indigenous unit, the media, the newspapers, my husband’s point of view, my friend’s point of view. I wanted to see firsthand what it was like, what it was really like.

Other motivations included seeing how health services operated in remote settings, to develop pre-existing interests and build upon current knowledge in Aboriginal health, to fulfil travel aspirations and enhance job prospects. Several students, who had prior experience working with or living in close proximity to Aboriginal families in rural areas, recalled the impact of these experiences on the development of their attitudes. One, a former lawyer, had travelled to the remote Kimberley region with a Supreme Court judge who presided over criminal trials. She was exposed to the complexities surrounding cultural evidence and the impact on families and communities of high incarceration rates. Another student had witnessed, as a child, discrimination experienced by Aboriginal people in rural areas and only in adulthood had come to understand the policy frameworks that allowed such discrimination to occur. The remote clinical placement was viewed by all students as an opportunity to gain valuable experience and a deeper understanding of Aboriginal health and cultures.

Although preparation for the Ngaanyatjarra Lands clinical placement varied, most students had successfully completed a compulsory core unit on Indigenous health and cultures in the first year of their degree (one student was exempt). The unit, which was designed and delivered by Aboriginal and non-Aboriginal staff was well received by students and all considered it to be important content. One student noted ‘I think (the unit) was valuable. Sometimes it is only when you look back on what you learnt and you are applying it that you realise how valuable it is’. The Royal College of Nursing scholarship that covered costs associated with the placement required students to complete an Online Cultural Orientation Training for Health Professionals offered by the Western Australian Centre for Rural Health, University of Western Australia (http://www.wacrh.uwa.edu.au). All considered this to be a very useful resource. Additional preparation was conducted independently by some students and included reading Ngaanyatjarra Council publications, academic articles and books specific to the region (with a focus on health, culture and language) and discussions with midwives who had worked remotely. An older student commented that it was her prior experiences and reading that had informed her about Aboriginal issues, and in particular, Kim Scott’s book Benang [20]. ‘I think that was the most educational book on the treatment of Aboriginals that I have ever read. It really, really shocked me’. Most students thought that they had prepared diligently for the placement, although in hindsight recognised that there were some situations for which one cannot prepare and require context for the learning to take place.

Getting there and responding to the setting
The remoteness of the setting took many students by surprise. Getting there involved a flight from Perth to Kalgoorlie or Alice Springs, and then a light plane to a community on the Ngaanyatjarra Lands. The second flight could take up to three hours and was a frightening experience for some.

I ended up being on the Lands for only one week because it took a couple of days to get there. I had to fly in to Kalgoorlie first, and then stay overnight, and then fly out in the morning in a 12 seater. . . . and it was pretty rough, I think it was the worst flight I’ve ever been on. . . . everyone was just sort of looking at each other thinking any second now we are all going to die together. I can’t even imagine what it would be like getting on a flight like that at 36 or 37 weeks pregnant, especially if it is your first baby, and it could be your first time on a plane, and it was like that (rough), and you are going to a place you don’t know, on your own. It would be just horrible.
The isolation and the cultural divide between local community members and white professional staff was also a shock for some students.

"I don't think I fully realised how isolated some Indigenous communities really are and that you are not really part of the community. Before I went I thought it would be like a small community at a camping ground or caravan park where everyone lives and gets on together, but it was not like that at all."

Another student explained a typical day this way:

"We would pile into the car... and drive to Papulankutja (Blackstone) and the nurse at the clinic would spread the word, the minymaku sisters ('belonging to women') were here... and women would just slowly filter in. They would have a chat for a while and often not get to the point of what they were in for... finally they would often whisper that they had come in for a health check."

At the clinic, pregnancies were monitored but as there were so few in such small communities, midwives (and students) were involved in many other health-related activities including health promotion, sexual health, arranging breast screening and ultra-sounds, post-natal care, Pap smears and contraception advice. ‘We were doing mostly pap smears, different vaginal swabs, talking about contraception... and then there were some women that talked about fertility problems.’ It was during these encounters with women and young teenage girls, that students who were delivering health care services also became recipients of valuable cultural knowledge passed on by patients and colleagues.

A student’s journal entry described a complex situation confronting a young teenage girl who came to a clinic for contraception. She had been in an abusive relationship and had broken bones and burns from a beating which were slowly healing. Her mother-in-law (an esteemed Elder) took the two children away from her while her man was in jail and the girl was missing them. The student started looking at the situation from a family law point of view but colleagues quickly reminded her that the community would turn their back on this girl if she did not follow local protocols. These involved ‘biding her time’ until the mother-in-law decided it was too much for her to look after these children as well as the numerous other grandchildren in her care. ‘That is what she was hanging around for. She still wants her community. She doesn’t belong anywhere else. That is all she has got.’

All students commented that anything could happen in a typical day. They observed the attributes of independence and flexibility that enabled health care professionals to work successfully in remote settings, and absorbed cultural learnings that could never be acquired from textbooks. The students gained insights into the complexity of people’s lives, the cultural obligations that must be met and the extraordinary creativity that can emerge within remote, disadvantaged communities and harsh landscapes. Difficulties emerged, however, in reconciling the contradictions in opportunities and realities of community members’ lives. One student described treating a man for burns on his buttocks that occurred...
when he sat on a fire. He was extremely polite when treated but it subsequently emerged that a few days earlier he had been associated with a violent incident in the community. The following year, the student was surprised to see one of his paintings on the wall of a major art gallery.

During encounters with patients, students also listened as staff incorporated local language into their conversations and observed how this gesture enhanced communication and trust. Most students acknowledged that they received more than they gave.

Highlights and challenges

Highlights of the remote clinical placement arose out of connections made with Aboriginal people, particularly women and children. Students described opportunistic encounters that provided insights into traditional Aboriginal beliefs and practices, including painting and weaving and birthing stories. Some were fortunate to observe artists at work.

We were driving around with the Aboriginal health worker trying to find some women but they weren’t there. We went to one house and there were two old ladies. It was a neat-as-a-pin yard . . . on the veranda there was a fire pit with two beds neatly arranged, and these ladies were sitting around a camp fire with all the dogs. The puppies were crawling through, you know, and they were making little sticks, little musical sticks, and one of them was burning a coat hanger in the coals and then she would mark the sticks, And so we said, ‘Oh, can we sit down and have a yack’ and they said ‘Yeah’, and so we sat there and it was just amazing. I will remember it for the rest of my life. I am tearing up just thinking about it. And they were telling me about the seven sisters (stars) and the painting she was doing and we just sat in the dirt and listened to them. It was just such a profound experience for me . . . you can’t learn about it (in the classroom).

Another student commented on her interactions with children at a sexual health fair where workers were handing out pamphlets. She assisted in a face painting stall and became very popular because she knew how to hand out pamphlets. She assisted in a face painting event that provided insights into traditional Aboriginal practices, including painting and weaving and birthing stories. Some were fortunate to observe artists at work.

Application to midwifery practice

All students considered that the learning experiences acquired on the Ngaanyatjarra Lands were transferable to urban settings and those who were practicing midwives provided examples of how they applied knowledge gained in everyday situations. One midwife described a 16 year girl in labour at a large metropolitan hospital in Perth who had flown in from a remote community. She established that she was comfortable, and her mother was with her, and ‘I think I stepped back a little more than I would have if I hadn’t had that remote experience. . . I spent nearly an hour just being quietly with her and that was enough for her, no chatty conversations’. Another student described how she spent time with a woman from the Kimberley’s who had a mitral valve problem due to rheumatic fever. She went with her in a taxi to another hospital to have an ultrasound on her heart. The cardiologist asked her if she drank alcohol and she said no. The student knew from her notes that she had 10 tinnies a day when she was in town. ‘I had to pipe up and say something. I said, oh xx, is it alright if I say something? I believe you have a few tinnies just when you are in town and she said, oh yeah, I do actually’. The cardiologist then changed the valve he was going to use because it was incompatible with her alcohol usage. The student realised that the knowledge gained on the Lands, particularly about direct questioning and the desire to please, helped avert a serious problem arising.

Other students commented on insights gained about the vast distances travelled by women to deliver, the huge contrast in settings, and the frightening nature of hospitals, especially if women had travelled to the city.
on their own. Occasionally connections were made with community members from the Lands.

One lady I met was in a wheelchair. She'd had a stroke when she was 17, not long after she had had her first baby. (Out on the Lands) we did part of her antenatal care for her next pregnancy . . . and she ended up coming to xx hospital (in Perth) to have her baby (when I was there). I met her when she came in with one of her sisters. I remembered her and gave her a photo of her family that I had taken out in the community, and she pinned that picture up on the board because she was really missing her family. Her baby was born at 33 weeks and I went to visit them both when they were moved to another hospital. Just to have someone say, “Oh, I’ve been to the Lands and do you know such and such” and they say, “Oh yeah, I know that girl, sister”. Making that connection really helps establish trust.

While most students acknowledged that they may never work remotely, they all cited examples of how their remote clinical placement had improved their midwifery practice and their interactions with all Aboriginal women encountered. ‘I find I tend to seek Aboriginal women out more because I feel their vulnerability much more than I did before’. While some of the students returned from the Lands with feelings of frustration and helplessness with regards to improving Aboriginal health, especially for women and their babies, nonetheless the experience provided insights into the complexity of the issues involved, the prevalence and richness of cultural traditions maintained in the region and a heightened awareness of the enormous transition required of women who are relocated from the remote Lands to towns and cities to birth.

Discussion
The aims of cultural immersion programs and the learning outcomes for students are influenced by many factors including the setting, partnership arrangements with communities, student preparation, length of placement, availability of clinical supervision, longevity of the program, opportunities for interaction and reciprocity, and degree of cultural differences encountered [2-6]. The midwifery remote clinical placement described in this paper offered students the opportunity to practice under supervision in very remote, traditionally-oriented Aboriginal communities within the Ngaanyatjarra Lands, Western Australia. The placement which was formalised in 2010 remains in the early phase of development although it is anticipated that more places will become available in future years and the length of the placement will increase from one to two weeks. Limiting factors relate to the availability of accommodation and the additional workload for the supervising midwife [Personal communications, Academic co-ordinator, midwifery program].

Key themes centred on the impact of geographic and professional isolation on midwifery practice; the significance of cultural protocols particularly with respect to communication, and the profound nature and relevance of the learning experience.

Geographic and professional isolation
The remoteness of the setting and health service delivery which required interminable hours of travel to very small communities widely scattered throughout the Ngaanyatjarra Lands, shocked many students - despite their thorough preparation for the placement. While their stay was brief, all were cognisant of the impact of isolation on pregnant women and their families and gained a deeper understanding of the emotional turmoil that surrounds transfer to regional or tertiary obstetric hospitals for birthing. Simmonds et al. [21] highlighted these issues in their study of the antenatal care and birthing needs of Ngaanyatjarra women. In-depth interviews with 36 women revealed a desire for a support person at antenatal appointments and when transferred to towns to await the birth, though not necessarily to be present at the delivery. Kildea [22] drew attention to the prohibitive costs associated with a family member accompanying women relocating for birth and called for appropriate resourcing to address the disadvantage suffered by remote, pregnant Aboriginal women.

Geographic isolation was also closely associated with professional isolation and this strongly influenced the nature of midwifery and nursing practice. Students observed professional staff taking on higher degrees of responsibility than in urban settings due to the absence of resident doctors, and recognised that characteristics including independence and flexibility were required to survive in remote settings. Cramer [23] used the term ‘amorphous practice’ to describe ‘the changing and inconsistent nature of practice’ with respect to nursing in remote communities. Amorphous practice included a degree of detachment from organisational systems due to isolation, and deviations from the official scope of practice such as assuming some medical roles. Stress associated with over-stepping professional boundaries and ‘the unrelenting demands to serve others’ were linked with fatigue and low morale [23]. Inherent risks are evident in this type of practice for both providers and recipients, and students were acutely aware of the weight of responsibility and high turn-over of staff in remote locations. Their supervising midwife was considered a long term resident; she had stayed for two and a half years before relocating to a less remote setting.
Significance of cultural protocols
Thorough preparation prior to the clinical placement ensured that students were conversant with cultural protocols surrounding ‘women’s business’ and interactions within the broader community. Nevertheless, they expressed surprise at the widespread use of local languages (mostly Ngaanyatjarra) by community members and the strategic use of ‘language’ by health professionals. Students themselves learned a glossary of terms which facilitated interactions and in the process discovered the significance of such small but important gestures in relationship building.

The role of silence in communication was less easily accommodated by students despite their awareness of its importance. On women’s verandas, conversations between the students and Aboriginal women about their paintings occurred without difficulty, but in health care settings where different dynamics existed and sensitive issues were discussed, communication was far more hesitant. In a paper on ‘conversational silence’ in remote Aboriginal communities, Mushin and Gardner [24] confirmed earlier findings that remote Aboriginal people are more comfortable with longer silences compared with Anglo-Australians, and ‘treat such silences as ordinary’. A number of explanations were offered including less orientation to clock time, more time to interact, proximity and ‘. . . an expectation that there are open ended opportunities to continue a conversation’ [24]. Students in this study identified numerous occasions where they were initially uncomfortable with long silences, but ultimately made connections by ‘listening to the silence quietly’. Given time, women and girls in clinic waiting rooms sometimes (but not always) raised the ‘women’s business’ issues that had brought them there in the first place, but this was usually done indirectly and in a faint whisper, highlighting the sensitive and embarrassing nature of such conversations. The students felt they became better communicators and more culturally secure practitioners as a result of this experiential learning and some subsequently applied these skills in large urban and rural settings.

The significance of cultural protocols also was reinforced when students were made aware of ‘sorry business’ and ‘sorry business’ camps (protocols surrounding death and dying), and conducted health promotion activities. They recognised that their role as visitors in the community did not give them a right to interfere with culturally prescribed patterns of behaviour such as the relationship between a mother-in-law and her grandchildren or the importance attached to Elders in the community. More specifically they became acquainted with cultural sensitivities surrounding ‘minynaku kutja tjukurpa’ (women’s secret/sacred business) as they shadowed the local supervising midwife [Personal communications, (past) Coordinator, Maternal and Women’s Health Program, Ngaanyatjarra Health Service].

Midwifery researchers and practitioners with extensive experience in remote Aboriginal communities have suggested adapting western biomedical approaches to pregnancy and birthing to incorporate cultural knowledge and protocols [7,11,21,22,25,26], Simmonds et al. [7] commented that ‘. . . older women (in their study) lamented the lack of opportunity for passing on knowledge to younger women . . . and (indicated) that many young women do not listen to their grandmothers anymore’. It is interesting to note that in this study one grandmother came to a clinic specifically to talk with a midwifery student about traditional birthing practices. For the student this conversation was the highlight of the practice experience; for the grandmother, it appeared to be an opportunity to disseminate information of importance to her and the wider community to an appreciative audience. Despite concerns expressed by older women about loss of traditional knowledge around birthing and the desire for opportunities to maintain these practices, most acknowledged the benefits of western medicine and the desirability of relocation for birthing, albeit with a support person [7,21].

With respect to cultural protocols students quickly learned that opportunities for social interactions with community members were limited. Not only was language a barrier, but maintenance of very traditional lifestyles on the Lands, meant the presence of an extensive social and cultural divide. This contrasted with other cultural immersion programs [3,6] but does not preclude the possibility that over time, and with more time, interactions may become less inhibited. When rare opportunities for social interaction did arise, these were identified as highlights of the placement.

While the focus of this study was upon midwifery students’ perceptions of the cultural immersion experience, it is recognised that the views of Aboriginal women, as recipients of the health services delivered by the students, would have added further richness to the data collected. Nevertheless, rapport and respect were the hallmarks of student interactions with Aboriginal women and as has been noted, women used these interactions as an opportunity to teach students about traditional cultural practices relating to minynaku kutja tjukurpa. This ‘two ways’ learning would not have occurred if students had been insensitive to their surroundings.

Profound and relevant learning experience
Extensive preparation, community involvement, voluntary participation and strong student support in the field are factors associated with successful student cultural immersion experiences [2,3,6]. Potential risks may arise if students are challenged or confronted by unfamiliar and/or unsafe situations, or where they themselves cause offense to community
members. Extensive interviews revealed that while feelings of helplessness and frustration were occasionally experienced by students with respect to the extent of health problems on the Lands, all participants in the clinical placement considered the learning experience to be profound and relevant to their midwifery practice, regardless of the setting.

Experiential learning that occurred was frequently referred to as learning that cannot be acquired from text books or lectures. Paul et al’s study [27] of medical student reflections following the completion of a case history of an Aboriginal patient reported similar sentiments expressed. Some students commented that they ‘learned a lot more than textbooks could ever teach’ and that the exercise was ‘beyond books!’ For others, it was their ‘first in depth interaction with an Indigenous patient’ [27]. Prout et al. [5] also reported on the transformative potential of facilitated learning ‘in situ’, especially where interactions with Aboriginal people were encouraged. Although midwifery students spent only one week on the Ngaanyatjarra Lands, they were keen to emphasise the positive and unforgettable nature of the experience and recommend it to others, especially younger students who were more reluctant to apply for the placement.

Conclusions
Cultural immersion programs which provide opportunities for students to learn from and interact with community members in supervised practice settings, have the potential to deliver rich learning experiences that cannot be acquired in classroom settings. In a clinical placement on the Ngaanyatjarra Lands, Western Australia, midwifery students gained valuable insights into the impact of isolation on health service delivery, the complexity of the issues involved in delivering care, the extent and strength of Aboriginal cultural traditions in the region, and a heightened awareness of the difficulties encountered by pregnant and birthing Aboriginal women in remote locations.

All participants valued the placement highly and identified profound learning experiences that arose out of their interactions with Aboriginal community members and health professionals on the Lands. While most acknowledged that they may never work remotely, they recognised the transferability of their learnings to urban and rural settings. By their own assessment, they had acknowledged that they may never work remotely, they and health professionals on the Lands. While most acknowledged that they may never work remotely, they were acutely aware of how little they really knew.

Endnote
4In the Australian context, the term ‘Aboriginal and Torres Strait Islander’ is frequently abbreviated to ‘Aboriginal’ and that is the usage in this paper. The term ‘Indigenous,’ which also refers to Aboriginal and Torres Strait Islanders, appears in this paper when reference is made to literature using the term or when it is used in quotations. These terms are often used interchangeably by government bodies, the academy and by Aboriginal people themselves and hence it is not possible to impose consistency.

Additional file 1
Additional file 1: Questions from the interview guide.

Competing interests
The authors declare they have no competing interests.

Authors’ contributions
RDT contributed to the study design, conducted the interviews, analysed the data and prepared the manuscript for publication. SRT supervised the study and provided critical feedback during the data collection and analysis phases and throughout the drafting and revision of the manuscript. AD provided critical feedback on the larger study and reviewed the manuscript prior to submission. All authors read and approved the final manuscript.

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References
4. Playford D, Lines A. Diminishing the distance between patients and providers: The impact of rural community immersion on students’ appreciation of primary health care. Focus Health Prof Educ 2013, 14:35–43.


Promoting women’s health in remote Aboriginal settings: Midwifery students’ insights for practice

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Abstract

Objective: To describe midwifery students’ insights on promoting health to Aboriginal women in remote Australia following a supervised clinical placement.

Design: Semistructured, in-depth interviews were conducted with all midwifery students who undertook the placement between 2010 and 2013.

Setting: Aboriginal communities on the Ngaanyatjarra Lands, Western Australia.

Participants: Undergraduate and postgraduate midwifery students from a Western Australian university.

Interventions: Remote cultural immersion clinical placement.

Main outcome measures: Student learning related to culturally respectful health care delivery and promotion of health.

Results: Students observed that, despite vast distances, high rates of participation in a breast screening program were achieved due to the informal provision of culturally relevant information and support. Opportunistic encounters in communities also enabled sexual health messages to be delivered more widely and in less formal settings. The role played by Aboriginal Health Workers and female family members was vital. The importance of culturally respectful approaches to sensitive women’s business, including discretion, the use of local language and pictorial representations of information, was recognised as was the socio-cultural context and its impact on the health and well-being of the community.

Conclusions: Although short in duration, the Ngaanyatjarra Lands clinical placement provided midwifery students with a rare opportunity to observe the importance of local contexts and cultural protocols in Aboriginal communities, and to adapt health promotion strategies to meet local needs and ways of doing things. These strategies embraced the strengths, assets and capacities of communities, yet students also witnessed challenges associated with access, delivery and acceptance of health care in remote settings.

KEY WORDS: Aboriginal health, communication, health promotion, midwifery education, remote health care.

Introduction

The Declaration of Alma Ata (1978) recognised primary health care as the principal approach for health service delivery and signalled a shift in power from providers to consumers. Empowerment of individuals and communities was subsequently reinforced in the Ottawa Charter for Health Promotion (1986) where access to information and a supportive environment were identified as pathways to optimal health.1 Health promotion, ‘the process of enabling people to increase control over the factors that improve their health...’, aims to strengthen individuals’ skills and capabilities.1 Strategies address disparities in health status and socioeconomic opportunities through engagement with communities and the political process. Determinants of good health, including access to health services, affordable healthy food, secure housing and waste disposal, are frequently absent in remote, disadvantaged communities. The impact of social and physical environments must be considered in health promotion and is particularly relevant in Aboriginal communities where cultural factors add another layer of complexity to service delivery.

In 2010, a program offering selected midwifery students from a Western Australian university a short clinical placement (up to two weeks, including travel) on the remote Ngaanyatjarra Lands commenced. The
Lands support 12 small, autonomous Aboriginal communities scattered across 250 000 km². The cultural immersion experience allowed students to deliver supervised care and participate in health promotion activities. All students had completed a unit on Aboriginal health and cultures prior to selection. Despite the potential risks, immersion programs can provide rich learning experiences. As women temporarily relocate for birthing, students focused upon antenatal care, sexual health, breast screening and promotion of healthy behaviours. Supervision was provided by a Ngaanyatjarra Health Service midwife.

The placement addressed National Competency Standards for the Midwife that requires culturally safe practice. This concept affirms the centrality of Aboriginal cultural values in service delivery, including recognition of and respect for customary law. In the primary health care context, competency standards identify active support of midwifery as a ‘public health strategy’ including the promotion of health-enhancing behaviours. In traditional communities, sensitive issues surrounding women’s business require health practitioners to be conversant with maternal and infant health risk factors and understand and respect cultural protocols. The role of grandmothers in inter-generational knowledge transfer is significant in this respect and contributes to culturally safe care.

Ongoing disparities in Aboriginal maternal and infant health outcomes have been identified in remote settings where services are fragmented and access is limited by distance. Higher teenage fertility rates, a threefold increase in low-birth-weight babies and under-utilisation of antenatal care demand attention. Risk factors including diabetes, poor nutrition, anaemia, urinary tract infections and high rates of smoking contribute to adverse pregnancy outcomes. While many of these factors are associated with socioeconomic disadvantage, health promotion strategies that favour ‘community development, capacity building and empowerment’ and incorporate Aboriginal knowledge are more likely to succeed. This study highlights how participation in health promotion programs is enhanced when women’s capacity for independent decision-making or agency is respected and cultural factors inform the basis of programs primarily designed for Aboriginal participants.

Methods

In-depth, semistructured interviews were conducted with seven female, mature-aged students who completed a clinical placement on the Ngaanyatjarra Lands between 2010 and 2013. At the time of the placement, six students were in their final undergraduate year and one was completing a postgraduate diploma. At the time of interview, three were practising midwives. All participants were given information about the study and signed consent forms. Six of the seven interviews were conducted face to face and one was completed by telephone. All interviews, which lasted between 1.5 and 2.5 hours, were conducted and recorded by the lead researcher and transcribed. One student’s reflective journal provided additional material for analysis.

Transcripts were thematically analysed and patterns of meaning discerned. This interpretative approach generated key words and facilitated the coding and mapping of themes. The study, part of a broader investigation into culturally secure practice in midwifery education and service provision for Aboriginal women, received ethics approvals from the Western Australian Aboriginal Health Ethics Committee and ethics committees at the University of Western Australia and Curtin University.

Results

Students accompanied the supervising midwife to community clinics throughout the Lands. Antenatal care was provided, but with few pregnant women in the
communities, students also embraced health screening and promotion of healthy behaviours.

Organised health promotion: breast screening Kiwirrkurra way

Kiwirrkurra is a remote community, lying 850 km west of Alice Springs with around 170 Pintupi-speaking people. As part of a national breast screening program, women were encouraged to undertake a 12-hour bus trip to Alice Springs for mammograms. Students participated in consultations with women, including at a community event where pictorial representations and local language were used to explain the screening process. The midwife had spoken to the older women in advance and they spread the word in the community; the strategy was carefully planned. ‘We spent an evening under the trees . . . explaining why we were going to Alice Springs for “mamograms” . . . the next morning we had a full busload of women.’ This was despite two ongoing sorry camps (mourning gatherings) and ‘. . . the women were just in the clothes they had been in for weeks . . .’ In the circumstances, staff were surprised that all women found their own way to the clinic on the morning of the screening.

We were getting quite upset but . . . they were all there and all in new clothes. It was an amazing experience for me because there were two sisters from the Pintupi tribe who were among a group who came out from the desert in the 1980s. One of the sisters grabbed me and made sure I went in with her . . . she couldn’t stay in the room with that machine . . . the radiographer was really good . . . she showed her the pictures afterwards . . . and she couldn’t stop laughing (when) she saw the pictures, but she wasn’t going to go into that room alone.

From a student perspective, trust, mutual respect, communication style and culturally relevant delivery of health promotion messages contributed to the success of the screening program, as measured by high rates of participation. One student also commented on what she learned about herself. ‘I learned how presumptuous and abrupt I can be . . . it is easy is slip back into that and then people ignore you. I had to concentrate on being respectful.’

Opportunistic health promotion: the circle of care

Opportunities for health promotion arose during informal encounters with women and their families. The involvement of Aboriginal Health Workers was central; they knew what was going on in the community. One student recounted an incident where young girls were accessing pornography.

The Aboriginal Health Worker said “oh, them girls . . . they are a bit young and they’ve got porn on a stick (USB)” and they were showing some boys, and so she said “oh, I think I need to bring them in” . . . and these four thirteen to fifteen year old girls came in, and the midwife got out all her pictures and she was using the local language to explain things . . .

This student observed how sexual health was tackled: ‘when you say something, don’t keep talking, but actually just wait, let them absorb it and they might ask something . . . the way she (the midwife) phrased things encouraged them . . . they wouldn’t actually ask directly, but would say “oh, and then that”’. Another student recalled a conversation with the teenage sister of a patient. ‘The midwife took her aside and was very, very careful to kind of say “I know you have a boyfriend now, and there are some things you need to think about” and the girl just sort of nodded and walked away, but it was a start.’

Students related how involvement of family members and health workers in health promotion messages enhanced engagement. For example, when a grandmother came in with a pregnant teenager and the conversation turned to nutrition, the midwife drew upon the older women’s knowledge by saying ‘well, what do you recommend that she should be eating?’ This respectful approach acknowledged the woman’s experience and encouraged her to then listen to the midwife’s ideas. ‘It made me think about the involvement of grannies in the circle of care and I learned so much from observing those interactions.’ Later, as a midwife, she delivered the baby of a 16-year-old Aboriginal girl when her grandmother was present. ‘It was so important to have the grannie there . . . information was relayed through her to the girl . . . and she will be there for her when she goes home.’

In one of the communities, Aboriginal Health Workers and older women played an important role encouraging attendance at a local fair where sexual health information was disseminated. Several students were involved in children’s activities, giving parents an opportunity to talk with the women and Health Workers. The fair enabled distribution of other health promotion material and also facilitated informal interactions between health professionals and community members.

Discussion

Models of health promotion that recognise the ‘strengths, assets and capacities’ of Aboriginal community members are more likely to succeed. Recognition of cultural protocols, local languages and contexts are paramount to the establishment of meaningful relationships. The Lands placement provided students with a
unique opportunity to participate in health promotion programs that drew upon strengths within communities. Simultaneously they observed the difficulties associated with access, delivery and acceptance of health care in remote settings. Students realised that routines learned in city clinics that centred round individual care and relative ease of access to services, needed to be adapted to reflect the realities of life on the Lands. Alternative strategies to encourage engagement with health promotion activities required staff and students to be culturally respectful, flexible in practice and creative in thinking.

Aboriginal women are often reluctant to attend mainstream health clinics on a regular basis. At Kiwirrkurra, this was addressed through careful preparation and consultation which increased the chances that women attended for breast screening and would return. Equally, opportunities to impart health promotion messages, especially regarding sexual health, arose in informal settings where teenage girls were with family members. Ngaanyatjarra women have identified family support, especially during antenatal visits, as important. This study revealed how providers can use opportunities with family members to promote healthy behaviours. Aboriginal Health Workers who understood the family dynamics played a significant role as cultural brokers and providers of health care, while the role of grandmothers as holders of traditional knowledge was respected and used by the health care team. This important contribution of older women has been recognised in other studies.

Our findings suggest that a short duration placement enabled students to understand local contexts, cultural protocols, community needs and barriers to care not previously encountered in prior practice experiences. Reluctance to access services was understood in the context of remoteness and cultural sensitivities around women’s health. The strength of communities, especially the role played by women, and the importance of culturally relevant health information were lessons learned on the Lands that had not been acquired elsewhere. These required understanding the social and cultural context of people’s lives, with students learning there is much more than clinical care needed to improve health outcomes. The preparation of health professionals to deliver culturally safe and respectful care is one important strategy to reform health systems at multiple levels and improve services to all Aboriginal women.

Conclusions

Despite the short duration of this clinical placement, the impact on students was profound. They learned that huge distances, prevalence of chronic diseases and shyness associated with women’s business had to be accommodated as part of health care delivery on the Lands. Equally important were lessons learned about working respectfully with Aboriginal women, asking and listening, and cultural factors that contributed to the acceptance of health promotion messages. Students recognised the importance of local contexts and cultural protocols, and the necessity to adapt their approach to meet community needs and ways of doing things. They observed and participated in health promotion activities, which embraced the strengths, capacities and people of those communities, recognising the value of the experience for them personally and for their professional practice.

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Authors contributions

R.D.T. contributed to the study design, conducted the interviews, analysed the transcripts and prepared the manuscript for publication. S.C.T. supervised the study and provided critical feedback during the data collection and analysis phases, and throughout the drafting and revision of the manuscript. A.D. provided critical feedback on the larger study and on the manuscript prior to submission.

References

5.3 The postgraduate cohort findings

As noted in Chapter Four, the postgraduate cohort comprised 59 students; 27 completed their diploma of midwifery at the end of 2013, and a further 32 completed their program in July 2014. The first group was surveyed in October 2013, but due to a low response rate, a second group was surveyed in May 2014. The response rates were 12/27 and 16/32 respectively, producing 28 completed questionnaires. This was a 48% response rate, and reflects the fact that some students lived in regional areas and received electronic versions of the questionnaire. Typically, emailed questionnaires have lower response rates. All students enrolled in the 18 month postgraduate program were qualified nurses.

5.3.1 Postgraduate student demographic characteristics

The postgraduate age distribution reflected the tendency for nurses to enrol in a midwifery qualification while still relatively young: 75% (21 students) were in the 21-30 year age bracket. This age distribution is also reflected in the years of nursing experience: just over 60% (17) qualified as a nurse less than four years earlier. Nearly 80% of the students (22) were Australian-born and only one acknowledged Aboriginal descent; this student also identified as an Aboriginal person. Of the six overseas-born students, five were from English-speaking countries (England, Ireland and New Zealand), and one was born in Hong Kong. This distribution of birth places closely resembles those of students in the undergraduate cohort. Similarly, nearly 90% of the Australian-born postgraduate students (19) were raised in urban settings and were working in the metropolitan area of Perth, or in large regional centres in Western Australia. The majority of all students expected to practice midwifery in similar locations, and within the public sector. Only one student expressed a preference for working in a small, remote setting in the first five years following graduation. Finally, nearly 60% of students (16) noted that they cared for Aboriginal patients quite frequently, with only 5/28 indicating this was a rare occurrence.

5.3.2 Key findings from the postgraduate student survey

As in the undergraduate study, important areas of investigation included: students’ knowledge about issues facing Aboriginal people, their history, culture and health; attitudes towards Aboriginal people and factors that shaped attitudes; and the adequacy of Aboriginal content in the program, and its influence on perceptions of Aboriginal health and communities. Students were also asked to comment on opportunities for clinical exposure to Aboriginal health in the program, and provide recommendations for additional content in this area.
Table 5.1 presents a comparison of undergraduate and postgraduate students’ self-reported knowledge about Aboriginal issues. The undergraduate responses reflect the combined first, second and third year groups, with all students having completed an Aboriginal health unit in the undergraduate program. Statistical tests included the Fisher’s exact probability test (Freeman-Halton version), and an ordered logistic regression model to predict the likelihood of one cohort responding differently to the other. The tests are appropriate when numbers are small and the requirements of chi-squared are violated (Allen & Bennett, 2012).

Table 5.1 Undergraduate (combined) and postgraduate students’ self-reported knowledge about Aboriginal issues.

<table>
<thead>
<tr>
<th>Knowledge statements</th>
<th>Combined undergraduate student responses (A=Adequate)</th>
<th>Postgraduate student responses (A=Adequate)</th>
<th>Fisher’s exact test results</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do you rate your knowledge of issues facing Aboriginal people?</td>
<td>Less than adequate 2</td>
<td>A 17</td>
<td>More than adequate 21</td>
</tr>
<tr>
<td>How do you rate your knowledge of Aboriginal history and culture?</td>
<td>Less than adequate 5</td>
<td>A 16</td>
<td>More than adequate 19</td>
</tr>
<tr>
<td>How do you rate your knowledge of Aboriginal health?</td>
<td>Less than adequate 7</td>
<td>A 14</td>
<td>More than adequate 19</td>
</tr>
</tbody>
</table>

Key: V = value; p is significant at .05 or less; N = number of participants.

Note: 4 missing undergraduate cases.

Table 5.1 reveals significant differences between the undergraduate and postgraduate cohorts with respect to knowledge of issues facing Aboriginal people, and Aboriginal history and culture. Despite the inclusion of some Aboriginal content in the postgraduates’ first degree in nursing (although not necessarily a full unit at that time), and additional content in the postgraduate program, only 3/28 (11%) considered their knowledge “more than adequate” in these areas. This compares with around 50% of the undergraduate students who all had completed a full unit on Aboriginal health. Postgraduate students were also more inclined than undergraduate students to consider their knowledge of issues facing Aboriginal people, and of Aboriginal history and culture, to be “less than adequate”. These differences reached statistical significance.
Differences were also observed between the two groups with respect to knowledge about Aboriginal health, although these differences did not reach statistical significance. When an ordered logistic regression test (StataCorp, 2011) was conducted with the postgraduates as the reference group and the undergraduates the comparator group, undergraduates were 8 times more likely than the postgraduates to perceive they were knowledgeable about Aboriginal issues ($p = .001$), and 5 times more likely to perceive they were knowledgeable about Aboriginal history and culture ($p = .001$). These findings are based on a 5-point Likert scale where students rated their knowledge levels from “poor” (1) to “comprehensive” (5). Three ordered logistic regression models were produced with the three outcomes variables being the knowledge statements identified in Table 5.1. Differences in self-reported knowledge about Aboriginal health did not reach statistical significance using either statistical method.

To further explore postgraduate students’ knowledge about Aboriginal health and service delivery, they were asked about their familiarity with the concepts of *shame* and *grandmothers’ law*; only 41% (11) and 29% (8) respectively were aware of these concepts. The final year undergraduate students were also asked these questions, but their reported awareness was even lower at 23% for each item. All students, postgraduate and undergraduate, were asked whether they had “read any books, poetry, or seen any plays by Aboriginal authors/playwrights”, and whether they were familiar with the Mabo judgement. These questions were included as the researcher’s teaching experience suggested that students who had studied literature and history were often more aware of Aboriginal issues and more inclined to respond to them positively. The Mabo question was presented in the following way: “In June, 2012 the twentieth anniversary was celebrated to commemorate a landmark judgement in the High Court of Australia affecting Aboriginal people. Do you know what the judgement was called?” Fifty-four per cent of the postgraduates (15) indicated having read Aboriginal authors, but only 11% (3) could name the Mabo judgement. The undergraduates were less likely to have read Aboriginal authors (41%) but more likely to be familiar with the Mabo judgement (33%).

Postgraduate students’ attitudes towards Aboriginal people, as measured by the attitude thermometer, produced a mean of 77.6°, almost identical to the first year students’ mean (78°), recorded immediately after completion of the *Indigenous Cultures and Health* unit. Table 5.2 presents students’ self-reported attitudes towards Aboriginal people by undergraduate year group and postgraduate cohort. The difference in attitudes between postgraduate students and final year undergraduates is particularly stark in the “highly favourable” category.
Table 5.2 Undergraduate and postgraduate students’ self-reported attitudes towards Aboriginal people.

<table>
<thead>
<tr>
<th>ATTITUDE</th>
<th>1st year post-unit students (N=12)</th>
<th>2nd year students (N=15)</th>
<th>3rd year students (N=13)</th>
<th>Postgraduate students (N=28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly favourable 90° – 100°</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Favourable 60° - 80°</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Neither favourable or unfavourable 50°</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Unfavourable 20° - 40°</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Highly unfavourable 0° - 10°</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12</td>
<td>14^1</td>
<td>11^2</td>
<td>28</td>
</tr>
</tbody>
</table>

Note: ¹ One missing case in 2nd years; ² Two missing cases in 3rd years; ⁰ = degrees; a 100 point scale was used.

When postgraduate students ranked the most important factors which shaped their attitudes towards Aboriginal people and understanding of Aboriginal issues, 53% (15/28) identified “lived experience” as the most influential factor. A further 21% (6/28) identified “Aboriginal people whom you have known personally”, while “Teaching in your midwifery course” was cited by only three students in all, and then only with a ranking of three out of the four most important influences. When compared with the undergraduate students, postgraduates had more interactions with Aboriginal people, possibly in their professional capacity, and these interactions were more influential in shaping their attitudes than content delivered in the program. It will be recalled that the postgraduate program does not include a full unit on Aboriginal health.

A comparison of responses to the 16 statements on Aboriginal health by undergraduate and postgraduate students is presented in Table 5.3. Several items were modified in the postgraduate survey to reflect the fact that their program did not include a full unit on Aboriginal health. Responses did not vary greatly between the groups. Only one item, “I will work for improvements in Aboriginal health as a personal priority in my health practice” reached statistical significance (Mann Whitney U Test; p= .035) with postgraduates less inclined to agree with this statement. Postgraduate students were less likely to disagree with a statement that poor Aboriginal health is mainly due to a lack of funding compared with undergraduate
students (29% vs 52%), but revealed more uncertainty about this issue (42% vs 5%). These differences did not reach statistical significance.

Table 5.3 Undergraduate and postgraduate midwifery student responses to statements about Aboriginal-related issues (adapted from Paul, Carr and Milroy, 2006).

<table>
<thead>
<tr>
<th>Social priority statements</th>
<th>Undergrad responses</th>
<th>Postgrad responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% N=40</td>
<td>% N=28</td>
</tr>
<tr>
<td></td>
<td>Agree Neither Disagree</td>
<td>Agree Neither Disagree</td>
</tr>
<tr>
<td>The state of Aboriginal health is a social priority.</td>
<td>97.5 0 2.5</td>
<td>92.0 4.0 4.0</td>
</tr>
<tr>
<td>Trust is a key for culturally secure health care.</td>
<td>95.0 2.5 2.5</td>
<td>100 0 0</td>
</tr>
<tr>
<td>Feeling intimidated is a barrier to culturally secure health care.</td>
<td>95.0 2.5 2.5</td>
<td>100 0 0</td>
</tr>
<tr>
<td>Health service delivery statements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Western medical model suits the health needs of Aboriginal peoples.</td>
<td>7.5 10.0 82.5</td>
<td>7.0 4.0 89.0</td>
</tr>
<tr>
<td>The state of Aboriginal health depends on the availability of appropriate health services.</td>
<td>80.0 10.0 10.0</td>
<td>86.0 14.0 0</td>
</tr>
<tr>
<td>The state of Aboriginal health is mainly due to a lack of funding for health services.</td>
<td>22.5 5.0 52.5</td>
<td>29.0 42.0 29.0</td>
</tr>
<tr>
<td>Aboriginal people have the same level of access to health services as all other Australians.</td>
<td>20.0 12.5 67.5</td>
<td>26.0 11.0 63.0</td>
</tr>
<tr>
<td>Community control in Aboriginal health care services is fundamental to the improvement of health for Aboriginal people.</td>
<td>75.0 17.5 7.5</td>
<td>86.0 14.0 0</td>
</tr>
<tr>
<td>Aboriginal people should take more individual responsibility for improving their own health.</td>
<td>80.0 17.5 2.5</td>
<td>63.0 37.0 0</td>
</tr>
<tr>
<td>Preparedness and ability statements</td>
<td>Undergrad responses % N=40</td>
<td>Postgrad responses % N=28</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>I think it will be difficult to get Aboriginal women to adhere to advice from health professionals.</td>
<td>62.5 27.5 10.5</td>
<td>54.0 28.0 18.0</td>
</tr>
<tr>
<td>I think I have the ability to communicate with Aboriginal women by myself.</td>
<td>62.5 27.5 10.5</td>
<td>47.0 50.0 3.0</td>
</tr>
<tr>
<td>I need to think beyond the individual when considering Aboriginal health issues.</td>
<td>92.5 7.5 0</td>
<td>82.0 11.0 7.0</td>
</tr>
<tr>
<td>The information I learned in the Indigenous Cultures and Health unit changed my views on Aboriginal issues.</td>
<td>65.0 22.5 12.5</td>
<td>N/A</td>
</tr>
<tr>
<td>I am better informed about Aboriginal health issues as a result of the content delivered in this program.</td>
<td>N/A</td>
<td>18.0 57.0 25.0</td>
</tr>
<tr>
<td>I think there should be a compulsory unit on Aboriginal health and cultures in our postgraduate program.</td>
<td>N/A</td>
<td>43.0 32.0 25.0</td>
</tr>
<tr>
<td>It is important that a unit on Indigenous Cultures and Health is compulsory in all health science courses.</td>
<td>90.0 5.0 5.0</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Future commitment statements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I will work for improvements in Aboriginal health as a personal priority in my health practice.</td>
<td>70.0 25.0 5.0</td>
<td>50.0 43.0 7.0</td>
</tr>
<tr>
<td>I have a social responsibility to work for changes in Aboriginal health.</td>
<td>80.0 15.0 5.0</td>
<td>71.0 25.0 4.0</td>
</tr>
</tbody>
</table>
The last section of the questionnaire invited postgraduate students to comment on the teaching of Aboriginal health in the midwifery program. Over half of the students (54%) described the amount of teaching in Aboriginal health as “inadequate” or “very inadequate”, with only 2 students (7%) stating that it was “more than adequate.” Interestingly, when they were asked the same question with reference to their undergraduate nursing program, 33% considered it “more than adequate”. The extent to which teaching in the program influenced “perceptions about Aboriginal communities and their health” varied according to postgraduate or undergraduate status: differences were statistically significant with undergraduates more likely to acknowledge the influence of Aboriginal content in the program on their perceptions ($z = -3.68; p = .000$). This is unsurprising given that the undergraduates had more exposure to Aboriginal health in their program and less professional or life experience with Aboriginal people.

Finally, when postgraduate students were asked about the adequacy of clinical experience in Aboriginal health during their program, 50% (14) considered it “less than adequate” or “very inadequate”, with only 25% considering it “more than adequate”. In open-ended questions, those who had clinical placements in a large public women’s hospital, or in Aboriginal health services, noted the valuable experience gained working with Aboriginal women and their families. Open-ended questions also gave students an opportunity to identify topics for additional Aboriginal content in their program. Responses included: Aboriginal women talking about their pregnancy and birthing journeys; the importance of extended family and connection to country; strategies to enhance health promotion; content on “women’s business”, particularly with reference to labour and birthing; the provision of culturally safe ante and post-natal education; the inclusion of Aboriginal women’s voices in conversations that involve them; communication to secure trust and understanding; the use of traditional medicines; barriers to utilising care; issues related to co-sleeping with infants; and opportunities for Aboriginal health service rotations.

5.3.3 Summary of postgraduate student survey findings

The findings presented are based on 28 returned questionnaires representing a response rate of 48%. While the response rate means that the findings should be interpreted with caution (see Chapter Six), they do provide a valuable overview, particularly when compared with the undergraduate findings. Despite having completed a nursing degree and acquired workplace experience, postgraduate students were more likely to consider their knowledge about Aboriginal issues, history and culture as inadequate, compared with their undergraduate counterparts. Attitudes towards Aboriginal people were very positive and comparable to the undergraduate students who had recently completed the *Indigenous Cultures and Health* unit.
Teaching about Aboriginal health in the postgraduate midwifery program apparently had little impact on shaping students’ attitudes towards Aboriginal people, which differed from the undergraduate cohort, and possibly reflects the absence of a dedicated unit on Aboriginal health in the postgraduate program, and the impact of prior and concurrent workplace experience. Little difference was observed between the cohorts with respect to the 16 statements on Aboriginal health used in other studies. Finally, half of the students considered their exposure to clinical experiences in Aboriginal settings to be inadequate, and many offered valuable suggestions for the inclusion of additional Aboriginal content in their program.

5.4 Chapter summary

This chapter has presented the key research findings. The focus of the research, as identified in the objectives, was upon the impact of Aboriginal content on midwifery students’ attitudes and knowledge acquisition. Emphasis was placed on the undergraduate cohort, as these students were exposed to a full unit on Aboriginal health. This provided an opportunity to observe the learning process across a semester, and assess the longer-term impact of content delivered in the first year of the midwifery program. The availability of a remote clinical placement for selected final year undergraduates also provided an opportunity to explore the impact of this cultural immersion experience on student learning. These findings were presented in the form of five published articles. Findings from the postgraduate students’ survey also presented in this chapter provided interesting comparisons with the undergraduate cohort. Due to the smaller population and lower response rate, the postgraduate findings were not prepared for publication but are valuable in their own right. Chapter Six draws together the key points of discussion identified in the published articles, and discusses the findings on postgraduate students in this context. Conclusions, recommendations, and comments on future directions for research are also presented.
Chapter Six: Discussion, Conclusions, and Recommendations.

6.1 Introduction to the chapter

This study investigated the preparation of midwifery students to provide culturally secure care to pregnant and birthing Aboriginal women in Australia. It focused on student responses to compulsory Aboriginal content in their program, including the acquisition of knowledge and shift in attitudes towards Aboriginal people. Learning acquired from a remote clinical placement on the Ngaanyatjarra Lands Western Australia was also documented.

The final chapter in the thesis draws together the key points of discussion identified in the published articles and the postgraduate students’ findings outlined in Chapter Five. A summary linking the research questions to the main findings, the implications of the study findings, and some general reflections are presented. The chapter concludes with a discussion of the significance of the research, the study limitations, the main conclusions and recommendations, and suggestions for future research.

6.2 Summary of the main study findings

As noted in Chapter One, this study arose out of the researcher’s extensive experience and interest in the preparation of health science students to deliver culturally responsive and secure care to Aboriginal people in Australia. While the preparation of medical students to work with Aboriginal people and the impact of Aboriginal content in medical curricula is well documented (Paul, 2012; Paul, Carr & Milroy, 2006; Rasmussen, 2001), less is known about the preparation and attitudes of other health professionals, including midwives. Midwives have a very intimate relationship with pregnant and birthing Aboriginal women. If the relationship is positive and characterised by mutual respect and trust, it is more likely that Aboriginal women will continue to access services for themselves and their children. While a definitive link between culturally competent care and improved health outcomes is yet to be established, it is known that the provision of health care, which is responsive to cultural sensitivities, especially around women’s business, leads to better access and improved levels of satisfaction (Beach et al., 2005; Kildea et al., 2012; Kruske et al., 2006; Lie et al., 2011). The education of health professionals, including midwives, to provide culturally secure care to Aboriginal people contributes towards the ultimate goal of improved health outcomes.
This study focused on student responses to, and the impact of, a compulsory Aboriginal health unit, *Indigenous Cultures and Health*, introduced into a Western Australian university as part of an inter-professional, common first year for all health science students. A multi-phased mixed methods research approach was adopted to determine how the unit was received by first year midwifery students, and to assess the longer term impact of this intensive instruction, including among those who partipicated in a remote clinical placement. The study explored undergraduate midwifery students’ responses to content in the unit, knowledge acquisition, attitude change, cultural immersion experiences and preparedness to deliver culturally secure care to pregnant and birthing Aboriginal women. Knowledge, attitudes and preparedness were also explored among postgraduate midwifery students who, as qualified nurses did not complete the unit, but provided a useful source of comparison with the undergraduate cohort. Table 6.1 presents the research questions, and the related findings and publications.

**Table 6.1 Summary of research questions, findings and related publications.**

<table>
<thead>
<tr>
<th>Research Questions</th>
<th>Findings</th>
<th>Research Publications</th>
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<tr>
<td>What constitutes culturally competent care in health service delivery and can it improve health outcomes for minority groups?</td>
<td>Studies in the US, NZ &amp; Australia emphasise development of knowledge, skills &amp; attitudes that support culturally inclusive health service delivery. Cultural safety, security and humility are concepts also used in health care delivery, but have slightly different frames of reference. Cultural competence is associated with improved satisfaction and utilisation of services, but there is little evidence of improved health outcomes.</td>
<td>Refining the concept of cultural competence: building on decades of progress. <em>Medical Journal of Australia</em>. 199(1). 201, pp.35-38.</td>
</tr>
<tr>
<td>What approaches are used to prepare midwifery students to work with and care for pregnant and birthing Aboriginal women?</td>
<td>Compulsory Aboriginal content in curricula is required by registration boards to meet competency standards. Approaches to the delivery of this content vary, but are more likely to be successful when designed and delivered with significant Aboriginal input &amp; applied to midwifery practice. Clinical practice placements in Aboriginal settings provide valuable learning experiences for students.</td>
<td>Confronting uncomfortable truths: Receptivity and resistance to Aboriginal content in midwifery education. <em>Contemporary Nurse</em>. 2013, 46(1), pp 113-122.</td>
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<th>Research Questions</th>
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<tr>
<td>How do midwifery students respond to Aboriginal content in their program?</td>
<td>In this study first year students responded positively to intensive instruction, although small pockets of resistance were observed. Postgraduate students considered content in their program inadequate.</td>
<td>“Friendly racism” and white guilt: midwifery students’ engagement with Aboriginal content in their program. <em>Forum on Public Policy.</em> Vol. 2013, 2.</td>
</tr>
<tr>
<td>What factors influence student receptivity and resistance to Aboriginal content in their program?</td>
<td>Receptivity was influenced by a safe learning environment, a well-informed and passionate tutor, inclusion of Aboriginal voices in the classroom, carefully sequenced content &amp; positive personal experiences. Small pockets of resistance were associated with a fear of being labelled, socialisation, guilt &amp; negative personal experiences.</td>
<td>Confronting uncomfortable truths: Receptivity and resistance to Aboriginal content in midwifery education. <em>Contemporary Nurse.</em> 2013, 46(1), 113-122.</td>
</tr>
<tr>
<td>Does experiential learning help students contextualise and apply content delivered in the classroom?</td>
<td>Students’ reflections indicated that experiential learning opportunities, especially those in remote Aboriginal settings, were highly valued. Students learned much more than the application of clinical skills. They observed and interacted with community members, applied knowledge learned about working in Aboriginal contexts and appreciated the impact of the tyranny of distance for community members and health professionals. They also learned how little they really knew. Students should be carefully selected for these experiences and have a sound understanding of Aboriginal health and cultures prior to clinical placements.</td>
<td>“Listening to the silence quietly”: investigating the value of cultural immersion and remote experiential learning in preparing midwifery students for clinical practice. <em>BMC Research Notes.</em> 2014, 7:685. Promoting women’s health in remote Aboriginal settings: Midwifery students’ insights for practice. <em>Australian Journal of Rural Health.</em> 2015, 23, 327-331.</td>
</tr>
<tr>
<td>Do students perceive that they are adequately prepared to care for Aboriginal women and their babies at graduation?</td>
<td>Despite being less confident in their knowledge about Aboriginal issues than those who had just completed intensive instruction, the vast majority of undergraduate students about to graduate considered they were adequately prepared to work with Aboriginal women and their babies. Those with remote clinical practice experience considered themselves to be better prepared than if they had not undertaken the placement.</td>
<td>Exploring undergraduate midwifery students’ readiness to deliver culturally secure care for pregnant and birthing Aboriginal women. <em>BMC Medical Education.</em> 2015, 15:77. Promoting women’s health in remote Aboriginal settings: Midwifery students’ insights for practice. <em>Australian Journal of Rural Health.</em> 2015, 23, 327-331.</td>
</tr>
</tbody>
</table>
A decline in the retention of knowledge about Aboriginal cultures and health and less positive attitudes towards Aboriginal people were observed among students in later years of their undergraduate program. While not affecting perceptions of preparedness, this raises questions about the sustained impact of content delivered in the first year of a program.

Postgraduate midwifery students, despite their clinical experience as nurses, overall were less confident about their knowledge of Aboriginal issues and culture compared with undergraduates. They were also more likely to consider content in their program inadequate to prepare them to work in Aboriginal settings.

How can this information be utilised to refine and improve programs to facilitate culturally informed health care delivery across the health sciences?

Aboriginal content must be vertically integrated to maximise gains following intensive instruction.

Safe learning environments & tutors confident with content are necessary. Significant Aboriginal involvement in the design & implementation of content is essential, as is the inclusion of Aboriginal voices in the classroom. Preparation for practice is enhanced by remote clinical exposure, regardless of future practice settings.

Additional opportunities should be provided for cultural immersion experiences & other clinical placements in Aboriginal settings. More content on traditional health beliefs & practices around birthing & communication skills is required.

Postgraduate programs must address students’ preparedness to work with Aboriginal women and their families.

6.3 Implications and general reflections

The implications of the various components of the research findings, apart from the postgraduate results, have been discussed in published articles in Chapter Five. To avoid repetition, this section identifies the emergence of a unifying theme, highlights the overall implications of the findings, and provides reflections on the study and its outcomes. The study
comprised four main components including investigations into: first year midwifery students’ responses to the *Indigenous Cultures and Health* unit; the longer term impact of Aboriginal content that was delivered to students in their first year; learning derived from a remote clinical placement for selected final year undergraduate and postgraduate students; and postgraduate students’ knowledge, attitudes and preparedness to deliver culturally secure care to Aboriginal women. The postgraduates were all qualified nurses and did not have a dedicated Aboriginal unit in their diploma program.

### 6.3.1 The power of exposure to dispel stereotypes and challenge assumptions

The main focus of the study was the undergraduate cohort. A theme that emerged from the first year classroom observations and students’ reflections on their remote clinical placement experiences, was the power derived from exposure to Aboriginal people and communities to dispel stereotypes and evoke empathy and respect. In the classroom setting exposure was facilitated through the use of vodcasts where Aboriginal people were interviewed, and a visit by Aboriginal guests; the impact on students was profound. This exposure and the opportunities for interactions shared an important characteristic: the power of the exchange was firmly in the hands of the Aboriginal speakers. Students were listening and learning from Aboriginal people who were the holders of knowledge.

A similar situation arose on the Ngaanyatjarra Lands: the clinical placement afforded opportunities for students to interact with community members in their own sociocultural context, on their own lands, and largely on their own terms, even in health care settings. The balance of power was shifted from health care providers to community members, a shift integral to the provision of culturally safe and secure care, and the promotion of health. Students’ exposure to traditional Aboriginal communities and the learning derived from this experience occurred due to the generosity of community members and Ngaanyatjarra Health Service staff. Exposure of this nature encouraged self-reflection on the part of students, and also enabled them to observe the strengths and capacities inherent in Aboriginal communities; they learned how to employ those attributes in the delivery of health care. Enormous respect flowed from the encounters, with students learning much in the process but also recognising how little they really knew.

Positive learning experiences from interactions with Aboriginal people have been observed in studies reviewed in this thesis. Cultural immersion programs have been associated with positive shifts in attitudes and a better understanding of the lived experience and challenges confronted by community members (Crampton et al., 2003; Jong, 2013; Playford & Lines, 2013; Prout et al., 2013; Rasmussen, 2001). Paul et al., (2011) recalled medical students’
reflections on one-on-one interactions with Aboriginal patients while conducting case history assessments. For many students, it was their first in-depth interaction with an Aboriginal person, and some noted that it was more valuable than reading a textbook or sitting in a lecture about Aboriginal health (Paul et al., 2011). Prout and colleagues recorded similar responses from students involved in an interprofessional country week where learning occurred “in situ” (Prout et al., 2013). Exposure using vodcasts as a learning tool, however, is a relatively new, technology-based approach about which little has been written. This study found the approach to be highly effective, especially when used in small classroom settings where the intimacy of the encounter was experienced.

Another aspect associated with exposure relates to a small number of first year students who had previous experience, either directly with Aboriginal people in the course of employment, or in earlier studies of Aboriginal history and cultures. These students responded to the Aboriginal unit quite differently; their contact and prior knowledge of Aboriginal issues caused them to be quite shocked by the attitudes of some of their peers. Furthermore, teaching in the unit had less impact on these students; their attitudes were already positive. It can be speculated that the postgraduate students too, the majority of whom considered Aboriginal content in their program to be inadequate, but whose attitudes towards Aboriginal people were very positive, may also have been influenced by increased opportunities for exposure; most had nursed Aboriginal patients and more were likely to have read Aboriginal literature.

6.3.2 Relationship building: the role of reciprocity, trust and respect

Reflections on how exposure and interactions of the type described are perceived and responded to by Aboriginal people are important. In the case of vodcasts, participants known to the interviewer (a Noongar man from the South-West of Western Australia), were invited to be involved. The arrangement was carefully managed to ensure a safe conversational environment and interviewees were financially recompensed for their contribution. An ongoing fee was also negotiated to cover future use of the vodcasts (see Appendix Four). These arrangements acknowledged the importance of reciprocity and trust in relationship building and maintenance of on-going relationships. Students on the Ngaanyatjarra Lands also recognised that as visitors they needed to be respectful and aware when their presence was perceived as an intrusion. When rapport and trust were established, students found community members to be very generous with their time; some recognised their novice status and used it as an opportunity to teach students about cultural traditions.
Risks associated with cultural immersion experiences have been identified (Crampton et al., 2003), but with careful management and sound preparation, students can receive a valuable learning experience while simultaneously providing a useful service to community members. Student placements in Aboriginal settings must prioritise community needs. In this study, although well informed about cultural protocols, and health and social problems confronting communities, students still needed to work hard on building relationships: many felt ill-equipped to decipher nuances in communication, especially silences, with others conscious of their own presumptuousness.

If future health professionals are expected to graduate as culturally competent practitioners they must, in addition to learning about Aboriginal cultures and health throughout their program, be given opportunities to interact with, build relationships, and provide health care to Aboriginal people in a range of locations: large hospitals, and small community-controlled health services, in urban, rural and remote settings. This study found that clinical placements need not be long in duration to have a profound impact, and transferability of learnings from remote to urban settings was evident. These opportunities have the potential to teach students much about relationship building in communities, and the importance of reciprocity, trust, and respect in health care delivery.

6.3.3 Exposure and disquiet

Exposure and interactions can have negative or discomforting consequences for both Aboriginal people and students. While the use of vodcasts in this study protected Aboriginal interviewees from the possibility of unguarded or hurtful comments, community members may encounter ignorance or racism, and there is also a risk that students are “cultural tourists” (Crampton et al., 2003). Therefore, the selection and preparation of students to participate in cultural immersion programs is very important. Aboriginal staff involved in the teaching of Aboriginal content may also be subjected to ill-informed and hurtful comments. Strategies of self care and support in teaching schools are required to address these issues. Aboriginal students too, may find themselves at the receiving end of prejudice and/or be expected to represent the views of all Aboriginal people in classroom settings. While the impact of these issues may diminish as Aboriginal student numbers rise, they may be a disincentive for some considering tertiary studies.

With respect to the non-Aboriginal students, some in the Indigenous Cultures and Health unit suggested that previous personal or family encounters with Aboriginal people had coloured their thinking, and in retrospect, clouded their judgements. For others, exposure to Aboriginal content caused “disquiet”: they showed signs of unease and anxiety when confronted with
content that disturbed or upset them. McDermott and Gabb (2010) viewed these emotions as an inevitable part of the learning process when dealing with difficult content, and discussed strategies for handling “manageable disquiet” in the classroom. The creation of a safe learning space is important. Disquiet was also observed in students who were conflicted by what they saw on the Ngaanyatjarra Lands, and although not a negative experience, they were discomforted as they tried to understand and find solutions to problems not previously encountered. Both the unit and the clinical placement provided opportunities for students to debrief and explore these reactions. Most came to understand the impact of poor living conditions on anti-social behaviour and domestic violence. When socioeconomic disadvantage and the presence of racism in society were recognised as contributing factors, students viewed their experiences through a different lens.

6.3.4 Dilution of impact over time

Lastly, with respect to the undergraduate findings, it is important to note that the impact of profound experiences may diminish over time if learnings are not revisited and reinforced throughout a student’s program, and beyond. In this study, it was found that knowledge acquisition and shifts in attitudes observed immediately following intensive instruction were less likely to be present among students in later years of their program, even though they had been exposed to the content in their first year. This has clear implications for the vertical integration of Aboriginal content throughout a program and expanded opportunities for clinical placements in Aboriginal settings. The intensity of the remote clinical placement experience appeared to last longer as most students were close to graduation, had opportunities to apply their learnings, and indicated that the experience was something they would never forget. Even so, as qualified midwives, some lamented their limited contact with Aboriginal women, and recognised a dilution in the power of the experience, which was considered very profound at the time.

6.3.5 Reflections on postgraduate findings

Final reflections relate to the postgraduate student findings. As noted in Chapter Five, due to lower response rates, these findings must be interpreted with caution. Despite this, the differences observed between the two student cohorts are instructive (see Table 6.1), and suggest that a dedicated unit in the program would enhance preparedness to work with Aboriginal women. The omission of an Aboriginal health unit in the postgraduate diploma is based on the assumption that this information was acquired in an undergraduate nursing degree, however, this is dependent on when and where nursing training was completed. The observation that many of these students who were about to graduate as midwives felt under-prepared to work with Aboriginal women, suggests that Aboriginal content in postgraduate programs and
opportunities for clinical placements in Aboriginal settings, should be expanded. Content that requires more sophisticated thinking appropriate for postgraduate studies, and is applied to midwifery practice, is likely to be well received; the attitudes of postgraduate students towards Aboriginal people were very positive. Many students recommended additional content in their program relating to cultural traditions around birthing and communication styles. They also requested more clinical placements in Aboriginal settings.

6.4 Significance of the study

This study has shed light on midwifery students’ preparation to work with pregnant and birthing Aboriginal women. National Competency Standards for the Midwife (2006) require midwifery practice to be culturally safe, yet little is known about how students are prepared to deliver culturally safe care. It is widely recognised that a culturally responsive workforce is an essential component of health service provision. The National Aboriginal and Torres Strait Islander Health Plan 2013-2023 identified the need for a “culturally respectful and non-discriminatory health system” which provides health care free of racism (Department of Health, 2013, p.14). At a time when a new national curriculum framework to guide the inclusion of Aboriginal content in health professional programs is under consideration, evidence on the immediate and longer term impact of this content can inform the framework’s implementation. Teaching and learning strategies to address student discomfort and resistance are required, and recognition of successful approaches to teaching this content is also important. This has been acknowledged at a national level in teaching fellowships awarded by the Office of Learning and Teaching (McDermott, 2015).

Findings from this study complement research conducted with medical students, and make an important contribution to understanding the impact of Aboriginal content in curricula; in teaching and learning strategies required to enhance engagement with content; and in the value of clinical placements in Aboriginal settings. In a climate of fiscal contraints and rising health costs, on-going commitments for short term rural clinical placements are not guaranteed. However, it is noteworthy that findings from this study highlighted the profound learning that can occur during a placement of a relatively short duration. Culturally responsive midwives are well placed to build strong relationships with Aboriginal women in urban, rural and remote settings, and influence future utilisation of health care services, making an important contribution to better health outcomes for women and their families.
6.5 Limitations of the study

The main limitation of the study relates to the small number of direct entry undergraduate midwifery students who provided the focus of the research. Midwifery is a relatively small health profession, and student numbers are influenced, in part, by the availability of clinical placements. Direct entry student numbers at the university where this study was conducted were capped at 20 places annually, apart from several additional identified places for Aboriginal students, which were rarely filled. In this study, the small undergraduate cohort meant that statistical analysis of survey findings was largely description, given the lack of statistical power associated with smaller numbers. Additional methods to triangulate and verify the findings were essential. While postgraduate student numbers were higher, lower survey response rates resulted in the inclusion of a second final semester group. Even with the addition of this group, the combined response rate was just under 50%; as a result the findings from the postgraduate cohort required cautious interpretation.

A second limitation relates to the cross-sectional rather than longitudinal nature of the study design. Student responses were observed before and after completion of the Indigenous Cultures and Health unit, and classroom observations were conducted across the semester. A longitudinal study would follow these students in subsequent years of their program to assess the longer term impact of the content. Due to time restrictions this was not possible, instead information was gathered simultaneously from students in the later years of their program. While this approach provided valuable information, a longitudinal study that followed the same group of students throughout their program would shed additional light on the impact of the content over time.

A further potential problem concerns the process of retrospectivity and the clarity of recall. All students interviewed about the Ngaanyatjarra Lands clinical placement reflected on the experience after the event, for some it was nearly 18 months later, when they were newly qualified midwives. While the time lag meant that these midwives could discuss the application of learnings to midwifery practice, their recollections may also have been less sharp. The powerful impact of the experience helped to mitigate problems with recall.

Lastly, it is important to draw attention to the fact that as the number of Aboriginal students in the program was very small, and although all were interviewed, their perspectives on the teaching of this content, and their personal reflections on the experience of being an Aboriginal student in the program, comprise only a very small component of the findings. While valuable insights were provided and discussed in a published article, it was necessary to consider issues
of anonymity when sensitive issues were raised among so few students. Some very interesting content, initially considered for a case study, was omitted for this reason, despite student willingness. However, feedback on the study was provided by Aboriginal academics, and dissemination of early findings allowed additional exposure to Aboriginal audiences.

6.6 Conclusions

Findings from this study revealed that student receptivity to Aboriginal content in health professional programs is optimised by the creation of a safe learning environment and the innovative inclusion of Aboriginal voices in the classroom. While students’ involvement in the development of guidelines for a safe learning space allowed viewpoints to be freely expressed, there was potential for offence and this required careful monitoring by teaching staff. The introduction of Aboriginal voices into the classroom through the use of vodcasts proved to be a powerful learning tool. Exposure to Aboriginal people using innovative technology combined with classroom visits, not only privileged Aboriginal voices and helped dispel stereotypes, but placed the power of the exchange in the hands of the Aboriginal speakers. The *Indigenous Cultures and Health* unit upon which this study was based, was conceived, developed, and implemented with substantial Aboriginal input. Its success in achieving significant enhancement of knowledge and shifts in attitudes highlighted in the study findings, confirms the value of the teaching and learning approaches adopted. Further acknowledgement was provided by a national teaching award bestowed on the unit in 2014 (See Appendix Four).

Conclusions can also be drawn about the longer term impact of Aboriginal content delivered in the first year of a program. The study identified that the impact and retention of Aboriginal health content diminished over time and positive attitudes declined. Priority given to other areas of the program, and lack of vertical integration of Aboriginal content may explain the decline, although longitudinal studies would be needed to confirm these findings. In common with their first year counterparts, students in later years of their program were enthusiastic about gaining clinical experience in Aboriginal settings. This interest was also observed among postgraduate students who, despite their existing clinical experience, were less inclined than undergraduates to feel confident about their knowledge of Aboriginal cultures and health, although their attitudes were very positive. Expanded opportunities for clinical placements in Aboriginal settings are likely to be well received by all students.

Similarly, when students were offered the chance for a clinical placement in a remote Aboriginal setting, expressions of interest exceeded places available. It was evident from the reflections of those who were selected that, although short in duration, the Ngaanyatjarra Lands
placement had a profound effect on student learning. It provided a rare opportunity to observe the importance of local contexts and cultural protocols in health care delivery in Aboriginal communities, especially those related to women’s business. While resourcing implications of rural and remote clinical placements are acknowledged, without the financial support offered, few, if any of the students in this study would have travelled to the Lands; they would have been denied an experience described by one student as “unforgettable, I’ll remember it for the rest of my life”.

6.7. Recommendations

Recommendations arising from the study findings are listed below.

- Aboriginal content in undergraduate midwifery programs should not be confined to one unit. While an introductory first year unit provides a sound foundation, more complex content, especially related to racism in institutions and the wider society, should be integrated into the second and third years of a program and into a post graduate unit. The concept of cultural competence provides a useful tool to facilitate analysis of institutional racism within health care systems and its impact on Aboriginal people.

- The inclusion of more midwifery-specific content as it applies to pregnant and birthing Aboriginal women is required in both undergraduate and postgraduate programs. Suggestions for additional content raised by students and referred to in this study, should be considered.

- A core unit on Aboriginal health should be included in postgraduate diploma programs if additional research supports the findings in this study. This unit should be pitched appropriately and build on existing knowledge.

- Teaching staff must be sensitive to the impact of content and classroom discussions on Aboriginal students who may experience discomfort.

- Where resources are available, team teaching with Aboriginal and non-Aboriginal staff should be considered to role model partnerships, and provide students with enhanced opportunities for interaction.

- Additional support to address the emotional impact of delivering this content may be required by teaching staff. Mentoring, debriefing, and opportunities for the exchange of ideas about teaching and learning in this space are useful strategies. Aboriginal staff may require further support if content and responses to it, impact on them personally.

- Consideration should be given to expanded opportunities for clinical placements in Aboriginal settings. On-going financial support for short and longer term rural and
remote placements should be maintained, and increased over time, to allow more students to gain experience in these settings.

- Funding is recommended for academic staff to visit students in rural and remote settings for the purposes of familiarisation, assessment, and student support. Staff exposure is also necessary to assess and refine clinical placement programs prior to expansion.

### 6.8 Areas for future research

On February 10th 2016, Prime Minister Malcolm Turnbull delivered the eighth annual *Closing the Gap* report, charting progress made on targets set by COAG in 2008 in the areas of health, education, and employment (Department of Prime Minister and Cabinet, 2016). The mixed report card revealed that targets to halve both child mortality by 2018 and the gap in Year 12 attainment by 2020 were on track, but remaining targets including closing the gap in life expectancy by 2031, were unlikely to be met.

The Indigenous-led *Close the Gap Progress and Priorities Report*, which was released a day earlier, noted the encouraging improvements of the last decade, however, Mick Gooda, co-Chair and Aboriginal and Torres Strait Islander Social Justice Commissioner, suggested that ongoing health inequalities remained “a stain on the nation”. The report identified “deliberate or accidental racism in Australia’s hospitals, and other health services” as partly to blame for health disparities and called for an inquiry into institutional racism in health care settings, especially hospitals (Close the Gap Campaign Steering Committee and Oxfam Australia, 2016). It also drew attention to the preparation of health professionals in training and in workplaces to deliver culturally respectful health services. It suggested that education programs must be evaluated for “...long-term improvements to practice”.

Communities of practice such as the Leaders in Indigenous Medical Education are working to embed lifelong learning skills for cultural competency within medical curricula. Such training across the sector is critical to achieving the institutional, professional and personal commitment required for systemic change. Healthcare providers need to not only reflect on their own attitudes, but take the lead to work collectively to effect systemic change. Self-reflection to eliminate bias, relationships with Aboriginal and Torres Strait Islander people and partnership building are seen as key to reducing health disparities.

(Close the Gap Campaign Steering Committee and Oxfam Australia, 2016, p. 23).
These sentiments have been strongly conveyed in this thesis and are implicit in proposals for areas of future research. Cultural competence training must be translated into practice and incorporated into on-going professional development. Health care institutions and organisations need to facilitate the application of this training. Further research is also needed to determine the impact of culturally competent care on health outcomes for Aboriginal Australians, as evidence of a positive association may provide the additional impetus required to effect systemic change.

- It is recommended that future studies investigate the extent to which knowledge gained in training programs is applied in health care settings.
- Further exploration of the way culturally competent health professionals are supported or impeded in their work to improve health outcomes for Aboriginal Australians, is required.
- Further research into how culturally competent care contributes towards reducing health inequities is recommended.

On the eve of the release of the eighth Closing the Gap report, Aboriginal leader Patrick Dodson, Yawura man, and former chairman of the Council for Aboriginal Reconciliation (and now Senator-elect), expressed his frustration at the slow rate of progress and limited engagement between government and Aboriginal communities (Robinson, 2016). He raised the topic of a “treaty” with Aboriginal people, an aspiration that has stalled politically, but is considered by many as long overdue as a means to improve relationships, and enhance empowerment and levels of trust (Durie, 2012; Williams, 2013). The importance of relationships, empowerment and trust as contributors to better health outcomes was observed by midwifery students on the Ngaanyatjarra Lands. One wonders why most politicians choose to look the other way.
References


Hancock, H. (2006). *Aboriginal women's perinatal needs, experiences and maternity services: A literature review to enable considerations to be made about quality indicators*. Alice Springs: Ngaanyatjarra Health Service.


Leaders in Indigenous Medical Education Network. (2015). *LIME Good Practice Case Studies (Vol.3)*. Melbourne: Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne.


Royal College of Nursing Australia. (2003). *Position statement: Nursing education for Aboriginal and Torres Strait Islander peoples.* Deakin: RCNA.


StataCorp. (2011). *Stata Statistical Software: Release 12.* College Station, TX: StataCorp LP.


VicHealth Koori Health Research and Community Development Unit and the Department of Rural Health (Shepparton). (2001). *Teaching Koori issues to health professionals and health students*. The University of Melbourne.


Appendix One: Questionnaires.

Note: The Combined Universities Centre for Rural Health is now known as the Western Australian Centre for Rural Health.

1. Undergraduate first year student pre-unit questionnaire
2. Undergraduate first year student post-unit questionnaire
3. Undergraduate second year student questionnaire
4. Undergraduate third year student questionnaire
5. Postgraduate diploma student questionnaire
CURTIN UNIVERSITY UNDERGRADUATE MIDWIFERY STUDENT SURVEY

Students enrolled in Indigenous Cultures and Health 130

(Pre-Unit Survey)

Research project: ‘Cultural security in midwifery education and service provision for Aboriginal women’.

July 2012

Approval has been granted by staff at the University of Western Australia, University of Melbourne and Murdoch University to include some questions used in earlier studies. Permission is acknowledged and appreciated.
SECTION ONE

This section seeks demographic information to help establish a profile of midwifery students at Curtin University who complete this questionnaire. Please fill in the circle that corresponds to your response. Please use a blue or black pen.

The numbers on the far right are for coding purposes only.

1.1 What age category do you belong to?

<table>
<thead>
<tr>
<th>Age Category</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>17-20 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>21-30 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>31-40 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>41-50 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>51 years and above</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
</tbody>
</table>

1.2 Were you born in Australia?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

If No, write your country of birth. .................................

1.3 If your country of birth is not Australia, how many years have you been living in Australia?

<table>
<thead>
<tr>
<th>Years</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 years</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
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<td></td>
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</tr>
<tr>
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<td></td>
<td>4</td>
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</tbody>
</table>

1.4 Are you of Aboriginal or Torres Strait Islander descent?

<table>
<thead>
<tr>
<th></th>
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<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>2</td>
</tr>
</tbody>
</table>

1.5 If you are of Aboriginal or Torres Strait Islander descent, do you identify?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
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<tr>
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<td>2</td>
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</tbody>
</table>
### 1.6 If you were born in Australia, where did you spend the majority of your childhood and teenage years?

<table>
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<tr>
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<td>☐ 3</td>
</tr>
<tr>
<td>Small, remote community</td>
<td>☐ 4</td>
</tr>
</tbody>
</table>

### 1.7 Do you already have a tertiary qualification?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 1</td>
<td>☐ 2</td>
</tr>
</tbody>
</table>

If Yes, please name the qualification and where it was obtained.

### 1.8 Where are you planning to practise midwifery in the first five years following graduation? (You may choose more than one response.)

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<tr>
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<td>☐ 5</td>
</tr>
<tr>
<td>Teaching and/or research</td>
<td>☐ 6</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>☐ 7</td>
</tr>
<tr>
<td>No preference at present</td>
<td>☐ 8</td>
</tr>
</tbody>
</table>
SECTION TWO

This section seeks information on your current knowledge about Aboriginal issues.

Please fill in the circle that corresponds to your response.

### 2.1 How do you rate your knowledge of issues facing contemporary Aboriginal Australia?

<table>
<thead>
<tr>
<th>Poor</th>
<th>2</th>
<th>Adequate</th>
<th>3</th>
<th>4</th>
<th>Comprehensive</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>○</td>
</tr>
</tbody>
</table>

### 2.2 How do you rate your knowledge of Aboriginal history and culture?

<table>
<thead>
<tr>
<th>Poor</th>
<th>2</th>
<th>Adequate</th>
<th>3</th>
<th>4</th>
<th>Comprehensive</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>○</td>
</tr>
</tbody>
</table>

### 2.3 How do you rate your knowledge of Aboriginal health specifically?

<table>
<thead>
<tr>
<th>Poor</th>
<th>2</th>
<th>Adequate</th>
<th>3</th>
<th>4</th>
<th>Comprehensive</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>○</td>
</tr>
</tbody>
</table>

### 2.4 The health status of Aboriginal people is significantly lower than that of non-Aboriginal people. Why do you think this is so?

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

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……………………………………………………………………………………………………………
2.5 What do you consider to be the key priorities in Aboriginal health today?

…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………

2.6 Please identify factors that may influence the ability of Aboriginal people to adhere to health treatment or advice.

…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………

2.7 Do you expect to have much involvement with Aboriginal patients once you have graduated?

<table>
<thead>
<tr>
<th>No involvement</th>
<th>1</th>
<th>2</th>
<th>Periodic involvement</th>
<th>3</th>
<th>4</th>
<th>Frequent involvement</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

Please expand on why you think this.

…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
2.8 Below you will see something that looks like a thermometer. We would like you to mark this thermometer to indicate your attitude towards Aboriginal people in Australia. Here is how it works. If you have a favourable attitude towards Aboriginal people, you would write a score somewhere between 50° and 100°, depending on how favourable you are towards them. On the other hand, if you have an unfavourable attitude towards Aboriginal people, you would write a score somewhere between 0° and 50°, depending on how unfavourable you are towards them.

The degree labels will help you to locate the group on the thermometer. However, you are not restricted to the numbers indicated - feel free to use any number between 0° and 100°.

Please write a number between 0° and 100°, to indicate your attitude towards Aboriginal people.

…………………………………….
2.9 Consider the following influences that may have shaped your attitudes towards Aboriginal people and understanding of Aboriginal issues. Please rank the four most notable influences from (1) to (4) by placing a number in the related box.

<table>
<thead>
<tr>
<th>Influence</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lived experience</td>
<td>1</td>
</tr>
<tr>
<td>Family</td>
<td>2</td>
</tr>
<tr>
<td>Friends</td>
<td>3</td>
</tr>
<tr>
<td>Primary and secondary school education</td>
<td>4</td>
</tr>
<tr>
<td>General media reporting (e.g. TV, newspaper, film, radio, electronic media, Aboriginal people in the media)</td>
<td>5</td>
</tr>
<tr>
<td>Aboriginal people whom you have known personally</td>
<td>6</td>
</tr>
<tr>
<td>Teaching in your midwifery course</td>
<td>7</td>
</tr>
<tr>
<td>Significant events (e.g. National Apology, NAIDOC week, Northern Territory Intervention)</td>
<td>8</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>9</td>
</tr>
</tbody>
</table>

2.10 Have you read any books, poetry or seen any plays by Aboriginal authors/playwrights?

<table>
<thead>
<tr>
<th>Response</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No (might in the future)</td>
<td>2</td>
</tr>
<tr>
<td>No (not interested)</td>
<td>3</td>
</tr>
</tbody>
</table>

If yes, please make a note of authors and/or titles and any impact (if any) these had on your understanding of Aboriginal issues.

……………………………………………………………………………………………………………
……………………………………………………………………………………………………………
……………………………………………………………………………………………………………
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……………………………………………………………………………………………………………
……………………………………………………………………………………………………………
……………………………………………………………………………………………………………
……………………………………………………………………………………………………………
2.11 In June, 2012 the twentieth anniversary was celebrated to commemorate a landmark judgement in the High Court of Australia affecting Aboriginal people. Do you know what the judgement was called?  

If Yes, please write the name here. ........................................  

Yes 1 No 2  

If you answered yes, please make a note of the significance of this judgement (if you know) and links (if any) you see between this judgement and the health of Aboriginal people.

..................................................................................................................  
..................................................................................................................  
..................................................................................................................  
..................................................................................................................
SECTION THREE requires you to indicate your level of agreement with the following statements. Please fill in the circle that corresponds to your response.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree 1</th>
<th>Agree 2</th>
<th>Neither Agree or Disagree 3</th>
<th>Disagree 4</th>
<th>Strongly Disagree 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>The state of Aboriginal health is a social priority.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3.2</td>
<td>The Western medical model suits the health needs of Aboriginal peoples.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3.3</td>
<td>The state of Aboriginal health depends on the availability of appropriate health services.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3.4</td>
<td>The state of Aboriginal health is mainly due to a lack of funding for health services.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3.5</td>
<td>Aboriginal people have the same level of access to health services as all other Australians.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3.6</td>
<td>Community control in Aboriginal health care services is fundamental to the improvement of health for Aboriginal people.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3.7</td>
<td>Aboriginal people should take more individual responsibility for improving their own health.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3.8</td>
<td>Trust is a key for culturally secure health care.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3.9</td>
<td>Feeling intimidated is a barrier to culturally secure health care.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3.10</td>
<td>I think it will be difficult to get Aboriginal women to adhere to advice from health professionals.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3.11</td>
<td>I think I have the ability to communicate with Aboriginal women by myself.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3.12</td>
<td>I need to think beyond the individual when considering Aboriginal health issues.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3.13</td>
<td>I expect the information I learn in this unit will change my views on Aboriginal issues.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3.14</td>
<td>It is important that a unit on Indigenous Cultures and Health is compulsory in all health science courses.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3.15</td>
<td>I will work for improvements in Aboriginal health as a personal priority in my health practice.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3.16</td>
<td>I have a social responsibility to work for changes in Aboriginal health.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Thank you for taking the time to complete this questionnaire. Your assistance is greatly appreciated.
CURTIN UNIVERSITY UNDERGRADUATE MIDWIFERY STUDENT SURVEY

Students enrolled in Indigenous Cultures and Health 130

(Post-Unit Survey)

Research project: ‘Cultural security in midwifery education and service provision for Aboriginal women’.

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</tr>
</tbody>
</table>

1.2 Were you born in Australia?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

If No, write your country of birth. ..............................................

1.3 If your country of birth is not Australia, how many years have you been living in Australia?

<table>
<thead>
<tr>
<th>Years</th>
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1.4 Are you of Aboriginal or Torres Strait Islander descent?

<table>
<thead>
<tr>
<th>Yes</th>
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</tr>
</thead>
<tbody>
<tr>
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1.5 If you are of Aboriginal or Torres Strait Islander descent, do you identify?

<table>
<thead>
<tr>
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<tbody>
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<table>
<thead>
<tr>
<th>Area</th>
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<tbody>
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</tbody>
</table>

1.7 Do you already have a tertiary qualification?  

<table>
<thead>
<tr>
<th>Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes 1</td>
</tr>
<tr>
<td>No 2</td>
</tr>
<tr>
<td>If Yes, please name the qualification and where it was obtained.</td>
</tr>
<tr>
<td>..................................................................................</td>
</tr>
</tbody>
</table>

1.8 Where are you planning to practise midwifery in the first five years following graduation? (You may choose more than one response.)

<table>
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<tr>
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</tr>
<tr>
<td>Teaching and or/research</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>No preference at present</td>
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Please fill in the circle that corresponds to your response.

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<td></td>
<td></td>
</tr>
</tbody>
</table>

2.2 How do you rate your knowledge of Aboriginal history and culture?

<table>
<thead>
<tr>
<th>Poor</th>
<th>1</th>
<th>2</th>
<th>Adequate</th>
<th>3</th>
<th>4</th>
<th>Comprehensive</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.3 How do you rate your knowledge of Aboriginal health specifically?

<table>
<thead>
<tr>
<th>Poor</th>
<th>1</th>
<th>2</th>
<th>Adequate</th>
<th>3</th>
<th>4</th>
<th>Comprehensive</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.4 The health status of Aboriginal people is significantly lower than that of non-Aboriginal people. Why do you think this is so?

…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
2.5 What do you consider to be the key priorities in Aboriginal health today?

.................................
.................................
.................................
.................................
.................................

2.6 Please identify factors that may influence the ability of Aboriginal people to adhere to health treatment or advice.

.................................
.................................
.................................
.................................
.................................

2.7 Do you expect to have much involvement with Aboriginal patients once you have graduated?

<table>
<thead>
<tr>
<th>No involvement</th>
<th>1</th>
<th>2</th>
<th>Periodic involvement</th>
<th>3</th>
<th>4</th>
<th>Frequent involvement</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>O</td>
<td>O</td>
<td></td>
<td>O</td>
<td>O</td>
<td></td>
<td>O</td>
</tr>
</tbody>
</table>

Please expand on why you think this.

.................................
.................................
.................................
.................................
.................................
2.8 Below you will see something that looks like a thermometer. We would like you to mark this thermometer to indicate your attitude towards Aboriginal people in Australia. Here is how it works. If you have a favourable attitude towards Aboriginal people, you would write a score somewhere between 50° and 100°, depending on how favourable you are towards them. On the other hand, if you have an unfavourable attitude towards Aboriginal people, you would write a score somewhere between 0° and 50°, depending on how unfavourable you are towards them.

The degree labels will help you to locate the group on the thermometer. However, you are not restricted to the numbers indicated - feel free to use any number between 0° and 100°.

Please write a number between 0° and 100°, to indicate your attitude towards Aboriginal people.

……………………………………

100° Extremely favourable
90° Very favourable
80° Quite favourable
70° Fairly favourable
60° Slightly favourable
50° Neither favourable nor unfavourable
40° Slightly unfavourable
30° Fairly unfavourable
20° Quite Unfavourable
10° Very Unfavourable
0° Extremely Unfavourable
2.9 Consider the following influences that may have shaped your attitudes towards Aboriginal people and understanding of Aboriginal issues. Please rank the four most notable influences from (1) to (4) by placing a number in the related box.

<table>
<thead>
<tr>
<th>Influence</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lived experience</td>
<td>1</td>
</tr>
<tr>
<td>Family</td>
<td>2</td>
</tr>
<tr>
<td>Friends</td>
<td>3</td>
</tr>
<tr>
<td>Primary and secondary school education</td>
<td>4</td>
</tr>
<tr>
<td>General media reporting (e.g. TV, newspaper, film, radio, electronic media, Aboriginal people in the media)</td>
<td>5</td>
</tr>
<tr>
<td>Aboriginal people whom you have known personally</td>
<td>6</td>
</tr>
<tr>
<td>Teaching in your midwifery course</td>
<td>7</td>
</tr>
<tr>
<td>Significant events (e.g. National Apology, NAIDOC week, Northern Territory Intervention)</td>
<td>8</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>9</td>
</tr>
</tbody>
</table>

2.10 Have you read any books, poetry or seen any plays by Aboriginal authors/playwrights?

<table>
<thead>
<tr>
<th>Response</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>○ 1</td>
</tr>
<tr>
<td>No (might in the future)</td>
<td>○ 2</td>
</tr>
<tr>
<td>No (not interested)</td>
<td>○ 3</td>
</tr>
</tbody>
</table>

If yes, please make a note of authors and/or titles and any impact (if any) these had on your understanding of Aboriginal issues.

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2.11 In June, 2012 the twentieth anniversary was celebrated to commemorate a landmark judgement in the High Court of Australia affecting Aboriginal people. Do you know what the judgement was called?

If Yes, please write the name here.  .........................

If you answered yes, please make a note of the significance of this judgement (if you know) and links (if any) you see between this judgement and the health of Aboriginal people.

…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
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…………………………………………………………………………………………………………
SECTION THREE requires you to indicate your level of agreement with the following statements. Please fill in the circle that corresponds to your response.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 The state of Aboriginal health is a social priority.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.2 The Western medical model suits the health needs of Aboriginal peoples.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.3 The state of Aboriginal health depends on the availability of appropriate health services.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.4 The state of Aboriginal health is mainly due to a lack of funding for health services.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.5 Aboriginal people have the same level of access to health services as all other Australians.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.6 Community control in Aboriginal health care services is fundamental to the improvement of health for Aboriginal people.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.7 Aboriginal people should take more individual responsibility for improving their own health.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.8 Trust is a key for culturally secure health care.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.9 Feeling intimidated is a barrier to culturally secure health care.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.10 I think it will be difficult to get Aboriginal women to adhere to advice from health professionals.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.11 I think I have the ability to communicate with Aboriginal women by myself.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.12 I need to think beyond the individual when considering Aboriginal health issues.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.13 The information I learned in this unit has changed my views on Aboriginal issues.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.14 It is important that a unit on Indigenous Cultures and Health is compulsory in all health science courses.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.15 I will work for improvements in Aboriginal health as a personal priority in my health practice.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.16 I have a social responsibility to work for changes in Aboriginal health.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
SECTION FOUR

This section seeks your opinions on the teaching of Aboriginal health in the midwifery program. Please fill in the circle that corresponds to your response and/or write on the dotted line.

4.1 List possible benefits of learning about Aboriginal health and related issues as part of the midwifery curriculum.

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4.2 List possible disadvantages of learning about Aboriginal health and related issues as part of the midwifery curriculum.

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................................................................................................................................................
................................................................................................................................................

4.3 Which of the following statements best describes your emotional response to content delivered in Indigenous Cultures and Health this semester?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Circle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resistant for most of the semester, couldn't see the point</td>
<td>1</td>
</tr>
<tr>
<td>Resistant at first, but this changed over the semester</td>
<td>2</td>
</tr>
<tr>
<td>Generally receptive, open to new information</td>
<td>3</td>
</tr>
<tr>
<td>Very receptive, would like more content in our program</td>
<td>4</td>
</tr>
</tbody>
</table>
4.4 Could you describe in more detail your emotional response to the content that you have learned this semester (for example, did issues arise that upset you, made you angry, resentful, hopeful, optimistic).

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4.5 With respect to your teaching in Indigenous Cultures and Health this semester, what did you find most useful and why?

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4.6 With respect to your teaching in Indigenous Cultures and Health this semester, what did you find the least useful and why?

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........................................................................................................................................................................
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4.7 To what extent has the teaching this semester influenced your perceptions about Aboriginal communities and their health?

<table>
<thead>
<tr>
<th>No influence</th>
<th>1</th>
<th>2</th>
<th>Some influence</th>
<th>3</th>
<th>4</th>
<th>Considerable influence</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>○</td>
<td>○</td>
<td></td>
<td>○</td>
<td>○</td>
<td></td>
<td>○</td>
</tr>
</tbody>
</table>
4.8 If there has been any change in your perceptions as a result of this teaching, can you outline this in more detail?

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4.9 For your level of midwifery training, how adequate would you describe the amount of teaching you have had up to now in Aboriginal health?

<table>
<thead>
<tr>
<th>Very inadequate</th>
<th>1</th>
<th>2</th>
<th>Adequate</th>
<th>3</th>
<th>4</th>
<th>Very adequate</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

Please expand on why you think this.

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………………………………………………………………………………………………………………
………………………………………………………………………………………………………………

4.10 What sorts of issues or topics would you like to see covered in any additional teaching on Aboriginal health and related issues?

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………………………………………………………………………………………………………………
………………………………………………………………………………………………………………
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………………………………………………………………………………………………………………
4.11 Would you be interested in more clinical exposure to Aboriginal settings in your training (for example, clinical practice in a rural or remote setting)?

<table>
<thead>
<tr>
<th>Yes 1</th>
<th>No 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

4.12 Please comment on any others issues related to teaching and learning in Indigenous Cultures and Health this semester.

………………………………………………………………………………………………………………
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Thank you for taking the time to complete this questionnaire. Your assistance is greatly appreciated. When the findings have been collated and analysed, a summary will be made available for all participants.
CURTIN UNIVERSITY UNDERGRADUATE MIDWIFERY STUDENT SURVEY

(S4): Second year midwifery students

Research project: ‘Cultural security in midwifery education and service provision for Aboriginal women’.

October 2012

Approval has been granted by staff at the University of Western Australia, University of Melbourne and Murdoch University to include some questions used in earlier studies. Permission is acknowledged and appreciated.
SECTION ONE

This section seeks demographic information to help establish a profile of midwifery students at Curtin University who complete this questionnaire. Please fill in the circle that corresponds to your response. Please use a blue or black pen.

The numbers on the far right are for coding purposes only.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 What age category do you belong to?</td>
<td>17-20 years: 1</td>
</tr>
<tr>
<td></td>
<td>21-30 years: 2</td>
</tr>
<tr>
<td></td>
<td>31-40 years: 3</td>
</tr>
<tr>
<td></td>
<td>41-50 years: 4</td>
</tr>
<tr>
<td></td>
<td>51 years and above: 5</td>
</tr>
<tr>
<td>1.2 Were you born in Australia?</td>
<td>Yes: 1</td>
</tr>
<tr>
<td></td>
<td>No: 2</td>
</tr>
<tr>
<td>If No, write your country of birth.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 If your country of birth is not Australia, how many years have you</td>
<td>0-4 years: 1</td>
</tr>
<tr>
<td>been living in Australia?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5-15 years: 2</td>
</tr>
<tr>
<td></td>
<td>16-25 years: 3</td>
</tr>
<tr>
<td></td>
<td>&gt;25 years: 4</td>
</tr>
<tr>
<td>1.4 Are you of Aboriginal or Torres Strait Islander descent?</td>
<td>Yes: 1</td>
</tr>
<tr>
<td></td>
<td>No: 2</td>
</tr>
<tr>
<td>1.5 If you are of Aboriginal or Torres Strait Islander descent, do you</td>
<td>Yes: 1</td>
</tr>
<tr>
<td>identify?</td>
<td>No: 2</td>
</tr>
</tbody>
</table>

……………………………

……
1.6 If you were born in Australia, where did you spend the majority of your childhood and teenage years?

<table>
<thead>
<tr>
<th>Metropolitan area (e.g. Perth)</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large regional centre (e.g. Bunbury, Albany)</td>
<td>2</td>
</tr>
<tr>
<td>Small to medium country town</td>
<td>3</td>
</tr>
<tr>
<td>Small, remote community</td>
<td>4</td>
</tr>
</tbody>
</table>

1.7 Do you already have a tertiary qualification? Yes 1 No 2

If Yes, please name the qualification and where it was obtained.

1.8 Where are you planning to practise midwifery in the first five years following graduation? (You may choose more than one response.)

<table>
<thead>
<tr>
<th>Metropolitan area (e.g. Perth)</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large regional centre (e.g. Bunbury, Albany)</td>
<td>2</td>
</tr>
<tr>
<td>Small to medium country town</td>
<td>3</td>
</tr>
<tr>
<td>Small, remote community</td>
<td>4</td>
</tr>
</tbody>
</table>

1.9 Please indicate, in order of preference (by placing a number in the related box) up to 3 areas of midwifery in which you would like to work when you graduate.

<table>
<thead>
<tr>
<th>Hospital based (government)</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital based (private)</td>
<td>2</td>
</tr>
<tr>
<td>Other private</td>
<td>3</td>
</tr>
<tr>
<td>Aboriginal focus</td>
<td>4</td>
</tr>
<tr>
<td>Community focus</td>
<td>5</td>
</tr>
<tr>
<td>Teaching and or/research</td>
<td>6</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>7</td>
</tr>
<tr>
<td>No preference at present</td>
<td>8</td>
</tr>
</tbody>
</table>
SECTION TWO

This section seeks information on your current knowledge about Aboriginal issues.

Please fill in the circle that corresponds to your response.

2.1 How do you rate your knowledge of issues facing contemporary Aboriginal Australia?

<table>
<thead>
<tr>
<th>Poor 1</th>
<th>2</th>
<th>Adequate 3</th>
<th>4</th>
<th>Comprehensive 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.2 How do you rate your knowledge of Aboriginal history and culture?

<table>
<thead>
<tr>
<th>Poor 1</th>
<th>2</th>
<th>Adequate 3</th>
<th>4</th>
<th>Comprehensive 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.3 How do you rate your knowledge of Aboriginal health specifically?

<table>
<thead>
<tr>
<th>Poor 1</th>
<th>2</th>
<th>Adequate 3</th>
<th>4</th>
<th>Comprehensive 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.4 Are you familiar with the Aboriginal concept of ‘shame’?

Yes 1

No 2

If Yes, explain what this might mean in the context of pregnancy and childbirth. .................................................................
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<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5 Are you familiar with the Aboriginal concept of ‘grandmothers’</td>
<td></td>
<td></td>
</tr>
<tr>
<td>law?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, explain what this might mean in the context of pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and childbirth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>...........................................................................................................</td>
<td></td>
<td></td>
</tr>
<tr>
<td>...........................................................................................................</td>
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<td>...........................................................................................................</td>
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<td></td>
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<tr>
<td>...........................................................................................................</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.6 The health status of Aboriginal people is significantly lower than</td>
<td></td>
<td></td>
</tr>
<tr>
<td>that of non-Aboriginal people. Why do you think this is so?</td>
<td></td>
<td></td>
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<tr>
<td>...........................................................................................................</td>
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<td>...........................................................................................................</td>
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<tr>
<td>...........................................................................................................</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.7 What do you consider to be the key priorities in Aboriginal health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>today?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>...........................................................................................................</td>
<td></td>
<td></td>
</tr>
<tr>
<td>...........................................................................................................</td>
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<td>...........................................................................................................</td>
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<tr>
<td>...........................................................................................................</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.8 Please identify factors that may influence the ability of Aboriginal people to adhere to health treatment or advice.

…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………

2.9 Do you expect to have much involvement with Aboriginal patients once you have graduated?

<table>
<thead>
<tr>
<th>No involvement 1</th>
<th>2</th>
<th>Periodic involvement 3</th>
<th>4</th>
<th>Frequent involvement 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

Please expand on why you think this.

…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
2.10 Below you will see something that looks like a thermometer. We would like you to mark this thermometer to indicate your attitude towards Aboriginal people in Australia. Here is how it works. If you have a favourable attitude towards Aboriginal people, you would write a score somewhere between 50° and 100°, depending on how favourable you are towards them. On the other hand, if you have an unfavourable attitude towards Aboriginal people, you would write a score somewhere between 0° and 50°, depending on how unfavourable you are towards them.

The degree labels will help you to locate the group on the thermometer. However, you are not restricted to the numbers indicated - feel free to use any number between 0° and 100°.

Please write a number between 0° and 100°, to indicate your attitude towards Aboriginal people.

……………………………………..
2.11 Consider the following influences that may have shaped your attitudes towards Aboriginal people and understanding of Aboriginal issues. Please rank the four most notable influences from (1) to (4) by placing a number in the related box.

<table>
<thead>
<tr>
<th>Influence</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lived experience</td>
<td>1</td>
</tr>
<tr>
<td>Family</td>
<td>2</td>
</tr>
<tr>
<td>Friends</td>
<td>3</td>
</tr>
<tr>
<td>Primary and secondary school education</td>
<td>4</td>
</tr>
<tr>
<td>General media reporting (e.g. TV, newspaper, film, radio, electronic media, Aboriginal people in the media)</td>
<td>5</td>
</tr>
<tr>
<td>Aboriginal people whom you have known personally</td>
<td>6</td>
</tr>
<tr>
<td>Teaching in your midwifery course</td>
<td>7</td>
</tr>
<tr>
<td>Significant events (e.g. National Apology, NAIDOC week, Northern Territory Intervention)</td>
<td>8</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>9</td>
</tr>
</tbody>
</table>

2.12 Have you read any books, poetry or seen any plays by Aboriginal authors/playwrights?

<table>
<thead>
<tr>
<th>Response</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No (might in the future)</td>
<td>2</td>
</tr>
<tr>
<td>No (not interested)</td>
<td>3</td>
</tr>
</tbody>
</table>

If yes, please make a note of authors and/or titles and any impact (if any) these had on your understanding of Aboriginal issues.

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2.13 In June, 2012 the twentieth anniversary was celebrated to commemorate a landmark judgement in the High Court of Australia affecting Aboriginal people. Do you know what the judgement was called?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

If Yes, please write the name here.  

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If you answered yes, please make a note of the significance of this judgement (if you know) and links (if any) you see between this judgement and the health of Aboriginal people.

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SECTION THREE requires you to indicate your level of agreement with the following statements. Please fill in the circle that corresponds to your response.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 The state of Aboriginal health is a social priority.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3.2 The Western medical model suits the health needs of Aboriginal peoples.</td>
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<tr>
<td>3.3 The state of Aboriginal health depends on the availability of appropriate health services.</td>
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<tr>
<td>3.4 The state of Aboriginal health is mainly due to a lack of funding for health services.</td>
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<tr>
<td>3.5 Aboriginal people have the same level of access to health services as all other Australians.</td>
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<td></td>
<td></td>
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<tr>
<td>3.6 Community control in Aboriginal health care services is fundamental to the improvement of health for Aboriginal people.</td>
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<tr>
<td>3.7 Aboriginal people should take more individual responsibility for improving their own health.</td>
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<tr>
<td>3.8 Trust is a key for culturally secure health care.</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>3.9 Feeling intimidated is a barrier to culturally secure health care.</td>
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<td></td>
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<tr>
<td>3.10 I think it will be difficult to get Aboriginal women to adhere to advice from health professionals.</td>
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<tr>
<td>3.11 I think I have the ability to communicate with Aboriginal women by myself.</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>3.12 I need to think beyond the individual when considering Aboriginal health issues.</td>
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<tr>
<td>3.13 The information I learned in the Indigenous Cultures and Health unit changed my views on Aboriginal issues.</td>
<td></td>
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<tr>
<td>3.14 It is important that a unit on Indigenous Cultures and Health is compulsory in all health science courses.</td>
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<tr>
<td>3.15 I will work for improvements in Aboriginal health as a personal priority in my health practice.</td>
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<tr>
<td>3.16 I have a social responsibility to work for changes in Aboriginal health.</td>
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</table>
SECTION FOUR

The final section seeks your opinions on the teaching of Aboriginal health in the midwifery program. Please fill in the circle that corresponds to your response and/or write on the dotted line.

4.1 List possible benefits of learning about Aboriginal health and related issues as part of the midwifery curriculum.

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4.2 List possible disadvantages of learning about Aboriginal health and related issues as part of the midwifery curriculum.

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4.3 Which of the following statements best describes your emotional response to content delivered in the Indigenous Cultures and Health unit you completed last year?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Circle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resistant for most of the semester, couldn’t see the point</td>
<td></td>
</tr>
<tr>
<td>Resistant at first, but this changed over the semester</td>
<td></td>
</tr>
<tr>
<td>Generally receptive, open to new information</td>
<td></td>
</tr>
<tr>
<td>Very receptive, would like more content in our program</td>
<td></td>
</tr>
</tbody>
</table>
4.4 Could you describe in more detail your emotional response to the content that you learned in the Indigenous Cultures and Health unit (for example, did issues arise that upset you, made you angry, resentful, hopeful, optimistic).

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4.5 With respect to your teaching in Indigenous Cultures and Health, what did you find most useful and why?

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4.6 With respect to your teaching in the Indigenous Cultures and Health what did you find the least useful and why?

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4.7 To what extent did Indigenous Cultures and Health change your perceptions about Aboriginal communities and Aboriginal health?

<table>
<thead>
<tr>
<th>No change</th>
<th>1</th>
<th>2</th>
<th>Some change</th>
<th>3</th>
<th>4</th>
<th>Significant change</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>O</td>
<td>O</td>
<td></td>
<td>O</td>
<td>O</td>
<td></td>
<td>O</td>
</tr>
</tbody>
</table>

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### 4.8 If there was any change in your perceptions as a result of this teaching, can you outline this in more detail?

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### 4.9 For your level of midwifery training, how adequate would you describe the amount of teaching you have had up to now in Aboriginal health?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very inadequate</td>
<td>O</td>
<td>O</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate</td>
<td>O</td>
<td>O</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very adequate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>O</td>
</tr>
</tbody>
</table>

Please expand on why you think this.

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### 4.10 What sorts of issues or topics would you like to see covered in any additional teaching on Aboriginal health and related issues?

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225
4.11 Would you be interested in more clinical exposure to Aboriginal settings in your training (for example, clinical practice in a rural or remote setting)?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

4.12 Please comment on any others issues related to the teaching of Aboriginal health and related issues.

………………………………………………………………………………………………………………
………………………………………………………………………………………………………………
………………………………………………………………………………………………………………
………………………………………………………………………………………………………………

Thank you for taking the time to complete this questionnaire. Your assistance is greatly appreciated. When the findings have been collated and analysed, a summary will be made available for all participants.
CURTIN UNIVERSITY UNDERGRADUATE MIDWIFERY STUDENT SURVEY

(S6): Third year midwifery students

Research project: ‘Cultural security in midwifery education and service provision for Aboriginal women’.

September 2012

Approval has been granted by staff at the University of Western Australia, University of Melbourne and Murdoch University to include some questions used in earlier studies. Permission is acknowledged and appreciated.
SECTION ONE

This section seeks demographic information to help establish a profile of midwifery students at Curtin University who complete this questionnaire. Please fill in the circle that corresponds to your response. Please use a blue or black pen.

The numbers on the far right are for coding purposes only.

1.1 What age category do you belong to?

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Circle</th>
</tr>
</thead>
<tbody>
<tr>
<td>17-20 years</td>
<td>1</td>
</tr>
<tr>
<td>21-30 years</td>
<td>2</td>
</tr>
<tr>
<td>31-40 years</td>
<td>3</td>
</tr>
<tr>
<td>41-50 years</td>
<td>4</td>
</tr>
<tr>
<td>51 years and above</td>
<td>5</td>
</tr>
</tbody>
</table>

1.2 Were you born in Australia?

<table>
<thead>
<tr>
<th>Response</th>
<th>Circle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>

If No, write your country of birth.  

1.3 If your country of birth is not Australia, how many years have you been living in Australia?

<table>
<thead>
<tr>
<th>Years</th>
<th>Circle</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 years</td>
<td>1</td>
</tr>
<tr>
<td>5-15 years</td>
<td>2</td>
</tr>
<tr>
<td>16-25 years</td>
<td>3</td>
</tr>
<tr>
<td>&gt;25 years</td>
<td>4</td>
</tr>
</tbody>
</table>

1.4 Are you of Aboriginal or Torres Strait Islander descent?

<table>
<thead>
<tr>
<th>Response</th>
<th>Circle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>

1.5 If you are of Aboriginal or Torres Strait Islander descent, do you identify?

<table>
<thead>
<tr>
<th>Response</th>
<th>Circle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>
1.6 If you were born in Australia, where did you spend the majority of your childhood and teenage years?

<table>
<thead>
<tr>
<th>Metropolitan area (e.g. Perth)</th>
<th>○</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large regional centre (e.g. Bunbury, Albany)</td>
<td>○</td>
<td>2</td>
</tr>
<tr>
<td>Small to medium country town</td>
<td>○</td>
<td>3</td>
</tr>
<tr>
<td>Small, remote community</td>
<td>○</td>
<td>4</td>
</tr>
</tbody>
</table>

1.7 Do you already have a tertiary qualification?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

If Yes, please name the qualification and where it was obtained. ...........................................................

1.8 Where are you planning to practise midwifery in the first five years following graduation? (You may choose more than one response.)

<table>
<thead>
<tr>
<th>Metropolitan area (e.g. Perth)</th>
<th>○</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large regional centre (e.g. Bunbury, Albany)</td>
<td>○</td>
<td>2</td>
</tr>
<tr>
<td>Small to medium country town</td>
<td>○</td>
<td>3</td>
</tr>
<tr>
<td>Small, remote community</td>
<td>○</td>
<td>4</td>
</tr>
</tbody>
</table>

1.9 Please indicate, in order of preference (by placing a number in the related box) up to 3 areas of midwifery in which you would like to work when you graduate.

<table>
<thead>
<tr>
<th>Hospital based (government)</th>
<th>☐</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital based (private)</td>
<td>☐</td>
<td>2</td>
</tr>
<tr>
<td>Other private</td>
<td>☐</td>
<td>3</td>
</tr>
<tr>
<td>Aboriginal focus</td>
<td>☐</td>
<td>4</td>
</tr>
<tr>
<td>Community focus</td>
<td>☐</td>
<td>5</td>
</tr>
<tr>
<td>Teaching and/or research</td>
<td>☐</td>
<td>6</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>☐</td>
<td>7</td>
</tr>
<tr>
<td>No preference at present</td>
<td>☐</td>
<td>8</td>
</tr>
</tbody>
</table>
SECTION TWO

This section seeks information on your current knowledge about Aboriginal issues.
Please fill in the circle that corresponds to your response.

2.1 How do you rate your knowledge of issues facing contemporary Aboriginal Australia?

<table>
<thead>
<tr>
<th>Poor</th>
<th>2</th>
<th>Adequate</th>
<th>4</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

2.2 How do you rate your knowledge of Aboriginal history and culture?

<table>
<thead>
<tr>
<th>Poor</th>
<th>2</th>
<th>Adequate</th>
<th>4</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

2.3 How do you rate your knowledge of Aboriginal health specifically?

<table>
<thead>
<tr>
<th>Poor</th>
<th>2</th>
<th>Adequate</th>
<th>4</th>
<th>Comprehensive</th>
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</thead>
<tbody>
<tr>
<td></td>
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</table>

2.4 Are you familiar with the Aboriginal concept of ‘shame’?

Yes 1  No 2

If Yes, explain what this might mean in the context of pregnancy and childbirth.  …………………………………………………………………………………
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……………………………………...
2.5 Are you familiar with the Aboriginal concept of ‘grandmothers’ law’?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

If Yes, explain what this might mean in the context of pregnancy and childbirth.

2.6 The health status of Aboriginal people is significantly lower than that of non-Aboriginal people. Why do you think this is so?

2.7 What do you consider to be the key priorities in Aboriginal health today?
2.8 Please identify factors that may influence the ability of Aboriginal people to adhere to health treatment or advice.

………………………………………………………………………………………………………………
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2.9 Do you expect to have much involvement with Aboriginal patients once you have graduated?

<table>
<thead>
<tr>
<th>No involvement</th>
<th>1</th>
<th>2</th>
<th>Periodic involvement</th>
<th>3</th>
<th>4</th>
<th>Frequent involvement</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o</td>
<td>o</td>
<td></td>
<td>o</td>
<td>o</td>
<td></td>
<td>o</td>
</tr>
</tbody>
</table>

Please expand on why you think this.

………………………………………………………………………………………………………………
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………………………………………………………………………………………………………………
Below you will see something that looks like a thermometer. We would like you to mark this thermometer to indicate your attitude towards Aboriginal people in Australia. Here is how it works. If you have a favourable attitude towards Aboriginal people, you would write a score somewhere between 50° and 100°, depending on how favourable you are towards them. On the other hand, if you have an unfavourable attitude towards Aboriginal people, you would write a score somewhere between 0° and 50°, depending on how unfavourable you are towards them.

The degree labels will help you to locate the group on the thermometer. However, you are not restricted to the numbers indicated - feel free to use any number between 0° and 100°.

Please write a number between 0° and 100°, to indicate your attitude towards Aboriginal people.

100° Extremely favourable
90° Very favourable
80° Quite favourable
70° Fairly favourable
60° Slightly favourable
50° Neither favourable nor unfavourable
40° Slightly unfavourable
30° Fairly unfavourable
20° Quite Unfavourable
10° Very Unfavourable
0° Extremely Unfavourable
2.11 Consider the following influences that may have shaped your attitudes towards Aboriginal people and understanding of Aboriginal issues. Please rank the four most notable influences from (1) to (4) by placing a number in the related box.

<table>
<thead>
<tr>
<th>Influence</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lived experience</td>
<td>1</td>
</tr>
<tr>
<td>Family</td>
<td>2</td>
</tr>
<tr>
<td>Friends</td>
<td>3</td>
</tr>
<tr>
<td>Primary and secondary school education</td>
<td>4</td>
</tr>
<tr>
<td>General media reporting (e.g. TV, newspaper, film, radio, electronic media, Aboriginal people in the media)</td>
<td>5</td>
</tr>
<tr>
<td>Aboriginal people whom you have known personally</td>
<td>6</td>
</tr>
<tr>
<td>Teaching in your midwifery course (e.g. Aboriginal health unit)</td>
<td>7</td>
</tr>
<tr>
<td>Significant events (e.g. National Apology, NAIDOC week, Northern Territory Intervention)</td>
<td>8</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>9</td>
</tr>
</tbody>
</table>

2.12 Have you read any books, poetry or seen any plays by Aboriginal authors/playwrights?

<table>
<thead>
<tr>
<th>Response</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No (might in the future)</td>
<td>2</td>
</tr>
<tr>
<td>No (not interested)</td>
<td>3</td>
</tr>
</tbody>
</table>

If yes, please make a note of authors and/or titles and any impact (if any) these had on your understanding of Aboriginal issues.

……………………………………………………………………………………………………………
……………………………………………………………………………………………………………
……………………………………………………………………………………………………………
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……………………………………………………………………………………………………………
2.13 In June, 2012 the twentieth anniversary was celebrated to commemorate a landmark judgement in the High Court of Australia affecting Aboriginal people. Do you know what the judgement was called?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

If Yes, please write the name here.  ……………………………….  

If you answered yes, please make a note of the significance of this judgement (if you know) and links (if any) you see between this judgement and the health of Aboriginal people.  

……………………………………………………………………………………………………………
……………………………………………………………………………………………………………
……………………………………………………………………………………………………………
……………………………………………………………………………………………………………
SECTION THREE requires you to indicate your level of agreement with the following statements. Please fill in the circle that corresponds to your response.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>The state of Aboriginal health is a social priority.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.2</td>
<td>The Western medical model suits the health needs of Aboriginal peoples.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.3</td>
<td>The state of Aboriginal health depends on the availability of appropriate health services.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.4</td>
<td>The state of Aboriginal health is mainly due to a lack of funding for health services.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.5</td>
<td>Aboriginal people have the same level of access to health services as all other Australians.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.6</td>
<td>Community control in Aboriginal health care services is fundamental to the improvement of health for Aboriginal people.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.7</td>
<td>Aboriginal people should take more individual responsibility for improving their own health.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.8</td>
<td>Trust is a key for culturally secure health care.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.9</td>
<td>Feeling intimidated is a barrier to culturally secure health care.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.10</td>
<td>I think it will be difficult to get Aboriginal women to adhere to advice from health professionals.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.11</td>
<td>I think I have the ability to communicate with Aboriginal women by myself.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.12</td>
<td>I need to think beyond the individual when considering Aboriginal health issues.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.13</td>
<td>The information I have learned in my program has changed my views on Aboriginal issues.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.14</td>
<td>It is important that a unit on Indigenous Cultures and Health is compulsory in all health science courses.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.15</td>
<td>I will work for improvements in Aboriginal health as a personal priority in my health practice.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.16</td>
<td>I have a social responsibility to work for changes in Aboriginal health.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
SECTION FOUR

The final section seeks your opinions on the teaching of Aboriginal health in the midwifery program and perceptions of your preparedness to work with Aboriginal mothers and their babies.

Please fill in the circle that corresponds to your response and/or write on the dotted line.

4.1 List possible benefits of learning about Aboriginal health and related issues as part of the midwifery curriculum.

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4.2 List possible disadvantages of learning about Aboriginal health and related issues as part of the midwifery curriculum.

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4.3 Which of the following statements best describes your emotional response to content delivered in the Indigenous Health and Culture unit completed in your first year?

Resistant for most of the semester, couldn’t see the point  □ 1
Resistant at first, but this changed over the semester  □ 2
Generally receptive, open to new information  □ 3
Very receptive, would like more content in our program  □ 4
4.4 Could you describe in more detail your emotional response to the content that you learned in the Indigenous Health and Culture unit (for example, did issues arise that upset you, made you angry, resentful, hopeful, optimistic).

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4.5 With respect to your teaching in Indigenous health, what did you find most useful and why?

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4.6 With respect to your teaching in Indigenous health, what did you find the least useful and why?

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4.7 To what extent has the teaching in your program changed your perceptions about Aboriginal communities and their health?

<table>
<thead>
<tr>
<th>No change</th>
<th>1</th>
<th>2</th>
<th>Some change</th>
<th>3</th>
<th>4</th>
<th>Significant change</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>〇</td>
<td>〇</td>
<td></td>
<td>〇</td>
<td>〇</td>
<td></td>
<td>〇</td>
</tr>
</tbody>
</table>
4.8 If there has been any change in your perceptions as a result of this teaching, can you outline this in more detail?

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4.9 For your level of midwifery training, how adequate would you describe the amount of teaching you have had in Aboriginal health?

<table>
<thead>
<tr>
<th>Very inadequate</th>
<th>1</th>
<th>2</th>
<th>Adequate</th>
<th>3</th>
<th>4</th>
<th>Very adequate</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
<td>O</td>
<td>O</td>
<td></td>
<td>O</td>
</tr>
</tbody>
</table>

Please expand on why you think this.

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4.10 How well prepared are you to work with Aboriginal mothers and their babies?

<table>
<thead>
<tr>
<th>Poorly prepared</th>
<th>1</th>
<th>2</th>
<th>Adequately prepared</th>
<th>3</th>
<th>4</th>
<th>Well prepared</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
<td>O</td>
<td>O</td>
<td></td>
<td>O</td>
</tr>
</tbody>
</table>
4.11 What sorts of issues or topics would you like to see covered in any additional teaching on Aboriginal health and related issues?

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…………………………………………………………………………………………………………

4.12 Would you be interested in more clinical exposure to Aboriginal settings in your training (for example, clinical practice in a rural or remote setting)?

Yes 1  No 2

4.13 Please comment on any others issues related to teaching and learning in Aboriginal health in your midwifery program.

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Thank you for taking the time to complete this questionnaire. Your assistance is greatly appreciated. When the findings have been collated and analysed, a summary will be made available for all participants.
CURTIN UNIVERSITY POSTGRADUATE MIDWIFERY STUDENT SURVEY

PG Diploma in Midwifery students

Research project: ‘Cultural security in midwifery education and service provision for Aboriginal women’.

May 2014

Approval has been granted by staff at the University of Western Australia, University of Melbourne and Murdoch University to include some questions used in earlier studies. Permission is acknowledged and appreciated.
SECTION ONE

This section seeks demographic information to help establish a profile of post graduate midwifery students at Curtin University who complete this questionnaire. Please fill in the circle that corresponds to your response and/or write on the dotted line. Please use a blue or black pen.

The numbers on the far right are for coding purposes only.

<table>
<thead>
<tr>
<th>1.1 What age category do you belong to?</th>
</tr>
</thead>
<tbody>
<tr>
<td>17-20 years</td>
</tr>
<tr>
<td>21-30 years</td>
</tr>
<tr>
<td>31-40 years</td>
</tr>
<tr>
<td>41-50 years</td>
</tr>
<tr>
<td>51 years and above</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1.2 Were you born in Australia?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

If No, write your country of birth.

<table>
<thead>
<tr>
<th>1.3 If your country of birth is not Australia, how many years have you been living in Australia?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 years</td>
</tr>
<tr>
<td>5-15 years</td>
</tr>
<tr>
<td>16-25 years</td>
</tr>
<tr>
<td>&gt;25 years</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1.4 Are you of Aboriginal or Torres Strait Islander descent?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1.5 If you are of Aboriginal or Torres Strait Islander descent, do you identify?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

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1.6 If you were born in Australia, where did you spend the majority of your childhood and teenage years?

<table>
<thead>
<tr>
<th>Option</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan area (e.g. Perth)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Large regional centre (e.g. Bunbury, Albany)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Small to medium country town</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Small, remote community</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

1.7 How many years experience do you have as a nurse?

<table>
<thead>
<tr>
<th>Years</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 years</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>5-15 years</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>16-25 years</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>&gt;25 years</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

1.8 Where do you currently practice?

<table>
<thead>
<tr>
<th>Practice Area</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan area (e.g. Perth)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Large regional centre (e.g. Bunbury, Albany)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Small to medium country town</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Small, remote community</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Not practising at present</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

1.9 If practising, in which setting (s) are you currently employed?

<table>
<thead>
<tr>
<th>Setting</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital based (government)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Hospital based (private)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Other private</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Aboriginal focus</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Community focus</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>
### 1.10 In which location(s) have you spent most of your nursing career?

<table>
<thead>
<tr>
<th>Location</th>
<th>Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan area (e.g. Perth)</td>
<td>1</td>
</tr>
<tr>
<td>Large regional centre (e.g. Bunbury, Albany)</td>
<td>2</td>
</tr>
<tr>
<td>Small to medium country town</td>
<td>3</td>
</tr>
<tr>
<td>Small, remote community (name of community ____________________________)</td>
<td>4</td>
</tr>
</tbody>
</table>

### 1.11 Have you cared for Aboriginal patients during your nursing career?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rarely, or not at all</td>
<td>1</td>
</tr>
<tr>
<td>Periodically</td>
<td>2</td>
</tr>
<tr>
<td>Frequently</td>
<td>3</td>
</tr>
</tbody>
</table>

### 1.12 Where are you planning to practise midwifery in the first five years following graduation? (You may choose more than one response.)

<table>
<thead>
<tr>
<th>Location</th>
<th>Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan area (e.g. Perth)</td>
<td>1</td>
</tr>
<tr>
<td>Large regional centre (e.g. Bunbury, Albany)</td>
<td>2</td>
</tr>
<tr>
<td>Small to medium country town</td>
<td>3</td>
</tr>
<tr>
<td>Small, remote community</td>
<td>4</td>
</tr>
</tbody>
</table>

### 1.13 Please indicate, in order of preference (by placing a number in the related box) up to 3 areas of midwifery in which you would like to work when you graduate.

<table>
<thead>
<tr>
<th>Area</th>
<th>Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital based (government)</td>
<td>1</td>
</tr>
<tr>
<td>Hospital based (private)</td>
<td>2</td>
</tr>
<tr>
<td>Other private</td>
<td>3</td>
</tr>
<tr>
<td>Aboriginal focus</td>
<td>4</td>
</tr>
<tr>
<td>Community focus</td>
<td>5</td>
</tr>
<tr>
<td>Teaching and or/research</td>
<td>6</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>7</td>
</tr>
<tr>
<td>No preference at present</td>
<td>8</td>
</tr>
</tbody>
</table>
**SECTION TWO**

This section seeks information on your current knowledge about Aboriginal issues.

*Please fill in the circle that corresponds to your response and/or write on the dotted line.*

### 2.1 How do you rate your knowledge of issues facing contemporary Aboriginal Australia?

<table>
<thead>
<tr>
<th>Poor (1)</th>
<th>Adequate (3)</th>
<th>Comprehensive (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2.2 How do you rate your knowledge of Aboriginal history and culture?

<table>
<thead>
<tr>
<th>Poor (1)</th>
<th>Adequate (3)</th>
<th>Comprehensive (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2.3 How do you rate your knowledge of Aboriginal health specifically?

<table>
<thead>
<tr>
<th>Poor (1)</th>
<th>Adequate (3)</th>
<th>Comprehensive (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2.4 Are you familiar with the Aboriginal concept of ‘shame’?

<table>
<thead>
<tr>
<th>Yes (1)</th>
<th>No (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If Yes, explain what this might mean in the context of pregnancy and childbirth.

………………………………………………………………………………………
………………………………………………………………………………………
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………………………………………………………………………………………

 0 0
### 2.5 Are you familiar with the Aboriginal concept of ‘grandmothers’ law’?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

If Yes, explain what this might mean in the context of pregnancy and childbirth.
………………………………………………………………………………………………………………
………………………………………………………………………………………………………………
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### 2.6 The health status of Aboriginal people is significantly lower than that of non-Aboriginal people. Why do you think this is so?

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………………………………………………………………………………………………………………
………………………………………………………………………………………………………………
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### 2.7 What do you consider to be the key priorities in Aboriginal health today?

………………………………………………………………………………………………………………
………………………………………………………………………………………………………………
………………………………………………………………………………………………………………
………………………………………………………………………………………………………………
………………………………………………………………………………………………………………
### 2.8 Please identify factors that may influence the ability of Aboriginal people to adhere to health treatment or advice.

- ...
- ...
- ...
- ...
- ...

### 2.9 Do you expect to have much involvement with Aboriginal patients once you graduate?

<table>
<thead>
<tr>
<th>No involvement</th>
<th>Periodic involvement</th>
<th>Frequent involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Please expand on why you think this.

- ...
- ...
- ...
- ...
Below you will see something that looks like a thermometer. We would like you to mark this thermometer to indicate your attitude towards Aboriginal people in Australia. Here is how it works. If you have a favourable attitude towards Aboriginal people, you would write a score somewhere between 50° and 100°, depending on how favourable you are towards them. On the other hand, if you have an unfavourable attitude towards Aboriginal people, you would write a score somewhere between 0° and 50°, depending on how unfavourable you are towards them.

The degree labels will help you to locate the group on the thermometer. However, you are not restricted to the numbers indicated - feel free to use any number between 0° and 100°.

Please write a number between 0° and 100°, to indicate your attitude towards Aboriginal people.

…………………………………….
2.11 Consider the following influences that may have shaped your attitudes towards Aboriginal people and understanding of Aboriginal issues. Please rank the four most notable influences from (1, most important) to (4) by placing a number in the related box.

<table>
<thead>
<tr>
<th>Influence</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lived experience</td>
<td>1</td>
</tr>
<tr>
<td>Family</td>
<td>2</td>
</tr>
<tr>
<td>Friends</td>
<td>3</td>
</tr>
<tr>
<td>Primary and secondary school education</td>
<td>4</td>
</tr>
<tr>
<td>General media reporting (e.g. TV, newspaper, film, radio, electronic media, Aboriginal people in the media)</td>
<td>5</td>
</tr>
<tr>
<td>Aboriginal people whom you have known personally</td>
<td>6</td>
</tr>
<tr>
<td>Teaching in your midwifery course</td>
<td>7</td>
</tr>
<tr>
<td>Significant events (e.g. National Apology, NAIDOC week, Northern Territory Intervention)</td>
<td>8</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>9</td>
</tr>
</tbody>
</table>

2.12 Have you read any books, poetry or seen any plays by Aboriginal authors/playwrights?

<table>
<thead>
<tr>
<th>Response</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No (might in the future)</td>
<td>2</td>
</tr>
<tr>
<td>No (not interested)</td>
<td>3</td>
</tr>
</tbody>
</table>

If yes, please make a note of authors and/or titles and any impact (if any) these had on your understanding of Aboriginal issues.

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2.13 In June, 2012 the twentieth anniversary was celebrated to commemorate a landmark judgement in the High Court of Australia affecting Aboriginal people. Do you know what the judgement was called?  

<table>
<thead>
<tr>
<th>Yes 1</th>
<th>No 2</th>
</tr>
</thead>
</table>

If Yes, please write the name here.  

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If you answered yes, please make a note of the significance of this judgement (if you know) and links (if any) you see between this judgement and the health of Aboriginal people.

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250
SECTION THREE requires you to indicate your level of agreement with the following statements. Please fill in the circle that corresponds to your response.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 The state of Aboriginal health is a social priority.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>〇</td>
<td>〇</td>
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</tr>
<tr>
<td>3.2 The Western medical model suits the health needs of Aboriginal peoples.</td>
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<td>〇</td>
<td>〇</td>
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<tr>
<td>3.3 The state of Aboriginal health depends on the availability of appropriate health services.</td>
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<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
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</tr>
<tr>
<td>3.4 The state of Aboriginal health is mainly due to a lack of funding for health services.</td>
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<td>〇</td>
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<tr>
<td>3.5 Aboriginal people have the same level of access to health services as all other Australians.</td>
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<td>〇</td>
<td>〇</td>
<td>〇</td>
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</tr>
<tr>
<td>3.6 Community control in Aboriginal health care services is fundamental to the improvement of health for Aboriginal people.</td>
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<td>〇</td>
<td>〇</td>
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</tr>
<tr>
<td>3.7 Aboriginal people should take more individual responsibility for improving their own health.</td>
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<td>〇</td>
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</tr>
<tr>
<td>3.8 Trust is a key for culturally secure health care.</td>
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<td>〇</td>
<td>〇</td>
<td>〇</td>
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<td>〇</td>
</tr>
<tr>
<td>3.9 Feeling intimidated is a barrier to culturally secure health care.</td>
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<td></td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
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</tr>
<tr>
<td>3.10 I think it will be difficult to get Aboriginal women to adhere to advice from health professionals.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
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</tr>
<tr>
<td>3.11 I think I have the ability to communicate with Aboriginal women by myself.</td>
<td></td>
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<td>〇</td>
<td>〇</td>
<td>〇</td>
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<td>〇</td>
</tr>
<tr>
<td>3.12 I need to think beyond the individual when considering Aboriginal health issues.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>3.13 I am better informed about Aboriginal health issues as a result of the content delivered in this program.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>3.14 I think there should be a compulsory unit on Aboriginal health and cultures in our postgraduate program.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>3.15 I will work for improvements in Aboriginal health as a personal priority in my health practice.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>3.16 I have a social responsibility to work for changes in Aboriginal health.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
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</tr>
</tbody>
</table>
SECTION FOUR

The final section seeks your opinions on the teaching of Aboriginal health in the midwifery program. *Please fill in the circle that corresponds to your response and/or write on the dotted line.*

4.1 How adequate would you describe the amount of teaching you had in Aboriginal health in your *undergraduate* nursing program?

<table>
<thead>
<tr>
<th>Very inadequate</th>
<th>1</th>
<th>2</th>
<th>Adequate</th>
<th>3</th>
<th>4</th>
<th>Very adequate</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><img src="1" alt="Circle" /></td>
<td><img src="2" alt="Circle" /></td>
<td><img src="3" alt="Circle" /></td>
<td><img src="4" alt="Circle" /></td>
<td><img src="5" alt="Circle" /></td>
<td><img src="6" alt="Circle" /></td>
<td><img src="7" alt="Circle" /></td>
</tr>
</tbody>
</table>

4.2 How adequate would you describe the amount of teaching you had in Aboriginal health in your *postgraduate* midwifery program?

<table>
<thead>
<tr>
<th>Very inadequate</th>
<th>1</th>
<th>2</th>
<th>Adequate</th>
<th>3</th>
<th>4</th>
<th>Very adequate</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><img src="1" alt="Circle" /></td>
<td><img src="2" alt="Circle" /></td>
<td><img src="3" alt="Circle" /></td>
<td><img src="4" alt="Circle" /></td>
<td><img src="5" alt="Circle" /></td>
<td><img src="6" alt="Circle" /></td>
<td><img src="7" alt="Circle" /></td>
</tr>
</tbody>
</table>

4.3 List possible benefits of learning about Aboriginal health and related issues as part of the postgraduate midwifery curriculum.

…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
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…………………………………………………………………………………………………………
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4.4 List possible disadvantages of learning about Aboriginal health and related issues as part of the postgraduate midwifery curriculum.

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…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………

4.5 To what extent has the teaching in your program influenced your perceptions about Aboriginal communities and their health?

<table>
<thead>
<tr>
<th>No influence</th>
<th>1</th>
<th>2</th>
<th>Some influence</th>
<th>3</th>
<th>4</th>
<th>Considerable influence</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td></td>
<td></td>
<td>O</td>
<td></td>
<td></td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>

4.6 If there has been any change in your perceptions as a result of this teaching, can you outline this in more detail?

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........................................................................................................................................
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........................................................................................................................................
........................................................................................................................................

4.7 How adequate would you describe the amount of clinical experience you had in Aboriginal health during your program?

<table>
<thead>
<tr>
<th>Very inadequate</th>
<th>1</th>
<th>2</th>
<th>Adequate</th>
<th>3</th>
<th>4</th>
<th>Very adequate</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td></td>
<td></td>
<td>O</td>
<td></td>
<td></td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>

Please expand by outlining any clinical experiences in Aboriginal health completed during your program.

........................................................................................................................................
........................................................................................................................................
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4.8 What sorts of issues or topics would you like to see covered in any additional teaching on Aboriginal health and related issues?

…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………

4.9 Please comment on any other issues related to the teaching of Aboriginal health and related issues that have a bearing on midwifery practice.

…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
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…………………………………………………………………………………………………………

Thank you for taking the time to complete this questionnaire. Your assistance is greatly appreciated. When the findings have been collated and analysed, a summary will be made available for all participants.
Appendix Two: Forms, Sample Notes and Schedules.

1. Participant Information and Consent Forms
2. Sample Classroom Observation Notes
3. Sample Interview Schedules
This research project, ‘Culturally secure practice in midwifery education and service provision for Aboriginal women’, is being conducted by Rosalie Thackrah, a long-term and current staff member of the School of Midwifery and Nursing at Curtin University. She is also undertaking doctoral research through the School of Aboriginal, Primary and Rural Health Care at the University of Western Australia.

What is the research about?

The focus of the study is upon the preparation of midwifery students to provide culturally secure care to Aboriginal and Torres Strait Islander women.

The findings from this research will be compared with previous research which has largely been undertaken with medical students, and it will be used to refine and improve programs that facilitate health care delivery to pregnant and birthing Aboriginal women. Culturally informed health care delivery is known to influence access to and utilisation of health care services by Aboriginal peoples. At the conclusion of the study the findings will be widely disseminated and an Executive Summary will be available to any participant who requests it.

Who is invited to participate?

Undergraduate and postgraduate midwifery students at Curtin University are invited to participate in this research by completing a questionnaire. The questionnaire seeks information on your knowledge and opinions about Aboriginal health, factors that have influenced your thinking in this area, your responses to and engagement with Aboriginal content in the midwifery program and views of your preparedness to work with Aboriginal peoples upon graduation (final year students only). Participants also will be invited to volunteer for a follow up interview. The interview will cover issues related to education for culturally secure practice and will provide an opportunity to expand on ideas presented in the questionnaire.

What will the information be used for?

Data collected from the questionnaires and interviews will be used by the researchers to better understand the factors that influence student responses to Aboriginal content in the curriculum and to refine educational programs that prepare health professionals to work with Aboriginal peoples.

Participation in this research is entirely voluntary and you may withdraw your consent at any time (see Participant Consent Form). Participation or otherwise will have no bearing upon your academic results. If you agree to participate, please sign two copies of the Participant Consent Form. One copy is retained by the researcher and the other copy is for your records.

For further information on this study please contact Winthrop Professor Sandra Thompson on 9956 0208 or Sandra.Thompson@cucrh.uwa.edu.au or Rosalie Thackrah on 9266 2737 or R.Thackrah@curtin.edu.au
PARTICIPANT CONSENT FORM

Culturally secure practice in midwifery education and service provision for Aboriginal women

I agree to participate in the research project titled ‘Culturally secure practice in midwifery education and service provision for Aboriginal women’ conducted by Rosalie Thackrah, a Curtin University academic staff member and PhD candidate in the School of Primary, Aboriginal and Rural Health Care at the University of Western Australia.

The project, which is being supervised by Winthrop Professor Sandra Thompson (UWA), Dr Angela Durey (Curtin), and Dr Marion Kickett (Curtin), has received ethics approval from the Western Australian Aboriginal Ethics Committee and approval from the University of WA and Curtin University (see statement below).

I have read the information provided and any questions I have asked have been answered to my satisfaction. I understand that I may withdraw my consent to participate at any time without reason and without prejudice and that my participation or otherwise has no bearing upon my marks. I understand that all identifiable (attributable) information that I provide is treated as strictly confidential and will not be released by the investigator in any form that may identify me. The only exception to this principle of confidentiality is if documents are required by law.

I have been advised as to what data is being collected, the purpose for collecting the data, and what will be done with the data upon completion of the research. I agree that research data gathered for the study may be published provided my name or other identifying information is not used.

Family Name ____________________ (please print)
First Name ____________________
Signature ____________________________ Date ___________

If you agree to participate in the research, you will be provided with a copy of the Participant Information Form and the Participant Consent Form relating to this research project.

This study has received ethics approval from the Western Australian Aboriginal Health Ethics Committee (HREC Ref.No.397) and has been granted reciprocal ethics approval from the Human Research Ethics Office, University of Western Australia. Reciprocal approval has also been approved under Curtin University’s process for lower-risk Studies (Approval Number SON&M 12-2012). This process complies with the National Standard on Ethical Conduct in Human Research (Chapter 5.1.7 and Chapter 5.1.18 – 5.1.21).

For further information on this study please contact the researchers named on the Participant Information Form or the Curtin University Research Ethics Committee c/- Office of Research and Development, Curtin University, GPO U1987, Perth 6845 or by telephoning 92669223 or by emailing hrec@curtin.edu.au

In addition, if you have any concerns related to the conduct of the research you may make complaints about the research project by contacting the Human Research Ethics Office at the University of Western Australia on (08) 6488 3703 or by emailing to hreo-research@uwa.edu.au
Indigenous Cultures and Health 130 Classroom Observations with Midwifery Students (408:1505) Tuesday 1-3pm Tutor: KT Observer: RT.

Week 11: 25/09/12 Theme: Health Story.

By the end of the tutorial, the students will be able to:
Relate the impacts of policies and history to the current cultural and health contexts of Australian Aboriginal and Torres Strait Islander peoples.
Analyse social determinants of health and cultural influences in relation to current health outcomes and the utilisation of health services for Aboriginal and Torres Strait Islander peoples.
Reflect on own personal development of cultural understandings as a health professional working in collaborative partnerships with Aboriginal and Torres Strait Islander peoples.

This week looks at: The Life Story of RN as he talks about his experiences of growing up in the South-West of Western Australia. His open and informative account of his life gives us an insight into the lived experiences of many Aboriginal people and challenges us to apply our understanding of what we have learnt so far in this unit.

Questions to consider in advance of tutorial
What do you think about the reasons given that made him face his mortality?
What experiences with the health system can you identify?
What were the key factors that contributed to his ill-health?
In discussing the events that changed his life, do you believe that his story is possible, or plausible, for all Aboriginal people?
What does the term "empowerment" mean to you?

Workshop questions:

1. What factors had a major impact upon RN as he was growing up. Can you relate these to his health?
2. What experiences with the health system can you identify?
3. RN states that he has been exposed to racism throughout his life, what examples does he offer? How does racism impact upon health?
4. What led RN to reflect over the reality of his life and initiate change? In discussing the events that changed his life how relevant are they to Aboriginal people?
5. What does empowerment mean to you? Do you think RN is an empowered Aboriginal man?
6. What are the experiences for Indigenous peoples in the Australian health service?
7. What are some of the differences in health disparities between Aboriginal and non-Aboriginal populations? (You might want to refer back to the health statistics charts provided in week 2 & 3)
8. Are there any comparisons, similarities and/or differences, between the circumstances and experiences of Australia's Indigenous population?
9. What health professionals might be involved in RNs situation?
RT Classroom Notes

KT touches on learning outcomes with respect to RN vodcast. Focus on an individual case study. Student asks about sexual abuse in the missions. Yes, but he doesn’t talk about that. No, does talk about mission experience.

Background on diabetes (RN suffers). Excerpt from vodcast. He discusses stigma attached to being a mission kid.

Group work to discuss questions: social determinants affecting RN, psychological impacts; physical impacts (health indicators), 15 minute group discussion (Students have viewed vodcast in advance as part of an assessment.

(Some students finish discussing topic after about 5 minutes and then talk about exams, assessments, marks etc., at least group close to me; KT talks to a group who remain on topic). Can hear students talk about the stresses of studying full-time and looking after kids. They are feeling very stressed. Want the semester to be over. Four assessments to go, students discuss these. They are talking about other units and papers due.

KT: asks students for feedback (anyone but XX!). Asks K who is always quiet. They identify a few positive factors – identity as ‘us mission kids’; life on a farm might have had positive features. KT: reinforces factors that shaped him, capacity to make friends with Europeans. Asks M - mission gave him a capacity to mix with others. L suggests he developed an ability to work within it or outside it (good point). KT agrees. Perhaps it gave him some resilience, had some choices later; developed some capacity to make changes. Another student – he is very perceptive person, raised in mission meant he was forced to go to school. He is a thinker, articulate. KT- what kind of mental health things are going on with him? Student – perhaps hasn’t experienced love as a child, normal warmth, and family traditions. KT: sometimes when people hit rock bottom, any resilience comes through if they are to survive. Student: he seemed to enjoy telling his story, there was a sense a pride, and very resilient.

K: What health professionals would be involved in his care now? Social workers, dietitian. Student: he seemed to have strong ideas about his health care, felt disempowered in the past but now quite empowered, talked about traditional medicines and his belief in those. He would need to be an active participant in his care as he would not like being told.

K: must appreciate what the client values and believes works, these might be quite different from health professional. Discussion about collective and individual health ideas. He has a sense of authority now; has reconnected with his culture and people.

Student: same can be said for a non-Aboriginal person.
KT: yes, but there are other factors at work here e.g. impact of stolen generation.
Student: did he know his parents? KT- yes, he did, he was told his parents didn’t want him but he knew they lived in town.

KT talks about how a mission upbringing can have a positive side. Aboriginal people have very different experiences; some Aboriginal people speak of the benefits. Student: didn’t feel he was angry, but another student feels differently, thought it was just beneath the surface.

KT: what about the fact that he returned to the mission. Student: he must have had some good memories, saw the potential of the place. He is embracing his history. KT: the place was instrumental in creating his identity. Student: found that very powerful. KT: this is who I am; it was about returning and building on this.

Student: is there a specifically Aboriginal aspect to this, the land, the mother, it is almost blameless, maybe it is a different way of looking at it. KT: it is all about the mission rather than parents, ‘my land’ so good point X, thinking about connection with land.

KT: 2 questions: Do Aboriginal Australians need ‘special’ treatment or benefits. Should Australian law be able to override traditional practices/law? Hot button issues. “Insight” program on SBS.
Student: do you mean positive discrimination? Student: from a midwifery perspective, definitely, we need Indigenous midwives. We must entice Aboriginal women into midwifery. KT: shall we have a debate, for and against the need for positive discrimination? Students do not want to go there. Others say yes, it is good to discuss this. Run out of time.

Students to read articles and then they will discuss earlier issues raised next week. KT has a handout to read. Students read article by Marcia Langton. They don’t give me one – another example of how invisible I have become! I’ve already read it.

Excellent articles, one on ‘Indigenous exceptionalism’.

Next week will consider article in context of rural/remote and urban settings; criteria for special treatment; Aboriginal identity.

RT reflections, comments.

I think this case study which students had already listened to (it was part of an e-test) was a very useful tool. Many issues were raised and some students really started to think about the complexities involved and how circumstances can shape people differently. Resilience was talked about a lot and also some benefits of a mission upbringing. It wasn’t all bad. Losses huge though. Also the idea of returning to XX and connecting again (a bit like Clontarf or Sister Kate’s) was discussed thoughtfully in the context of connection to land and place and where identity is forged.

Some students really seemed engaged with this story; a few others decided to switch off some weeks ago. Resistance (if that is what I’m detecting) takes many forms: quietness, facial expressions, raising the refrain ‘it’s like that for everyone’, texting. For those who are engaged, I sense that they are now much more thoughtful and considered in their responses, drawing content together from across the semester which is impressive. Am I imagining it or has the group fractured?
Research project: ‘Culturally secure practice in midwifery education and service provision for Aboriginal women’

Interview with XXXX (Code: 02M) September 24th 2012, School of Nursing and Midwifery. XXXX to be given copies of PIF and PCF. Agreement has been given to record interview.

Yarning questions

Can you tell me a little about your family background? Where you grew up, where your parents are from, how many kids in the family, your own circumstances now, that sort of thing.

When did you leave school and what did you do then?

What made you think about midwifery as a career? Was it something you had always wanted to do?

Can you tell me a little about where you are working now and the scope of your midwifery practice?

Semi-structured interview questions

1. You started midwifery in 2008? Can you tell me a little bit about your experience of being a student in this program and the only Aboriginal student in the group? How did you feel about this and was it ever an issue?

2. In your transition to university, can you tell me about any help you got with returning to study – learning how to use the library, do assignments etc. Did you register for ITAS and access additional tutoring support? How did this work for you?

3. In what units apart from Indigenous Cultures and Health was Indigenous content raised?

4. When Aboriginal-related issues have been raised in the classroom, how did you feel – student responses, staff handling of them, that sort of thing?

5. Have you ever been placed in a situation in the classroom where you were called upon to give an ‘Aboriginal’ response? If yes, how did this make you feel?

6. What are your perceptions about how students in your cohort responded to the Aboriginal content delivered in the classroom?

7. Do you have any suggestions as to how your midwifery program could better prepare students to work with Aboriginal women?

8. From your experience as a midwife, what more needs to be done to improve the interaction with Aboriginal women in obstetric and midwifery settings? What were your experiences as a mother of four children?

9. Did you ever encounter racism in the classroom setting or in the university setting more generally? If yes, could you elaborate?

10. Have you ever encountered racism in your interactions with the health care system – as a patient or family member or as student and now a midwife? If yes, could you elaborate?
11. There is a lot of interest in Indigenous cultural competency as an attribute of all university graduates. In the health context, and more specifically, in midwifery, what do you think constitutes a culturally competent practitioner?

12. Medical schools have been successful in attracting and graduating Aboriginal doctors. Why do you think it has been more difficult to attract and retain Aboriginal students in nursing and midwifery?

13. To what extent was your progress in the midwifery program influenced by external factors, such family, finances, health and so on. Can you tell me about any challenges you faced and any things that helped you to overcome them?

14. Do you consider that the university overall at an administrative level was supportive of your circumstances? What about support from individual staff members?

15. As a practising midwife what do you hope to contribute to the profession and your community?

16. One question which arises often is how health care providers can encourage Aboriginal women to present earlier in pregnancy and to minimise risks to their unborn child through unhealthy exposures in pregnancy. What are your thoughts on what is needed?

17. Did you see a change in the attitudes of individuals through the midwifery program which makes you feel they are being better prepared to provide culturally respectful care?

18. What are the challenges that you face being one of very few Aboriginal midwives?

Is there anything else you would like to comment on?

Thank you so much for sharing your experiences and perspectives on midwifery education with me. Would you like to see a copy of the transcript of this interview before it is collated with other interviews and analysed as part of this study?
Sample Interview Schedule

Research project: ‘Culturally secure practice in midwifery education and service provision for Aboriginal women’

Interview with XXXX. Midwife currently employed at XXXX.
Date of interview: January 31st 2014.
XXXX to be given copies of PIF and PCF.

Semi-structured questions

XXXX, I’m really interested to hear about your remote community clinical prac experience as a student in 2011. I’m also interested in preparation that students receive to work with Aboriginal women in a range of settings.

1. You started midwifery in 2009? What motivated you to embark upon this program?
2. You qualified in 2011. Can you tell me about your midwifery career since you graduated?
3. Casting your mind back, was there very much Aboriginal content in the midwifery program? Can you tell in which units this content was covered?
4. What are your perceptions about how students in your cohort responded to the Aboriginal content delivered in the classroom?
5. Some students have commented that this area has received too much emphasis, and that people from others cultures are neglected in comparison. What’s your view on this?
6. So, tell me a little about why you applied to go remote for a final year clinical prac?
7. How did you manage to organise the visit? Did you receive any financial assistance?
8. Tell me a bit about the setting, who you worked with and the nature of your role?
9. Was the clinic well resourced?
10. Can you describe a typical working day for me?
11. What about the evenings?
12. What were the best things that came out of this experience?
13. What were the challenges you encountered?
14. Would you recommend it to other students as a good learning experience?

15. Do you think the Aboriginal content in your program was adequate to prepare you for this experience?

16. Looking back on that experience now after 2 years as a midwife, what impact do you think it has had on your practice?

17. Do you have any suggestions as to how your midwifery program could better prepare students to work with Aboriginal women?

18. From your experience, what more needs to be done to improve interactions with Aboriginal women in obstetric and midwifery settings?

19. There is a lot of interest in Indigenous cultural competency as an attribute for all university graduates. In the health context, and more specifically, in midwifery, what do you think constitutes a culturally competent practitioner?

20. One question which arises often is how health care providers can encourage Aboriginal women to present earlier in pregnancy and to minimise risks to their unborn child through unhealthy exposures in pregnancy. What are your thoughts on what is needed?

21. What are your work plans for the future?

Is there anything else you would like to comment on?

Thank you so much for sharing your experiences and perspectives on midwifery education with me. Would you like to see a copy of the transcript of this interview before it is collated with other interviews and analysed as part of this study?
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