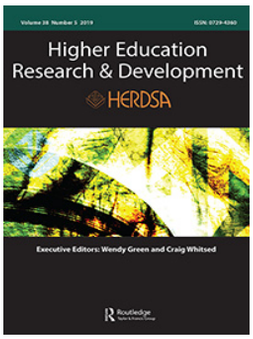

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Impact of a discrete First Peoples health course on students' experience and development of cultural capabilities

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ABSTRACT

As Australian universities move towards the mandatory inclusion of First Peoples content into undergraduate health professional programs, it is imperative to evaluate course impact and quality of teaching. A discrete First Peoples Health course underpinned by The Aboriginal and Torres Strait Islander Health Curriculum Framework was evaluated using the Cultural Capability Measurement Tool (CCMT). Tool items reflect the five core cultural capabilities outlined in The Framework (Respect, Communication, Safety and Quality, Reflection, and Advocacy). All enrolled students ($n = 297$) were invited to complete an online survey before and after the course. Students' experience of course quality was assessed using a university-generated online survey. Completed surveys could be matched for 87 students (29.3% response rate). Mean increase in CCMT scores from baseline to post-course was 10.85 (95% CI 8.84, 12.86). The eta squared statistic ($\eta^2 = 0.57$) indicated a large effect. Students' satisfaction with course quality was high ($M = 4.1$ SD = 0.96). Free text comments indicated that students valued small group teaching and reflective processes. Improved CCMT scores suggest development in students' cultural capability. Further research needs to examine the extent to which students can sustain development of their cultural capabilities in practice.

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Aboriginal and Torres Strait Islander; cultural capabilities; competencies; First Peoples; health professional students

Introduction

In this article, Australia's Aboriginal and Torres Strait Islander people are referred to as *First Peoples*. The term *Indigenous,* is used with respect when referring to First Peoples of other countries. In the Australian context, significant disparities between First Peoples and non-Indigenous peoples are evident across all social determinants of health. More recently, the deeply embedded and structural influence of racism has been recognised as a determinant of health in its own right (Paradies et al., 2015). A lack of access to culturally safe health services reinforces this systemic oppression (Durey, Thompson, & Wood, 2012). To address this, health professional programs accredited with the Australian Health Practitioners Regulatory Authority (AHPRA) are required to include content on First Peoples cultures, histories and health. Incorporation of First Peoples health content in undergraduate health professional curricula aims to improve

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students' confidence and preparedness to work with, and care for First Peoples and their communities (Department of Health, 2014). However, there remains a paucity of empirical evidence on the impact of education related to First Peoples health (Clifford, Mc Calman, Jongen, & Bainbridge, 2017; Ewen, Paul, & Bloom, 2012; Milne, Creedy, & West, 2016).

Recently, the Australian Government released the Aboriginal and Torres Strait Islander Health Curriculum Framework (hereafter, *The Framework*) (Department of Health, 2014). *The Framework* outlines learning and graduate outcomes which include five interconnected core capabilities: Respect, Communication, Safety and Quality, Reflection, and Advocacy (Department of Health, 2014). *The Framework* uses the concept of 'cultural capability' which has gained recent prominence and differs from cultural competence – the term commonly used in much of the published literature. 'Competence' can denote a possible 'tick-box' approach to assessment of knowledge and skills, and not reflect sustained and meaningful improvements in practice (Carey, 2015; Department of Health, 2014; West et al., 2017). Cultural capability implies a process of life-long learning as graduates develop their capacity to act on cultural awareness and knowledge to provide culturally safe care (Department of Health, 2014).

The inclusion of Indigenous content in health professional programs has often been fragmented and inconsistent. In a scoping review of health sciences programs in Canada, Guerra and Kurtz (2017) concluded that few programs aimed to increase awareness, or embed cultural competency and cultural safety concepts. In the USA and Canada cross-cultural education is more common than education focussing on Indigenous health (McDougle, Ukockis, & Adamshick, 2010). Cross-cultural and multicultural education are vastly different to education about Indigenous peoples from colonised countries. Indigenous peoples share similar histories involving the displacement from traditional lands, loss of language, law, leadership and traditions, resulting in ongoing adverse health impacts (Sherwood, 2013; United Nations, 2009). Where Indigenous content is included, numerous challenges are reported by academic staff (Wolfe, Sheppard, Le Rossignol, & Somerset, 2017). These include perceived barriers at an institutional level (e.g., failure to engage Indigenous reference groups), and discomfort when teaching Indigenous content, particularly in the presence of Indigenous students (Wolfe et al., 2017). Combined, these studies highlight the lack of Indigenous content in health curricula, as well as the propensity for current higher education practices to perpetuate existing inequalities and limit the development of a culturally capable workforce. The current article attempts to address this gap and reports on the evaluation of a discrete First Peoples health course. Specifically, what is the impact of a discrete First Peoples Health course on students' experience and development of cultural capabilities?

Literature review

The review of literature underpinning the current study critiques the formats used to deliver Indigenous health, key content, the presence of an established framework, teaching approaches, and evaluation methods. Published evaluations of discrete Indigenous health courses in undergraduate programs are relatively rare. Rather than discrete courses, our search identified evaluations on diverse learning and teaching strategies that included cultural immersion experiences (Glickman, Olsen, & Rowthorn, 2015); workshops (Carter

et al., 2006); online modules as part of a course (Evans & Hanes, 2014); and integration of cultural content throughout the curriculum (Coombe, Lee, & Robinson, 2016; Paul, Carr, & Milroy, 2006; Smith et al., 2015) or during the clinical practicum (Chen, McAdams-Jones, Tay, & Packer, 2012; Shattell et al., 2013).

Of those studies evaluating discrete courses, three studies conducted in the USA related to 'intercultural' or 'cross-cultural' course content (Chiodo, Sonn, & Morda, 2014; Durand, Abel, Silva, & Desilets, 2012; Hawala-Druy & Hill, 2012). Ten studies from Australia related to First Peoples, however, one evaluated students' attitudes towards cross-cultural care and anti-discrimination in a discrete undergraduate community health course (Ponterotto, Potere, & Johansen, 2002). While some course content centred on First Peoples communities, the course predominantly focussed on people from culturally diverse backgrounds.

According to *The Framework*, use of a theoretical framework is important when teaching First Peoples health content (Department of Health, 2014). For example, to support students' interrogation of discourses that expose power differences (a key concept in this field), a safe learning environment is required (Nicoll, 2004). However, few authors described a framework or philosophically aligned concepts for their course. Two studies utilised the theoretical concepts of cultural safety and cultural security (Thackrah & Thompson, 2013; Thackrah, Thompson, & Durey, 2015). Cultural safety recognises First Peoples as recipients of healthcare and requires students to deconstruct their cultural value systems; whilst cultural security ensures First Peoples' cultural values are central in health service delivery (Thackrah et al., 2015; Thackrah & Thompson, 2013). Kickett, Hoffman, and Flavell (2014) used the concept of 'cultural competency' and 'critical self-reflection' in this space. Some authors synthesised information from literature reviews to inform course content and teaching (Allen, Brown, Duff, Nesbitt, & Hepner, 2013; Pedersen & Barlow, 2008). Another study developed course content based on feedback from a reference group (Ranzijn, McConnochie, Day, Nolan, & Wharton, 2008). More recently, a conceptual framework for building cultural competence (Power et al., 2016), as well as an assessment criteria template for integration in health education (Power et al., 2018) was developed but not yet evaluated.

Increasingly, published studies describe the contribution of Indigenous peoples and/or representatives from cultural groups to course content or as part of the teaching team. Chiodo et al. (2014), for example, invited First Peoples as guest speakers and emphasised the use of literature written by First Peoples authors. Kickett et al. (2014), utilised innovative blended learning pedagogies, such as 'vodcasts' of First Peoples discussing key cultural issues, to ensure First Peoples' perspectives were embedded in course content. Evaluation approaches include quantitative and mixed method studies using a variety of measures, but not all have been tested for validity or report reliability.

Of the ten evaluation studies in the Australian context, none focussed on cultural capability. Some authors measured changes in students' attitudes towards Australia's First Peoples. For example, pre–post course administration of the Attitude Thermometer revealed positive shifts in attitudes by undergraduate psychology (Pedersen & Barlow, 2008) and midwifery students (Thackrah et al., 2015; Thackrah & Thompson, 2013). Another study evaluated a trans-cultural nursing course that aimed to reduce racial discrimination and enhance cultural self-efficacy (Allen et al., 2013). In some evaluations, single items have been used. For example, when evaluating a compulsory course on

First Peoples health in contemporary society, Hunt et al. (2015) asked students three questions related to knowledge, interest and confidence when working with Indigenous Australians. Similarly, Isaacs et al. (2016) asked a cohort of nursing students two questions related to 'cultural desire', and 'being interested in First Peoples health'. While positive attitudes towards First Peoples are important, development of cultural capability extends beyond attitudes and reflects a life-long process of reflection and learning, respectful communication skills, and a desire to advocate for changes in the health system to address inequities (Department of Health, 2014).

The two qualitative evaluations of discrete courses on First Peoples health content revealed challenges. One analysis of written comments by a large sample of health professional students ($n = 745$) found that although most valued course content and found learning experiences engaging, some students struggled with the 'cultural divide'; found the content 'one-sided'; and felt 'victimised' and 'blamed' (Kickett et al., 2014, p. 43). Likewise, in an evaluation of a six-week cultural psychology course on First Peoples and migrant issues, many students reported an increased awareness of cultural matters, but were dissatisfied or disengaged with content (Chiodo et al., 2014).

Our review revealed a relative lack of empirical research evaluating the impact of discrete courses specifically related to First Peoples health. Outcomes were predominantly related to cultural knowledge and competence, cross-cultural understanding, attitudes and perceived confidence to provide care. Many studies included small samples and did not always report on the reliability and validity of measures. Some courses were not underpinned by a clear conceptual framework, did not involve First Peoples lecturers or leadership, or consider appropriate learning and teaching approaches that privilege First Peoples' ways of being, knowing, and doing.

Methods

Design

A First People-led pre–post intervention, cohort design was used.

Participants

A convenience sample of undergraduate health professional students ($n = 297$) enrolled in a 12-week discrete course on First Peoples Health were invited to participate.

Course overview and First Peoples' learning and teaching approaches

The semester-long, mandatory course was offered in mixed mode, using 5 × 3-hour face to face workshops and approximately 10 hours of self-directed learning using online mini-lectures and resources. Course content and teaching approaches were supported by *The Framework*. The course emphasised the attitudes, values, skills and knowledge underpinning each cultural capability (Respect, Communication, Safety and Quality, Reflection, and Advocacy).

All members of the core teaching team were First Peoples academics as well as qualified staff from the Aboriginal and Torres Strait Islander Health Community Controlled Sector.

This collaboration brought a 'real-life' context to student learning and merged both clinical and First Peoples cultural knowledge systems (Nakata, 2007). The teaching team utilised First Peoples' pedagogies (Nakata, 2007) as recommended by *The Framework*. Drawing on the *8 Ways of Learning* (Yunkaporta & McGinty, 2009), First Peoples' realities are privileged and ways of learning integrated using strategies such as: story sharing, learning maps, use of non-verbal symbols and images, deconstruction and reconstruction of information, land links, non-linear approaches and community links. *The Framework* also recommends a partnership approach through team teaching. Team teaching affords a diversity of content, technical, and health professional expertise as well as diverse First Peoples knowledges. First Peoples academics also taught in partnership with non-Indigenous educators. This approach highlighted the principle that First Peoples health is a shared responsibility. Teaching in partnership conveys positive messages to students and assists the 'pedagogy of Aboriginal and Torres Strait Islander curricula to be based on intercultural and collaborative practice principles' (Department of Health, 2014, p. 18).

Critical reflection and reflexivity are fundamental processes outlined in *The Framework*. Reflexivity is an advanced form of self-knowledge and involves critical thinking about what one is experiencing in the moment (Nagata, 2004). Reflexivity is increasingly important within rapidly changing health care environments that require practitioners who can critically reflect, exercise reflexivity, and create the changes needed to improve health care for First Peoples. Both the teaching team and students were encouraged to engage in critical reflection and reflexivity. Teaching team members met weekly to reflect on their own responses and biases, especially when challenging concepts such as racism and white privilege were being discussed in class. Challenging conversations can be uncomfortable for students. This discomfort may be important in the transformative learning experiences of students (Boler, 1999). Critical reflection during class discussions and in assessment pieces enabled students to challenge their assumptions and develop new ways of knowing, being and doing (Dudgeon, Milroy, & Walker, 2014).

Attendance at the face-to-face workshops was high, with 85% of students attending all workshops. The completion of three reflective questions by students at the end of each workshop helped to consolidate their learning and guide the teaching team about areas that may need to be addressed in the next workshop. The online discussion board was used extensively and allowed students to post questions regarding course content, assessments, or other issues which could be answered by peers or the teaching team. There were two formative assessment items. The first was a group presentation. This required students to critically analyse historical policies and how they have influenced contemporary First Peoples health outcomes. The second was an online quiz addressing the understanding of key course concepts. The summative assessment involved an analysis and critical reflection on ways in which the dominant cultural paradigm influenced their life personally, as well as perceptions of, and professional interactions with, First Peoples in healthcare. Assessment pieces were guided largely by the Framework which describes critical analysis, reflection and reflexivity as central tenants when learning First Peoples health content (Department of Health, 2014).

Materials

Online survey

The pre-course survey asked students to provide their personal identification code, demographic information including age, gender, program, and enrolment type (domestic/international), whether they identified as being First Peoples, their ethnicity, and previous education and training in cultural awareness or cultural safety. Students were then asked to complete the 24-item Cultural Capability Measurement Tool (CCMT) at both pre and post course. CCMT items reflect the capability constructs within *The Framework*: Respect (Factor 1); Communication (Factor 2); Safety and Quality (Factor 3); Advocacy and Reflection (Factor 4). Responses are given on a 5-point Likert scale of 1 = strongly disagree to 5 = strongly agree. The CCMT was developed following a staged, decolonising process that centred on First Peoples' knowledges (West et al., 2017) and was recently validated (West, Mills, Rowland, & Creedy, 2018). In the current study, Cronbach's alpha coefficients of 0.82 pre-course and 0.86 post-course indicated good reliability.

Students' experience of the course

As part of the university's quality assurance processes, all courses are evaluated after every offering using a standardised questionnaire. The Student Experience of Courses (SEC) consists of 6 items including 'this course is well-organised', 'teaching in this course engaged me in learning' and 'teaching in this course was effective'. Responses are given on a 5-point Likert scale of 1 = strongly disagree to 5 = strongly agree. Three additional questions specific to this course asked students about the extent to which the course: 'developed my sense of social responsibility'; 'increased my appreciation of the importance of further learning and professional development throughout life'; and 'increased my awareness of and respect for the values and knowledges of Australian First Peoples'. Students could also provide written comments about their course experience and areas for course improvement.

Procedures

Cultural Capability surveys were uploaded to an online platform on the course website in February (pre-course) and June 2017 (post-course) for a two-week period. Students received emails from the course convenor, as well as announcements on the course site, inviting participation. An information sheet was provided and completion of the survey implied consent. In the final fortnight of teaching, students were also invited to complete the SEC through the centrally administered university email system and was anonymous.

Approach to analysis

Descriptive statistics and frequencies were used to analyse age, gender, program of enrolment, and prior training. Negatively worded items on the CCMT were reverse coded. Cronbach's alpha was used to test scale reliability. Scores were calculated for the total scale. Pearson's correlation coefficients tested associations amongst continuous scores. Paired samples t-tests examined differences over time. Eta squared was calculated to

determine effect size. Data were analysed using the Statistical Package for the Social Sciences (SPSS) 22.0 (2014) personal computer version. SEC responses were centrally analysed by the university's survey centre, and results provided to the course convenor as part of routine course evaluation. It was not possible to match SEC responses with the Cultural Capability surveys.

Ethical considerations

Ethical approval was granted by the Institution's Human Research Ethics Committee. The centrality of First Peoples' perspectives was maintained using processes described by West et al. (2017). A researcher not associated with the course analysed all responses in a group format to maintain confidentiality.

Results

Sample characteristics

Pre–post survey responses were matched using students' unique identification code. Eighty-seven surveys could be matched, giving a response rate of 29.3%. One hundred and thirteen students (out of 297) completed the anonymous SEC post-course survey, giving an overall response rate of 38%. Mean age of participants was 25.8 (SD = 8.01, range 17–49). Participant characteristics are presented in Table 1. Students were enrolled in 14 different degree programs with most enrolled in the

Table 1. Participant characteristics ($n = 87$).

Characteristic	*N* (%)	Mean (SD), range
Age		25.8 (8.1), 17–49
Gender		
Female	79 (90.8)	-
Male	8 (9.2)	
Program		-
Nursing	26 (30)	
Occupational Therapy	16 (18.4)	
Health/ Biomedical Sciences	14 (3.5)	
Midwifery	10 (11.5)	
Oral Health	6 (2. 9)	
Other *	15 (17.2)	
Ethnicity		-
Caucasian/Australian	64 (73.6)	
Asian	4 (4.6)	
Middle Eastern	6 (6.9)	
First Peoples	2 (2.3)	
Other	13 (14.9)	
Enrolment		-
Domestic	81 (93.1)	
International	6 (6.9)	
Completed prior cultural safety education		-
Yes	13 (14.9)	
No	74 (85.1)	
Completed university online First Peoples cultural awareness module		-
Yes	17 (19.5)	
No	70 (80.5)	

Bachelor of Nursing (30% $n = 26$) followed by Bachelor of Occupational Therapy (18% $n = 16$). Most participants (90.8% $n = 79$) were female and enrolled as a domestic student (93.1% $n = 81$). Students were from a range of ethnic backgrounds, the most common being Caucasian/ Australian (69% $n = 64$), with 2.3% ($n = 2$) reporting a First Peoples background.

Prior cultural safety training

Most students ($n = 74$) had not undertaken any education on First Peoples health prior to commencing the course. Sixteen students had completed the one-day 'Cultural Practice Program' offered online by the State Health Department and the one-hour First Peoples Health and Practice online training module ($n = 17$) offered by the University.

Cultural capability Measurement tool

Paired samples t-tests evaluated course impact on students' perceptions of cultural capability using total and individual item scores. There was a statistically significant increase in CCMT mean scores from baseline ($M = 92.4$, SD = 8.9) to post-course ($M = 103.25$, SD = 9.6), t (86) = 10.75, $p < .001$ (two-tailed). The mean increase in scores was 10.85, 95% CI [8.84, 12.86] indicating a large effect ($\eta^2 = 0.57$) (Table 2).

Students' evaluation of the course

Overall, students reported being satisfied with the course ($M = 4.1$, SD = 0.96). Student responses to additional course-specific items revealed a high sense of responsibility ($M = 4.4$, SD = 0.97); appreciation of the importance of life-long learning ($M = 4.3$, SD = 1.06); and awareness of and respect for the values and knowledges of First Peoples ($M = 4.5$, SD = 1.02) (Table 3). When considered with the CCMT scores, course evaluation scores reflect a positive transformation in students' views, as do many of the qualitative responses. For example, one student wrote:

> *I loved the way the course explored the socio-cultural, historical, political and dominant cultural paradigms that influence First Peoples' health today. It forced students to confront the state of First Peoples' health today and look deeper into why things are the way that they are.*

However, some written feedback reflected a struggle with First Peoples Health content. Themes included: being unsure of course relevance to the student's overall program; feeling guilty/blamed and resentful; and questioning the omission of other cultures. One student wrote:

> *This course has good content, but it should not be compulsory for my degree, as it is barely relevant (paramedicine). It should may be classed as a "seminar" course and worth half the credit points and be half the cost of a normal course, with a slightly reduced workload.*

Two students expressed some guilt and resentment when they wrote:

Table 2. CCMT item means at pre and post course.

Factor and Item	Pre-course mean on 5 point scale (SD)	Post-course mean on 5 point scale (SD)
Factor 1: Respect		
1. Understanding Australia's colonial history impacts on First Peoples health	4.11 (0.66)	4.63 (0.51) *
3. Understanding First Peoples cultural values will influence how I practice	4.18 (0.72)	4.57 (0.60) *
4. Understanding First Peoples social practices impacts on my practice as a health professional	4.11 (0.64)	4.48 (0.71) *
9. Reflecting on my own cultural values and beliefs will impact on my ability to practice in a culturally safe way as a health professional	3.80 (0.96)	4.44 (0.76) *
13. Improving First Peoples health is the responsibility of all health professionals	4.25 (0.74)	4.60 (0.58) *
15. I have a responsibility to challenge the ways things are done in health practice	4.11 (0.72)	4.39 (0.71) *
16. My relationship with First Peoples can impact on their clinical outcomes	4.30 (0.78)	4.63 (0.61) *
17. A holistic approach to First Peoples health is important.	4.33 (0.73)	4.76 (0.43) *
23. Equity is treating everyone the same[a]	2.36 (1.19)	3.46 (1.43) *
Factor 2: Communication		
7. Understanding First Peoples cultural beliefs impacts on my practice as a health professional	4.05 (0.76)	4.43 (0.74) *
8. I feel comfortable working with First Peoples	3.85 (0.86)	4.28 (0.76) *
11. I am confident in my ability to communicate in a culturally safe way with First Peoples	3.34 (1.02)	4.22 (0.71) *
21. I am aware of the need to be culturally inclusive towards First Peoples	4.00 (0.74)	4.54 (0.57) *
22. I have a social responsibility to work for changes in First Peoples health	3.90 (0.81)	4.40 (0.71) *
Factor 3: Safety and Quality		
2. Understanding Australia's colonial history impacts on my practice as a health professional	3.90 (0.78)	4.51 (0.59) *
5. In order to improve First Peoples health, First Peoples cultures need to be visible in clinical and community health settings	4.15 (0.79)	4.51 (0.3) *
10. Awareness of cultural differences is the first step to becoming culturally safe	4.31 (0.58)	4.57 (0.56) *
12. Comprehensive primary health care services are fundamental to improving First Peoples health.	4.06 (0.74)	4.37 (0.63) *
14. Research evidence can help me practice as a health professional in First Peoples health	4.16 (0.66)	4.30 (0.72)
Factor 4: Reflection & Advocacy		
6. There may be few exceptions but in general First Peoples are all the same[a]	3.72 (1.03)	3.80 (1.36)
18. All First Peoples are treated equally by health professionals[a]	3.28 (1.24)	3.41 (1.37)
19. First Peoples have the same level of access to health services as all other Australians[a]	3.64 (1.15)	3.67 (1.25)
20. I understand how to advocate for improvements in First Peoples health	2.67 (0.87)	3.93 (0.80) *
24. I intend to work for changes in First Peoples health	3.82 (0.74)	4.36 (0.68) *
Total CCMT Score	92.4 (8.95)	103.25 (9.59)

*Significant difference on paired samples t-test at $p < 0.05$.
[a]Reverse coded items.

> *It makes you feel guilty for being white which is a little unfair. In today's society, we have been raised to treat every as an equal but by having this subject as mandatory it's just reinforcing that we need to feel guilty and that we shouldn't be happy with ourselves. (Student A)*

Another student wanted the inclusion of other cultures and wrote:

> *I understand why there is such a need for a focus on First Peoples, but perhaps expanding the course to include other cultures, even if just touched on.*

Table 3. Student Experience of Courses (SEC) survey.

Item	Post-course mean on 5 point scale (SD)
1. This course was well-organised.	4.1 (0.97)
2. The assessment was clear and fair.	3.7 (1.09)
3. I received helpful feedback on my assessment work.	3.7 (1.12)
4. This course engaged me in learning.	3.9 (1.10)
5. The teaching (lecturers, tutors, online etc.) on this course was effective in helping me to learn.	4.0 (1.22)
6. This course has developed my sense of social responsibility (e.g., social and civic responsibilities, human rights or sustainability).	4.4 (0.97)
7. This course increased my appreciation of the importance of further learning and professional development throughout life.	4.3 (1.06)
8. This course increased my awareness of and respect for the values and knowledges of Australian Aboriginal and Torres Strait Islander First Peoples.	4.5 (1.02)
9. Overall I am satisfied with the quality of this course.	4.1 (0.96)

Discussion

Evaluation of this discrete First Peoples health course aimed to examine the development of students' cultural capabilities and their experience of the course. Producing culturally capable graduates is essential for the delivery of culturally safe care to First Peoples communities. Unlike some previous studies (e.g., Thackrah et al., 2015; Thackrah & Thompson, 2013), a valid and reliable tool was used to measure change. CCMT items reflect *The Framework* capabilities which were also addressed in course content and assessment. This alignment between course content, assessment and impact evaluation aimed to establish synergies amongst key concepts for students and reinforce their understanding of cultural capability.

The concept of 'capability' offers a holistic approach to identifying and assessing behaviours and understanding, and moves beyond the application of a knowledge and skill set. Cultural capability is future focused, requires students to actively engage in learning and reflection, and is a life-long learning process (Snook, Nohria, & Khurana, 2011). The course encouraged students to explore the historical, socio-cultural, political and dominant cultural paradigms that influence First Peoples health today as reflected in Factor One (Respect). There was a significant change from baseline to post course scores on all items in this factor indicating that students gained a better understanding of the adverse impact of Australia's colonial history on First Peoples health and the need to respect difference.

The course aimed to promote cultural awareness which is the beginning step towards understanding that there is difference. Items in Factor Two (Communication) and Factor Three (Safety and Quality) are particularly relevant for health professional practice. During the course, students were asked to reflect on ways they acted on and legitimised difference through understanding, accepting, respecting and validating (known as cultural sensitivity). Furthermore, students explored elements of cultural safety and how they could create caring interactions in their practice that reflect shared respect, meaning, knowledge, experience of learning together with dignity and empathic listening. Once again, the majority of student responses on these CCMT items demonstrated positive change after the course. Although there was no difference on item 14 which asked about the role of research evidence in First Peoples health practice, this was because

students agreed strongly with this statement both prior (item mean 4.16) and after the course (item mean 4.30).

There was less consistency in responses on Factor Four (Reflection and Advocacy). According to *The Framework*, development of cultural capabilities requires students to critically reflect on their own culture and consider these insights from the perspective of the dominant cultural paradigm and their health discipline (Department of Health, 2014). Adopting a 'critical reflective' lens is difficult, requiring students to explore their own identity and power associated with their social positioning (Department of Health, 2014). The challenges experienced by students were also reflected in written comments on the SEC.

Emotional responses such as anger and guilt were evident. This finding is consistent with those of other researchers teaching in this space (Thackrah et al., 2015; Thackrah & Thompson, 2013). Exposure to previously unknown historical events and information about the ongoing socio-economic and health disparities between First Peoples and non-Indigenous Australians can be extremely confronting for students (Ramjan, Hunt, & Salamonson, 2016). Undertaking critical and reflective learning processes where students are challenged to question their preconceived ideas about First Peoples while also unpacking assumptions about their own identity and privileges in society can lead to discomfort (Boler, 1999).

Students experiencing strong emotions in response to course content may not be willing to accept these challenging learning processes (Schick & St Denis, 2003) and educators may experience resistance. Student discomfort and resistance can manifest as lack of engagement with content, vocal resistance in class, as well as feelings of shame and guilt (leading to withdrawal), anger, or ambivalence. It is the discomfort, however, that holds considerable potential for taking students through transformative learning experiences. Boler (1999) argues discomfort can be a transformative teaching and learning strategy, rather than a traumatic experience, and a 'call to action' in students' learning.

Success of the First Peoples Health course in developing students' cultural capabilities could be attributed to various factors. The course was aligned with the guiding principles of *The Framework* therefore ensuring a purposeful approach to course content, teaching approaches and assessment. Another factor could have been commitment by the Unit Director to recruit a teaching team that included First Peoples and non-Indigenous members (Universities Australia, 2011). Careful consideration was given to planning and delivery of the course which was acknowledged by students' high SEC scores. The partnership approach to teaching acknowledged that the core teaching team did not hold expertise in all areas of First Peoples health or across different health professional disciplines. Specifying limits around teaching expertise is important as a common misconception by non-Indigenous students is that First Peoples academics know 'everything' about First Peoples.

Thackrah et al. (2015) found that although the inclusion of a discrete course on First Peoples health in an undergraduate midwifery program enhanced knowledge and shifted attitudes towards Aboriginal people in a positive direction, these gains were not sustained. Thackrah et al. (2015) recommended vertical integration of content and reinforcement of key concepts throughout the program. In that course, additional midwifery-specific First Peoples content related to pregnancy and birthing-on-country may provide opportunities for future curriculum development.

From an organisational perspective, *The Framework* specifies the importance of monitoring and reviewing its implementation. Incorporation of the CCMT into course evaluation processes will ensure the ongoing quality of the course to meet students' needs and that teaching and learning approaches are rigorous, specific, and evidence-based (Rigney, 1999).

Limitations

This study aimed to evaluate a discrete course using reliable tools to assess course impact and development of students' cultural capability. Although matching participants' responses was a strength, a relatively small sample was obtained as many surveys could not be matched. The sample was also recruited from a single program at one university, limiting generalisability. Sampling bias is also likely because results obtained from these students may differ from those of students who did not wish to participate. Although validated, the CCMT is relatively new and needs to be tested further with large diverse samples of undergraduate health professional students.

Recommendations

In line with the recommendations of Thackrah and Thompson (2013), content on First Peoples health and cultures needs to extend beyond one course in a program of study. Learning and knowledge must be carefully integrated to maximise understanding. The evidence of 'discomfort' revealed in the current study should prompt other educators in this field to ensure that unresolved issues such as guilt or anger are addressed before completion of the course. Further research could investigate the effectiveness of debriefing strategies at the end of a class to help resolve feelings, enhance students' insights and facilitate new learning. Research on pedagogical interventions that encourage students to not only critically reflect on their emotions but be transformed by them towards cultural safety may also be important.

Collaborative engagement and partnership with a First Peoples community would benefit and enhance the quality of the student experience and their understanding of how First Peoples culture, cultural competence, cultural safety and Indigenous history, shape health and healthcare (Hunt et al., 2015). This could be achieved through increasing the number of First Peoples clinical placements, and First Peoples lecturers. Further, inviting First Peoples guest speakers, community members and elders to share their experiences with students in the learning environment and be involved in curriculum development at all levels could enrich students' transformative experience.

Conclusions

Few studies have evaluated the impact and quality of a discrete First Peoples course in undergraduate health professional programs. Research rigour was enhanced by our First People-led, pre–post intervention, matched cohort designed study, and the use of a reliable and valid tool. The significant increase in CCMT scores indicated promising results for the course in improving students' understanding of factors influencing First Peoples health, as well as their sense of cultural capability. Students' evaluation of

course quality revealed a high level of meaningful satisfaction, but also 'discomfort' with some content and processes. Our application of *The Framework* in course content, assessment and evaluation was novel, and provided a platform for future research on education interventions to develop a culturally capable health workforce.

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