Charles Sturt University

Report

Cultural Competence: the health sciences journey

Report and Recommendations for Faculty of Science

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Contents

Introduction

This report will focus on my learning as a teaching/research academic within the Faculty of Science at Charles Sturt University (CSU). As agreed through my SSP outcomes, this report will provide a narrative on how we can move forward as a faculty in the area of cultural education.

The purpose of this Special Studies Program (SSP) was to support the School of Nursing, Midwifery and Indigenous Health (SNMIH) – and, by association, the Faculty of Science (FOS) and Charles Sturt University (CSU) – to more comprehensively implement and evaluate achievement of the recommendations of the CSU Indigenous Education Strategy (IES). This includes the achievement of higher levels of Indigenous cultural competence for students and staff alike.

Why I am interested in cultural competence?

I began my nursing career working in metropolitan and regional hospitals in neurological, intensive care, medical, surgical, nuclear medicine and Justice Health. Importantly, my early experiences in mainstream healthcare, led me to notice that healthcare isn't responsive to the needs of ALL Australians. I observed the inherent racism that was evident in health services. As a new graduate nurse, I remember sitting at a nurse's station listening in silent horror to nurses sharing 'jokes' that involved Aboriginal people. As someone who was dating (and is now married to) a man who is Aboriginal, I was appalled but also deeply interested. I wondered how racism existed in my profession …. a profession that 'cared'. Situations like this scenario made me reflect on my own practice and consider the biases that influenced my nursing and impacted clients. These situations sparked my interest in cultural competence in healthcare and helped me find my voice (I now work hard to not be a 'bystander' to racism).

These early career situations shaped my professional identity and nourished my interest in people, behaviours and how culture influences care. This then led to my enrolment in a higher degree by research study. In 2017, I completed my PhD, a phenomenological study looking at cultural competence development across a cohort of students within a Bachelor of Nursing degree – “Indigenous Australian Cultural Competence and Nursing".

After teaching subjects focused on Indigenous Australian healthcare, I noticed that often the pedagogical focus of teaching and learning was geared towards the deficit model. To me, this didn’t align with my personal or professional values and lived experiences. This model isn’t sustainable or successful (Sherwood, 2013). The onus of responsibility should not be on the patient, instead it should be geared towards the clinician. How can the clinician adapt to suit the needs of the client/community, rather than how can the client adapt to suit the needs of the health professional? Coupled with my personal experiences raising two girls it was clear that we needed to learn from history, consult, collaborate, respect and reorientate our focus to a strengths-based approach.

Between 2017-2019, I co-edited a textbook with 25 authors inclusive of community members. We were privileged that community members bravely shared their stories. In fact, each case study in the text is a real-life story. Some case studies have used pseudonyms to protect the privacy of individuals. What became evident was that the real-life experiences of community members could guide best practice in higher education within healthcare courses and that meaningful consultation impacted learning and teaching experiences.

In addition, during the creation of the textbook it became evident that there was much interest in cultural competence outside of academia. To be accessible to local health districts, community-controlled organisations and community members' information must be presented in a quick accessible format that complemented the busy lives of regional people. SSP has provided me with the opportunity to explore online cultural competence. Cultural competence is not only my research passion but also a major focus of CSU's core business.

My limitations

Importantly, working at the interface requires deep and consistent self-reflection. It is imperative that I ensure that I am being authentic, true and honest, working towards understanding and living the Wiradjuri philosophy of *Yindyamarra*. As a white woman with marriage links to the Murrawarri Nation, I strive to understand and give honour to all people (Sullivan, Grant & Grant, 2016). Yet, I am also very aware of my "whiteness" and how this influences my understandings and indeed all facets of this report.

Itis important to note that my philosophical positioning in the world is responsive to the notion of there being multiple truths and multiple realities (Crotty, Willis & Neville, 1996) with truth being value bound by relationships. My values and personal experiences go with me into my professional world and impact how I interpret and construct new truths (Ajjawi & Higgs, 2007). This has influenced my interpretations throughout my special study program.

My SSP

This program of study was designed to enable the development of stronger collaborations and links with key external academics and between Aboriginal and Torres Strait Islander stakeholders; and to raise the profile of CSU in the community generally as a force working 'for the public good'.

On a more personal level, the program was designed for my own professional development as an early career academic with a strong commitment to CSU. For example, I recently completed my PhD at CSU, focusing on the factors that influence BN students' journeys in developing Indigenous Australian cultural competence. My research findings gave rise to a model of student learning in relation to Indigenous Australian cultural competence. I developed this SSP to further strengthen my capacity to support students and staff alike in this important area of online teaching and learning. It is important to note my recent work undertaken as the Associate Head of School in the SNMIH. In addition to developing my leadership capabilities, my focus when in the role of Associate Head 'Students', included examining ways and means of addressing student attrition and improving the student experience, particularly for students who are enrolled online. My work in this area included my leadership of a HEPPP funded project, which implemented a range of strategies to support students from lower socio-economic backgrounds. This program of study (SSP) was designed to enable me to address learnings generated from that project and thereby achieve better outcomes for students.

The SSP had two overarching objectives:

Objective 1: Collaboratively evaluate the efficacy of incorporating Indigenous content into a CSU graduate entry to practice program, the Graduate Diploma of Midwifery

The current CSU Graduate Diploma of Midwifery (GDM), delivered by the SNMIH, is an externally accredited graduate entry to practice program that began taking enrolments in early 2019. The GDM, which is offered fully online, comprises a standalone Indigenous Australian subject, with Indigenous Australian content also embedded throughout. The efficacy of this approach to supporting the development of Indigenous cultural competence for CSU GDM students remains unknown.

I worked collaboratively with key academics at Griffith University to evaluate the cultural capability of the CSU GDM, using an assessment tool developed and validated by Griffith University (West et al., 2007). The project aligns with a much larger Griffith University study.

Reportable outcomes of Objective 1 include:

- Partially address CSU IES Recommendations 25 and 26, with a focus on the SNMIH and FOS;

- Provide an evidence-based methodological approach to assessing the cultural capability of a key CSU health program;
- Provide an evidence-based methodological approach to evaluating the efficacy of embedding Indigenous Australian content in a key CSU health program;
- Use learnings to assess and evaluate other CSU programs for cultural capability and efficacy of embedding Australian Indigenous content, in the future;
- Build on emerging links between CSU and Griffith University related to the evaluation of the cultural capability or efficacy of embedding Indigenous Australian content in tertiary-level courses;
- Complete and submit a research journal publication, outlining findings of the project;
- Start working towards a collaborative (CSU and Griffith University) competitive research grant submission in 2021;
- Strengthen my capacity to inform culturally competent curriculum design at CSU;
- Support my professional development as an early career researcher at CSU.

Objective 2: Build networks between CSU and key external stakeholders, with a focus on building research capacity in the area of online learning in cultural competence

There are several peak academic bodies, nationally and internationally, that support the important work that is being undertaken in the area of cultural competence. These include:

- The National Centre for Cultural Competence (NCCC), which operates from the University of Sydney and provides strategic guidance and leadership on cultural competence to various stakeholders across Australia. For example, the Australian NCCC facilitates understanding of Universities Australia's interpretation of the term 'Cultural Competence'.
- The US National Center for Cultural Competence (NCCC), which operates out of Georgetown University. The aim of the US NCCC is to increase the capacity of healthcare and mental health care programs to design, implement, and evaluate culturally and linguistically competent service delivery systems. This work is undertaken to address growing diversity, persistent disparities, and to promote health and mental health equity.

Specifically, in 2019, the SNMIH undertook a scoping review of progress rates and attrition in the Bachelor of Nursing (BN) degree. It was identified that currently the BN has a 47% online attrition rate for learners who identify as Aboriginal or Torres Strait Islander people. A number of researchers have demonstrated that culturally responsive curriculum leads to the retention of Aboriginal and Torres Strait Islander learners (Usher et al., 2005; Gore et al., 2017). This provides good reason to ensure that online curricula developed by CSU are contemporary and evidence-based. As an invited Zoom guest at the National Centre for Cultural Competence Australia and America, my knowledge and expertise in the area of cultural competence has grown. From this, I committed to develop an implementation plan for building online cultural competence for the Faculty of Science (the basis of this report). Developing online opportunities for cultural competence is nuanced. This will be discussed further on page 32.

Methodology

My program of study was largely exploratory. Initially I focused my time conducting a scoping review of evidenced-based literature and practice documents relating to cultural competence. From this initial review, a snowball approach (Liamputtong, 2012) was deemed useful in ensuring that new knowledge was acquired through both literature/practice exploration and advice/wisdom from key scholars. All methods were aimed at enhancing my understanding in cultural competence online development. This knowledge was synthesised and translated into this report. It is important to note that the literature was synthesised and is nuanced to my understanding the Faculty of Science, CSU. Therefore, the findings may not translate to other faculties or higher education institutions. Importantly, in my exploration is was clear that online education cannot be separated from institutional approaches to cultural competence, therefore some recommendations moved beyond online learning. Where possible, during my exploration, gaps in knowledge were leveraged to a grant application and funding sought (see appendices 1 & 2). The body of this report will describe and interpret my understanding and then provide recommendations for the Faculty of Science in relation to cultural competence online development. The interrelationship of key points is an important when reading this report.

What we know about the healthcare gap

It is known that there is a significant gap in morbidity and mortality between Aboriginal and Torres Strait Islander people and non-Indigenous Australians (Australian Institute of Health and Welfare, 2015). Accessing mainstream healthcare has been challenging and attests to the indirect and direct racism expressed by healthcare professionals to Aboriginal and Torres Strait Islander clients. This is cited as being a major inhibiter to service access (Clifford, McCalman, Bainbridge, & Tsey, 2015) impacting many Aboriginal and Torres Strait Islander people's health outcomes. Since early 2000, tertiary education systems within Australian have recognised the benefits of embedding cultural competence education within professional courses (Universities Australia, 2011). At Charles Sturt University this is complemented by a focused Indigenous Education Strategy (CSU, 2017) with all Aboriginal and Torres Strait Islander content governed by the Indigenous Board of Studies (CSU, 2012). In the healthcare curriculum, this is also supported by The Aboriginal and Torres Strait Islander Health Curriculum Framework (Commonwealth, 2016) and a variety of learning interventions that have been attested to support the learning journey of students in healthcare (Bertilone, McEvoy, Gower, Naylor, Doyle & Swift-Otero, 2017; Clifford, McCalman, Bainbridge, & Tsey, 2015).

Cultural competence and healthcare

To understand cultural competence, it is important to consider where cultural competence was first developed and why. The term first emerged in the 1980s in the USA. It was particularly prevalent with teachers and social work, health and welfare workers as they were seeking ways to better meet the needs of multicultural communities. Although the term has been used within literature for some time, the implementation of cultural competency skills, capabilities and behaviours has been varied.

In the context of health, there is evidence that people from ethnic and racial minorities experience significantly poorer health outcomes than people from the majority/dominant culture (Betancourt, 2003; Brach & Fraser, 2000). While a range of biomedical models have explored why this may have occurred, it has taken time to shift our thinking from the 'problem patient' to the responsive clinician. For example, what

we "*do, say, be*" impacts each individual client. As clinicians we make choices within the structures of our workplace to respond or not respond to individual cultural, spiritual, social and physical needs. A vast amount of literature about cultural competence has been generated mainly from the USA and Canada (Truong, Paradies & Priest, 2014; Clifford, McCalman, Bainbridge & Tsey, 2015), with an increasing body of work from Australia.

The literature indicates that while the term is used frequently, there remains confusion over the definition. Within healthcare, although a consensus has not been reached over the definition of 'cultural competence', many definitions share key elements (Betancourt, Green & Carillo, 2002). These elements include but are not limited to the following: valuing diversity; having the capacity for cultural self-assessment; being conscious of the dynamics inherent in cross-cultural interactions; institutionalising the importance of cultural knowledge; and making adaptations to service delivery that reflect cultural understanding (Humphery, 2000; Ranzijn, McConnochie, Day, Nolan & Wharton, 2008). In other words, there are many models that suggest ways that nursing and allied health practitioners can become more culturally responsive.

The language/terminology of cultural competence has been contested. The very nature of the language assumes that the journey and learning have an end point (competence) and requires certain parameters to be obeyed. However, more recent models within Australia have indicated that cultural competence does not have an end point, and nor is it linear—instead, it is reliant on skill attributes and transformative learning. It has been shown that the journey of cultural competence is complex, occurs across a career and stimulates a change in an individual's viewpoint (Biles, Coyle, Bernoth & Hill, 2016). There are many ways that one can learn cultural competence skills, behaviours and attitudes. What seems to be common across the literature is that the cultural competence needs to be viewed as a journey that may never reach an end point (Hains, Lynch & Winton, 2000).

Models of cultural competence

There are many ways that one can learn how develop culturally responsive skills and behaviours. Models have been developed over time to assist in the delivery of cultural education within undergraduate degrees. These models can focus on individual approaches as well as institutional approaches in the journey of cultural competence (Cross, Bazron, Dennis & Isaacs, 1989; Campinha-Bacote, 2019.

Other western nations such as the United States and Canada have nuanced perspectives on cultural competence. These models emphasise that the development of cultural competence involves a two-way learning process between the organisation and the individual—that is, the nurse or allied health professional and/or client or health service and employee (Campinha-Bacote, 2002). Cultural competence is much more than awareness; it is a philosophical approach to healthcare that influences the delivery of health services (National Health & Medical Research Council, 2005).

Recent research in Australia has indicated that cultural competence training has resulted in an increased preparedness to work with Aboriginal people (Paul et al., 2006; McRae, Taylor, Swain & Sheldrake, 2008), a greater understanding of health challenges for Aboriginal and Torres Strait Islander people (Mooney, Bauman, Westwood, Kelaher, Tibben & Jalaludin, 2005) and improved relationships between Aboriginal and Torres Strait Islander people and non-Indigenous Australians, all of which can enhance access to services (Si, Bailie, Togni, Abbs & Robinson, 2006). Education of Australian health professionals in cultural competence is believed to be paramount (Hunt, Ramjan, McDonald, Koch, Baird & Salamonson, 2015).

One trigger for embedding cultural competence in Australian health courses is in response to high levels of racism within the Australian healthcare system. Racism causes illness, cost the Victorian health system over $39 billion across a six-year period and 75% of the general population of Australia cites a negative bias towards Aboriginal and Torres Strait Islander people (Elias & Paradies, 2016; Paradies et al, 2015; Shirodkar, 2019). This is an impetus to rethink how we prepare undergraduate students for healthcare professions.

Professional bodes play a key role in the development and understanding of cultural competence (Ranzijn et al., 2008). For example, the Australian Nursing & Midwifery Accreditation Council (2015) has mandated the inclusion of a core subject in all undergraduate Bachelor of Nursing courses. It can be argued that the inclusion of a core subject requires educators to be on a journey of cultural competence. Achieving this requires support at an organisational level (Grote, 2008), an area that many universities are still striving to achieve. In addition, cultural safety is now a mandated requirement for all health professionals and health districts (APHRA, 2020).

Changing the narrative

In health, we have some insight into methods to improve access and participation of Aboriginal and Torres Strait Islander people in healthcare. For example, the mainstream health Inala Clinic (https://www.health.qld.gov.au/iihs/publications) through extensive community consultation and culturally responsive patient care, was able to increase consultation rates from 12 patients per year to 4000 patients (Hayman, 2010). Initiatives were not focused towards "fixing" the client but on **preparing health workforce with the practise tools that empower clients**. This has resulted in healthier communities and is an example of making a significance difference in healthcare experiences through systematic change. This approach took the clinic about nine years but the impact is lasting and an example of how mainstream approaches can adapt and change to respond to the needs of communities.

In higher education, our ultimate goal is to retain Aboriginal health students and prepare the future healthcare workforce to be culturally responsive and safe. This means we need to focus on building culturally capable opportunities for professional growth and a responsive institution that hosts empirically validated culturally responsive health curricula. At CSU, we are still on the road to translating this in sustainable and cost-effective ways that maximise community and students as partners.

Cultural competence in healthcare: our learning from 2017-2020

It was important to immerse myself in current literature to gain an understanding of our learning over the past three years. This paper has been accepted for publication and helps position evidenced based literature from 2017-2020.

Background

Contemporary Australian models of cultural competence in nursing are increasingly adopting the New Zealand approach to culturally safe practice where clinicians understanding power differentials are at the forefront (Australian Institute of Health and Welfare, 2019). Carberry (1998), writing from an Australian nursing perspective, suggests that competency alone is dangerously insufficient. She contests that the way

to being culturally safe through the nurses' competence in delivery of cultural care is foundationally flawed through the power imbalance between nurse and client. The mere fact that individuals can be excluded from health professional expert knowledge and 'othered' (p. 10) suggests that models need to move beyond being "safe".

The education of Australian professionals in cultural competence is believed to be paramount (Hunt et al., 2015). More recent research in Australia has indicated that cultural competence training has resulted in preparedness to work with Aboriginal people (Paul et al., 2006; McRae, 2008; Hunt et al., 2015; Biles, 2017), understanding of health challenges (Mooney et al., 2005; Biles, 2017) and improved relationships between Indigenous Australians and non-Indigenous Australians, all of which can enhance access to mainstream service care (Si et al., 2006). The onus of cultural competence is largely directed to educators providing learning opportunities to prepare health professionals for delivering their services in culturally appropriate ways rather than on individual leadership of health professionals. Further, Australian understanding in cultural competence is largely directed towards Indigenous Australian cultural competence.

Of notable interest is that culture is not static making models depicting a static end point as problematic. . More recently, this has been further explored by Universities Australia (2012) adding that the incorporation of institutional cultural competence as paramount in the development of undergraduate professionals. Steady progress has been made in implementing policy and frameworks regarding cultural competence in Australia but the impact of such is yet to be determined.

Internationally, cultural competence is generally perceived in healthcare as a five-step process that is not static or linear and expands well beyond a monoculture and involves health equity more broadly (Yee, Breslin, Goode, Havercamp, Horner-Johnson, Iezzoni, & Krahn, 2018). Cultural and linguistic competence is seen as vital to a large body of professionals across America, the United Kingdom and Canada (Haywood, Goode, Gao, Smith, Bronheim, Flocke, & Zyzanski, 2012; Papadopoulos, 2011; Aboriginal Nurses Associate

of Canada, 2009). Initiatives are tested using a variety of tools with the Camphina-Bacote instrument being the most widely cited in health professional research.

Despite such approaches, health outcomes remain imbalanced in most major developed nations. Minority populations have poorer health and racism towards clients is being increasingly reported (United States Department of Health and Human Services, 2020; Australian Institute of Health and Welfare, 2019). With cultural competence education spanning further than 40 years it raises questions about its application and evidenced-based approaches. Therefore, this review has focused on identifying what has been evidenced via peer reviewed publications in the area of cultural competence in healthcare over the past three years with the view of seeking an understanding of where our knowledge has been reported and areas that require research focus.

Search Strategies

The following journal databases and websites were searched – CINAHL (Ebsco), Medline (Ovid), Health Collection (Informit), Primo Search and Libraries Australia (for updated texts), Australian Indigenous Health Infonet, using the keywords “cultural competence*”, Indigenous, Australia*, education, health, nurs*, students, Subject Headings: (Cultural Competence OR Cultural Sensitivity – Education), Indigenous Peoples Australia, (Education – Nursing OR Transcultural Nursing) and Medical Subject Headings (MeSH): Cultural Competency, (Oceanic Ancestry Group OR Australia), Education (exploded). Grey literature was not excluded in the initial search to ensure a comprehensive evaluation of lessons learnt in higher education could be executed. This resulted in a total of 37 peer reviewed articles, four books and one report. Literature reviews and text were excluded to ensure that evidenced approaches were at the forefront of the exploration. In line with qualitative approaches this integrated review sought to identify common, rich trends in each paper that were unearthed through rigorous evaluation of content and meaning (Polit & Beck, 2019). Through a process of thematic analysis, the following themes emerged: Values, Teaching and learning cultural competence, Measuring cultural competence and Pedagogical approach to cultural competence. While the search strategies incorporated health and nursing, an overwhelming portion of research was driven from the nursing discipline.

Findings

Teaching and learning cultural competence

Teaching and learning cultural competence have been reported in a number of research projects over the past three years. Largely, approaches are based on encouraging student reflective exercises and immersive experiences (Merritt, Savard, Craig & Smith, 2018; Gower, Dantas, Duggan & Boldy, 2018). More novel approaches include Bennett, Hamilton and Rochani (2019) who discuss the challenges faced by academic teaching racial inequalities within nursing degrees. Their research spoke of the ART acronym (Affirmation, Reflection, Teachable moment, and Summary) and evidenced its success. Through affirming students' willingness to discuss important and sensitive subjects and then reflect the emotion of the experience enabled teachable moments. This was then followed by a summary to reaffirm the learning experience. . They discuss that nursing academia in America is largely made up of white women who lack skills in building a safe environment to discuss racial inequalities. Building on case studies and personal experiences is seen to be imperative to student teaching and learning (Bennett, Hamilton & Rochani, 2019).

Immersive experience are evidenced as generating impact to cultural competence development for both staff and students (Merritt, Savard, Craig & Smith, 2018; Gower, Dantas, Duggan & Boldy, 2018). The duration of programs influences learning with short programs generating no influence at all in medical programs (Gower, Dantas, Duggan & Boldy, 2018) and longer, immersive experiences generating more meaning, however, they also require significant pre-immersive education and training for cultural shift to be lasting (Merritt, Savard, Craig & Smith, 2018).

The incorporation of case studies seems to be a common thread across many disciplines and case studies are also often seen as a way to measure the cultural capability of the approach (Kiersma et al. 2013; Hogan, Rossiter & Catling, 2018). Further exploration of how community groups can influence/drive case study development should be the future focus of teaching and learning in this area.

Measuring cultural competence

While Universities Australia (2012) mandated the inclusion of cultural competence in all undergraduate courses, we have seen little published research that the impact of the content is being rigorously evaluated. In America, popular measurement tools include the Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals – student version IAPCC-SV© (Campinha-Bacote, 2009; Bryne, 2020). Using a mixed methodological approach, Bryne (2020) cited that nursing students learning in cultural competence using simulation versus traditional lectures was reportedly no different and cited student learning to be at a point of being cultural aware. The same inventory tool was used in two unlinked nursing cohorts in Australia to assess student learning during an international placement highlighting a marked difference in many aspects with the exclusion of cultural desire (Choi & Kim, 2018; Gower, Duggan, Dantas & Body, 2019) cementing the importance of behaviours in cultural competence development. In an American study focused on pre and post cultural competence development after an international immersive experience using the same tool as the Australian studies indicated an overall increase that was maintained one year post the experience (Roller, & Ballestas, 2017) raising interesting considerations about the role of curriculum and pedagogical approaches.

An Australian study focused on the role of empathetic cultural competence in midwifery students. Using the Jefferson scale of empathy, a pre and post study indicated that empathy levels increased immediately after students completed the module and then decreased one month post but still remained higher than initial scores (Hogan, Rossiter & Catling, 2018). It remains unclear how empathy aligns with foundational steps in most models of cultural competence. Another Australian institution focused on measuring midwifery students' learning using a newly developed tool that measured content against the Aboriginal and Torres Strait Islander Health curriculum framework that importantly links capabilities to skills (West, Mill, Rowland and Creedy, 2018).

Interestingly, one approach to measuring cultural competence in health degrees was through mental health content. This group of scholars were interested in assessment educational tools and their impact in cultural competence and development. The tool was based on a validated empathy tool: Kiersma-Chen Empathy Scale a 15-item instrument (Kiersma et al. 2013). Coupled with semi-structured interviews, the study highlighted an increase in students' confidence when engaging with materials. While Turkish nursing academics have focused on a pre and post evaluation using an Intercultural Sensitivity Scale and Cultural Intelligence Scale that identified that sensitivity increased with higher cultural intelligence, adding value to pedagogical approaches (Goi & Erkin, 2019)

Australian and New Zealand physiotherapist academics (Te, Blackstock, Fryer, Gardner, Geary, Kuys, Chipchase, 2019) have focused on assessing student self-reported growth through an America tool called the Cultural Competence Assessment (CCA) instrument (Schim, Doorenbos, Miller, Benkert, 2003). Insight into personality traits in leaners that impact their ability to respond to cultural competence was at the forefront with dogmatism being reported as a major inhibitor.

While a dentistry course at an Australian university focused on the use of an adaptation to a tested American tool importantly focusing on both staff and students in their research (Rowland, Bean, Casamassimo, 2006; Forsyth, Irving, Tennant, Short, & Gilroy, 2018). The tool involved a mixture of qualitative and quantitative components and found a significant pedagogical gap that needed to be addressed by the course team. This study was then expanded to include in-depth interviews with learners (Forsyth, Irving, Short, Tennant, & Gilroy, 2019), citing a greater need for Indigenous Australian focused content aligning with other health students' perceptions of their learning (Biles, 2017). What seems to be lacking is a consistent approach to cultural competence understanding across health disciplines and therefore evaluation. With such a mixture of tools being used for evaluation it is challenging to make sense of lasting meaningful changes.

Pedagogical approach to cultural competence

Moving beyond teaching and learning is the pedagogical approach to cultural competence. This was the overarching focus of nine articles. These articles looked beyond single subjects and instead focused on pedagogical approaches to embedding the philosophy of cultural competence within curricula. In a mixed methodological study, faculty staff expressed an overall lack of support in their health disciplines that inhibited the attainment of cultural competence in their teaching (Chen, Jensen, Chung & Measom, 2020). Concurring with this research, a midwifery study indicated that midwifery academics required ongoing professional development in the concept of cultural safety to support their journey in cultural competence and the overall teaching and learning experience of midwifery students (Fleming, Creedy & West, 2019). While there are many teaching and learning resources that have been developed there was limited discussion on pedagogical approaches to cultural competence within health curricula. Aligning with a values system, one American nursing school cites embedding an emancipatory approach to cultural competency can truly prepare nurses for social justice, racism and discrimination within the healthcare environment (Wesp, Scheer, Ruiz, Walker, Weitzel, Shaw, Mkandawire-Valhmu, 2018). A scoping review of cultural competence pedagogy in heath courses revealed that cultural competence is seen to combat racism and disparities in healthcare education yet a varied understanding of culture and cultural competence was common yet rarely defined, creating a praxis in understanding and teaching (Lewis & Steinert, 2019).

One Australian university seeking to embed cultural safety in a midwifery curriculum and retain Indigenous student midwives created structural changes within the program, developing the role of an Indigenous Academic Liaison Midwife. While the program cited increased learner satisfaction and overall retention from Indigenous midwives, little was reported on the impact of the operational change (Schulz, Dunne, Burdett-Gamble, Kosiak, Neal & Baker, 2018)

Butler and Berry (2018) present an interesting approach from a Canadian perspective that indicates that systemic structural changes need to occur in nursing policy and strategy to make a lasting impact and change for consumers of healthcare. This places the onus on the professional bodies rather than the overreliance on curriculum approaches. Instead, 360-degree communication and consultation should be the

priority when delivering cultural competence curricula. This is imperative to professional body and health service strategy implementation. While some progress has been made in implementing such a philosophy within health curricula, the impact of the course is underreported.

Values

The appreciation and role of values in cultural competence education is still evolving although not entirely new to the discourse. In her widely tested approach, Campinha-Bacote (2019) argues that humility and competence need to be blended for organisations to truly generate change. Most recently she has called this cultural competemility. Campinha-Bacote (2019) argues that cultural competemility is the way forward and essentially involves the total permeation of cultural humility into the five components of cultural competence. Humility being the process of thinking of "self" less and competence having five traditional domains that require synchronous progression to generate meaningful change. Now, essentially the synchronous progressions have been contested (Biles, 2017) but most importantly the notion of competemility focuses on a values-based system of reflection. Abdul-Raheem (2018) argues that cultural humility must be learnt by nursing educators to then be perceived and learned by students with simulation being an evidenced approach (Foronda, Baptiste, Pfaff, Velez, Reinholdt, Sanchez & Hudson, 2018).

Notably in this exploration of literature other scholars have dabbled in values-based approaches to cultural competence. Schultz and Baker (2017) describe the need for a clear understanding in unconscious bias. This requires skill development in unconscious bias training as well as attributes like accepting feedback and self-reflection. In this study the scholar argues that cultural competence skills don't focus or reduce unconscious bias in nursing curricula impacting on client care (Schultz & Baker, 2017) and that unconscious bias tends to increase as students' progress through their degree (Chapman, Kaatz, & Carnes, 2013). Relying on a behaviour management system that explicitly details the behaviours that learners are required to take on with a variety of strategies that engage the behaviour was seen to be effective in a cohort of nursing students.

Markey and Okamtey (2019) believe that one way to overcome bias, insensitivity and develop competence is through professional values. They highlight that it is evidenced that nurses generally disengage from client care when not understanding cultural considerations, demonstrating culturally insensitive approaches to their practice (Markey et al., 2017, 2018). For example, if a linguistic barrier emerged, this research suggested that a nurse was more likely to disengage then work with the client. This suggests that cultural competence alone won't combat nursing behaviours and our current professional understanding of cultural competence in health isn't enough to combat such behaviours. Instead a focused curriculum on lived values such as care, compassion, commitment, communication and courage is said to lead to culturally responsive behaviours in nurses (Markey et al., 2017, 2018). Alexander-Ruff and Kinion (2019) echo Markey et al.'s sentiments through their narrative on cultural consciousness – citing this as the central term for nurses' education to focus education and assessment. They believe that cultural consciousness is developed through self-reflection on values and behaviours, dialogues about race and immersive experiences. How values translate is largely unknown in both assessment and clinical practice.

Discussion

In this review of literature pertaining to cultural competence both nationally and internationally in healthcare courses the focus was learning what has evolved in peer reviewed articles during the past three years within the bounds of the search strategies. What emerged was a relatively small body of work. It is apparent that nursing has a broad focus on cultural competence and has tried to develop resources, embed cultural competence as pedagogy and measure outcomes. This makes sense with nursing occupying a large portion of the health workforce both nationally and internationally (Wesp, Scheer, Ruiz, Walker, Weitzel, Shaw, Mkandawire-Valhmu, 2018: Butler & Berry, 2018). It is evident that allied health has made some steady progress in the development of resources with little evidenced exploration of pedagogical application (Te, Blackstock, Fryer, Gardner, Geary, Kuys, Chipchase, 2019; Rowland, Bean, Casamassimo, 2006; Forsyth, Irving, Tennant, Short, & Gilroy, 2018).

What is evident in all the literature is that cultural competence focused education is seen to combat racism in healthcare settings (Truong, Paradies & Priest, 2014; Clifford, McCalman, Bainbridge, & Tsey, 2015). By preparing undergraduates or graduates through education the translation will become a culturally responsive workforce. While measuring the success of strategies in curriculum is varied, institutions are somewhat confused on how to embed cultural competence with each paper citing nuanced definitions making understanding challenging. This is heightened in the approaches to measure cultural competence. Camphina-Bacote's approach, by large, is the most cited scholastic approach to cultural competence both within Australia and other nations. Interestingly the approach somewhat differs from Universities Australia's (2012) recommendations yet reveals the importance in exploration of values and behaviours in cultural competence learning and teaching.

From this review it is clear that an institutional approach is imperative to any course success. Staff teaching and learning cultural competence require systemic support to ensure that experiences are meaningful to learners, align with the value systems of the institution and are embedded in evidence-based application. In the past three years, while we have made some headway in measuring the success of cultural competence initiatives, the tools used by health courses are often different and piecemeal, making it challenging to gauge overall progression.

What is apparent is that personal values of learners are now being linked to cultural competence education. This is an exciting evolution that needs to be explored further and will make a difference in developing culturally competent approaches. The problem that is revealed when considering this is that most health disciplines enact cultural competence in different ways. This generates an interesting situation when measuring the success of applications will be challenging particularly when unearthing the nuanced values of cultural competence for health professionals rather than disciplines. As technology in healthcare advances and remains the priority, the perceived soft behavioural aspects of professionals' education remain overlooked. Yet it is these very skills that have the power to transform experiences for consumers of care.

Leadership in higher education in collaboration with health services is imperative to the progression of cultural competence in healthcare.

One problematic focus to this review was the lack of voice of Indigenous and multicultural students. Unearthing their voices in teaching and learning experiences holds great weight that is yet to be discussed. In addition, if the end game of cultural competence is an improved health system that acknowledges staff bias and evokes a less racist healthcare system then the voice of Indigenous and multicultural patients is paramount. Surely, the voices of Indigenous and multicultural consumers of healthcare hold the greatest weight in assessing pedagogical, institutional learning and teaching experiences of healthcare professionals. This should be a priority for future research in this area.

Conclusion

While some progress has been made in cultural competence research to achieve optimal patient outcomes, this work needs the support and funding of higher education and health districts to continue. Currently, research and initiatives are piecemeal, making progress difficult to determine.

Key practice documents for health sciences

During my exploration, I completed a scoping review of key documents and practice approaches to cultural competence that relate to health sciences. These documents are all published and freely available to higher educational institutions. It is important to note that cultural competence was viewed in broad terms that led me to explore resources/polies/practice guides beyond the focus of Aboriginal and Torres Strait Islander peoples. A synopsis of the following documents is provided in this section of the report and will support recommendations discussed later:

- The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025
- Universities Australia: Good Practice Principles for Course Accreditation and Review of Indigenous Curriculum (2019)
- Aboriginal and Torres Strait Islander Cultural Capability: A framework for Commonwealth Agencies. Commonwealth of Australia (2015)
- Aboriginal and Torres Strait Islander Health Curriculum Framework
- Universities Australia Indigenous Strategy 2017-2020
- Federation of Ethnic Communities Councils of Australia. Cultural Competence in Australia: A Guide (2019)
- National Cultural Respect Framework 2016- 2026 For Aboriginal and Torres Strait Islander Health

The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025

The aim of this strategy is to identify, implement and monitor the National Scheme's Strategy and role in ensuring patient safety for Aboriginal and Torres Strait Islander people in Australia's health system. This document details the strategic focus of initiatives over the next five years. Importantly, it acknowledges the need for consensus within terminology as imperative to achieving outcomes.

Universities Australia: Good Practice Principles for Course Accreditation and Review of Indigenous Curriculum (2019)

This document was created by Universities Australia to guide the implementation and accreditation of courses with Indigenous Australian content. Section six of this document is particularly relevant to the Faculty of Science health courses.

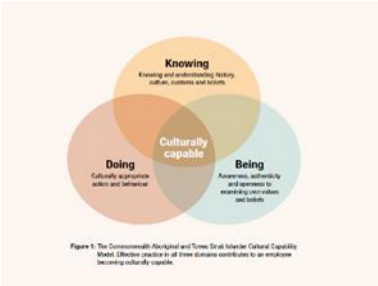
SYNOPSIS OF SECTION 6

- The university should have an Indigenous graduate attribute (or similar graduate outcome or course learning outcome) to develop an appreciation or sensitivity to Indigenous Australian cultures, and the course accreditation process should ensure that all courses are aligned to the achievement of this attribute.

- Indigenous curriculum should be coherently integrated into degree curricula, allowing students opportunities to build from introductory to advanced learning.
- The appreciation or sensitivity to Indigenous knowledge and understanding as set out in the learning outcomes should be formally assessed.
- Teaching staff should be sensitive to, appropriately prepared and experienced in the Indigenous content that they teach. Professional development should be offered to staff to develop and enhance their capacity to teach Indigenous content.
- Courses should include formal recognition of the Indigenous knowledge and sources drawn upon and explicitly acknowledge relevant endorsements by Indigenous bodies where relevant.
- Courses should use language which reflects the diversity and multi-lingual practices of Indigenous Australians where possible.
- The integration of continuing professional development for staff is paramount for these recommendations to be enacted.

Aboriginal and Torres Strait Islander Cultural Capability: A Framework for Commonwealth Agencies. Commonwealth of Australia (2015)

This framework is a guide for foundational capability development of government employees and cites skills, actions and behaviours as being of importance.



Interestingly, Knowing, Being and Doing in this document is based on a western educational leadership framework (Snook, Scott & Khurana, 2012) rather than the Indigenist Knowing, Being, Doing framework (Martin-Booran Mirraboopa, 2003). The framework cites a roadmap for becoming culturally responsive.

Figure 1: Aboriginal and Torres Strait Islander Cultural Capability

Aboriginal and Torres Strait Islander Health Curriculum Framework

A framework designed to guide the implementation of developing Aboriginal and Torres Strait Islander health curriculum content. It also provides guidelines for clinical placement pathways. There are eight governing principles and five graduate capabilities that influence curriculum development.

Figure 2: Aboriginal and Torres Strait Islander health curriculum

https://www1.health.gov.au/internet/main/publishing.nsf/Content/aboriginal-torres-strait-islander-health-curriculum-framework . Within this framework, implementation guidelines have been set for tertiary institutions' professional cultural development. Interestingly, Charles Sturt University is well positioned on a number of guidelines. For example, our GLO and IES strategy aligns with "commitment and leadership across health professional programs".

However, areas that we should focus on include:

- Resourcing and enabling a safe environment for community collaboration
- Role modelling Aboriginal and Torres Strait Islander protocols
- Health professional staff cultural capability – while we have foundational training in place for all CSU staff, focused attention on ongoing cultural opportunities is paramount for progressing student learning.

Importantly, the health curriculum framework is the national reference point for health courses and scaffolds learner capabilities across three skills areas: novice, intermediate and entry to practice. It offers an organisational readiness tool that would be useful for health courses at CSU.

Universities Australia Indigenous Strategy 2017-2020

A seminal document endorsed through Universities Australia that indicated the following operational consideration in relation to Indigenous content in courses:

1. That embedding content in courses is seen as a whole of university approach that is inclusive of higher education, research, employment, strategy, business plans and reconciliation action plans (RAP).
2. Community partnerships are integral to success.

Federation of Ethnic Communities Councils of Australia. Cultural Competence in Australia: A Guide (2019)

This is a seminal guide that was the result of a twelve-month research project, which sought to understand Australia's position on cultural competence development. The document encompasses interpretations of cultural and linguistic diversity.

Key points of learning pertaining to this document and relevant to health sciences:

1. Organisations that employ culturally diverse executives outperform organisations that don't by 33% (McKinsey, 2018)
2. Policies and processes in cultural competence coupled with a rigorous diversity recruitment strategy and support for staff development leads to needs-based product development.
3. Rigorous evaluation is imperative
4. Consumer feedback should be planned, constant and within a framework
5. Cultural competence training is often seen as second to other operational foci
6. A central peak body is required
7. An online platform for training, research and resources needs to be established
8. A matrix is provided for organisations to evaluate training programs focused on cultural competence development.

National Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health

This framework provided health services key priority areas to embed cultural respect domains. These domains align with other national documents such as the National Aboriginal and Torres Strait Islander Health Plan 2013-2023, Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023, National Aboriginal and Torres Strait Islander Health Performance Framework, The

National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2023, the Australian Commission on Safety and Quality in Health Care: Draft version 2 of the National Safety and Quality Health Service Standards and the Australian Charter of Healthcare Rights. For this review, a synopsis of learning for all of the documents will be shared in this section.

The six domains are inclusive of:

- Whole-of-organisation approach and leadership (inclusive of funding, led in the area of anti-racism and anti-discrimination campaigns)
- Communication – both health professional and consumer foci
- Workforce development and training – training, consumer consultation, policy
- Consumer participation and engagement – consumer informed design, performance and evaluations. Reliant on all other domains
- Stakeholder participation and collaboration – consumer partnerships, community collaboration through panning, delivery and research
- Data, planning, research and evaluation – building evidenced-based practice and evaluation

These criteria should guide curriculum development in all health courses to prepare work ready graduates.

Summary

In each of these documents we can see recurring themes. These themes suggest that evidenced-based tertiary level education is imperative to meaningfully increase workforce participation and culturally safe care as determined by the consumer. Each document raises the following as essential criteria:

- Continuous learning, development and practise for learners and academics
- Organisational “readiness” is paramount
- Success needs to be measured
- Invest in research
- Ongoing community, state and national consultation

What is happening at CSU?

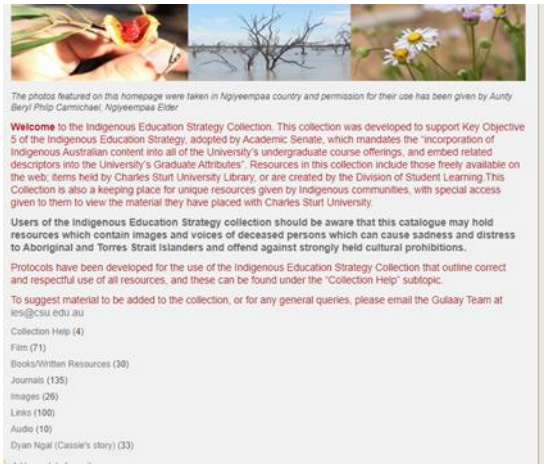
CSU cites a Wiradjuri phrase in its ethos and has values that are responsive to inclusive education for all (CSU, 2020). We have a governance structure for curriculum development that is led by the School of Indigenous Australian Studies (CSU, 2020).

We are fortunate at CSU to host the Gulaay team and Bathurst Elders, which provide extensive support for staff and students in the journey of Indigenous Australian cultural competence. We have the IASP access program targeted to recruit and retain Aboriginal and Torres Strait Islander students and a newly appointed PVC Indigenous (CSU, 2020). We are well positioned to "*make a difference*". Within the Faculty of Science two working parties are operational: One focusing on curriculum design (FoS wide) and the other on school based curriculum design pertaining to Aboriginal and Torres Strait Islander content (SCH).

Where should the road take us? Educational frameworks that enable success

Healthcare

Evidence indicates that Aboriginal and Torres Strait Islander people do not feel culturally safe and experience high levels of racism when accessing mainstream healthcare (Australian Institute of Health and Welfare, 2019). Two linked strategies to address this are mainstream workforce development in cultural competence and building workforce capacity through greater success in attracting and retaining Aboriginal and Torres Strait Islander students.



This requires a commitment to embed culturally responsive curriculum. While CSU is achieving some progress, much improvement is needed with courses like the Bachelor of Nursing which has exceeded parity (9%) in recruiting Aboriginal and Torres Strait Islander students, however, still citing online attrition as high as 47% for Aboriginal and Torres Strait Islander students.

Figure 2: Charles Sturt University Indigenous Education Strategy

Higher education

Nationally, students in higher educational institutions who are from a minority group do not feel safe (Graycar, 2010; Plater, Mooney-Somers, Barclay & Boulton, 2019). Unfortunately, CSU is not unlike other institutions. For example, we witnessed racially motivated behaviours in the incidents involving students from the Faculty of Science in Wagga Wagga in 2019 and in the health systems that we serve (Coroners NSW, 2019). **This suggests that we need take time to reflect on our scope and focus when developing online cultural competence within the Faculty of Science community.**

Much work has been written about Indigenous Australian cultural competence as a praxis that is a philosophy and a pedagogy (Sherwood & Russell-Mindine, 2017; Pecci, Frawley & Nguyen, 2020). Transformative learning, relational learning and Indigenist standpoint theory have been evidenced as successful pedagogy that can promote a change in worldview by both learner and educator (Martin-Booran Mirraboopa, 2003; Mezirow, 2000).

My learning from the American approach drew my attention to the key characteristics of culturally responsive schools. While universities are seemingly different to traditional schools (primary and secondary) they are both a “house” of learning. Therefore, we can certainly draw on this literature to work towards implementing change.

Lee (2001) shared key characteristics that build culturally responsive schools. These elements are applicable to higher educational institutes and could certainly guide the Faculty of Science approach in the future. You will note that the characteristics have a strong sense of asset learning that is reliant on behaviours/values, for example, inclusive practise is essential, diversity is an asset to learning experiences of all (students/academics).

Figure 1: Key Characteristics of Culturally Responsive Schools

	Characteristic
1	The school has adopted a "salad bowl" as opposed to a "melting pot" philosophy of education.
2	The school has been able to forge a sense of community out of cultural diversity.
3	The school has been able to capitalize on cultural diversity and maintain academic standards (i.e., it has the same high academic expectations for all students).
4	The school has a curriculum that is neither Eurocentric nor Afrocentric nor Asian-centric, but rather is Centered (i.e., it has a curriculum that fairly and accurately reflects the contributions of many cultures).
5	The school goes "beyond Black History Month" (i.e., it infuses multiculturalism and diversity in a non-stereotypical manner *throughout* the curriculum and the school year).
6	The school provides students with forums outside of the classroom to communicate with and learn about their peers from diverse cultural backgrounds.
7	The school has mechanisms in place to deal with racial/cultural tensions.
8	The school has committed educators who engage in ongoing staff development and are not afraid to take risks or improvise when necessary.
9	The school actively attempts to recruit a diverse staff of educators.
10	The school has high levels of parental involvement and the educators consider language and cultural customs in their interactions with parents.
11	The school broadly defines cultural diversity to include people with disabilities, people with diverse sexual orientations, people with diverse religious traditions, and older people.

Figure 3: Characteristics of Culturally Responsive Schools (Lee, 2001)

Internationally, the American National Centre for Cultural Competence embraces a conceptual developmental framework and definition of cultural competence that requires organisations to:

- have a defined set of values and principles, and demonstrate behaviours, attitudes, policies, and structures that enable them to work effectively cross-culturally.
- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) institutionalise cultural knowledge, and (5) adapt to diversity and the cultural contexts of the communities they serve.
- incorporate the requirements above in all aspects of policy development, administration, and practice/service delivery and involve consumers systematically (modified from Cross, Bazron, Dennis, & Isaacs, 1989).

Importantly, successful outcomes require congruence between values and practise within organisations and a clear understanding of the multiple layer of culture (Goode, 2019). Therefore policies, procedures, leadership, practise and people (internal and external) are all aligned to cultural competence development (Goode, 2019). As national online learning leaders (CSU, 2020) it is important that we consider the impact of these areas in the nuanced space of online learning.

Online resourcing, Values, Consultation and Comprehensive evaluation

It is clear that Charles Sturt University is making steady progress in online cultural education within health science courses. Yet, like many other institutions there is still work to do in moving forward. My SSP has allowed me the time to meet with key scholars, network, explore contemporary cultural literature and begin to piece together some key priority areas for us to move forward. Importantly, these are recommendations to discuss with other key people at CSU. In no way, would I recommend moving forward without significant consultation. Extensive consultation has not been possible within the timeframe and context (COVID 19 pandemic) of my SSP. However, my study and exploration of literature has led to four important focus areas for the Faculty of Science (and wider CSU community) to consider: online resourcing, values, consultation and comprehensive evaluation. This section of the report will provide a brief summary of each focus area.

Online resourcing

Online learning experiences are increasingly becoming popular in the Australian tertiary sector with around 81% of learners working remotely off campus in the online space in 2010 (ABS, 2010). Online learning experiences are seen to be cost effective and have the capacity to target audiences that would not normally have access to university teaching (Button, Harrington, & Belan, 2014). The National Regional, Rural and Remote Tertiary Education Strategy Final Report (Napthine, Graham, Lee & Wills, 2019) identifies three key current issues in Australia's tertiary education sector: Less options for tertiary education in regional, rural and

remote communities; additional financial costs, social isolation; and lower completion rates. Online study is one way that universities increase access to otherwise marginalised regional communities.

Challenges associated with online learning have been raised in health curriculums. These include increased anxiety (Deltsidou, Voltyraki, Mastrogiannis, & Noula, 2010; Glaister, 2007); learners not being prepared with the appropriate skills for online spaces (Bond, 2009; Levett-Jones et al., 2009; Jackson, Power, Sherwood, & Geia, 2013); and varied levels of comfort and accsess to information technology (think NBN), particularly in regional, rural and remote areas (Creedy et al., 2007).

Online learning is seen to be more accessible, particularly for regional universities (Napthine, Graham, Lee, & Wills, 2019). Yet, how this is mode of learning translates to cultural health education (and thus the journey of cultural competence) is not widely explored. In current Indigenous Australian cultural competence education, it is considered important that learners should feel safe in their learning experiences. Safety leads to the desire to create meaningful learning experiences that encourage connection that then promotes a transformative learning experience (Durey, 2010; Thackrah & Scott, 2011; Hunt et al., 2015). Academics in the online learning environment are faced with a challenge, not only to provide unique experiences but to ensure that students in their classes have foundational knowledge, skills and behaviour to be culturally safe clinicians. Many health academics have used online tools, including communication, emails, video/audio recordings to enhance individual students' learning experiences (Soper & Ukot, 2016).

Online learning has been grappling in the area of culturally responsive curricula (Commonwealth, 2019). The Aboriginal and Torres Strait Islander Health Curriculum Framework suggests the following strategies to support online learning:

- online learning environments monitored by staff to ensure that inappropriate and unsupportive learning material about Aboriginal and Torres Strait Islander people doesn't find its way into online forums
- consider specific training for educators teaching online to enhance their skills in terms of appropriate techniques to engage students in discussion – and challenge them where necessary

- carefully consider topics for online discussions – some topics in the classroom may not be suitable in an online environment
- early in the unit, focus on building trust between educators and students, which is key to supporting effective engagement and facilitation of confronting and emotive conversations in a safe space
- ensure Aboriginal and Torres Strait Islander vodcasts/footage/voices are used in every session to enhance student exposure and encourage emotional engagement in content
- develop opportunities for yarning online – using Skype/video/learning management system collaboration tools/tele-conferencing. Provide incentives for students to engage in these powerful learning tools, such as an Aboriginal and Torres Strait Islander guest presenter participating in one of the online yarning forums
- develop practice-based/community engagement learning activities and assessments to ensure students are actively engaging with their local Aboriginal and Torres Strait Islander community (Commonwealth, 2019).

Clearly, on-line teaching is not the same as face-to-face teaching, and there are inherent limitations. The further students' progress in their studies, the more they will be required to demonstrate intermediate and entry-to-practice learning outcomes that look for more nuanced, reflective and mature knowledge and understanding, as well as abilities that are assessed in practice. Different forms of assessment in authentic contexts are one way of overcoming limitations of assessing student achievement of outcomes. Essentially, we don't yet know enough about cultural health education in the online space. (Refer to Appendix A – NCSEHE submitted grant application).

Community of Practice

According to Pyrko, Dorfler and Eden (2017), communities of practice are a method of discussing the learning process within a community focusing on knowledge and knowledge sharing. Delridge, Wilson and Palermo (2015) evaluated a university led COP focused on Indigenous health and identified a positive shift in learning, understanding and knowledge generation by members. Based on social learning theory, communities of practice provide a means to enhance practice through unintended, informal learning through experiences within a group of people (Wenger, 2000).

Evidence has shown that cultural praxis is a respectful pedagogical approach to online education in the area of Aboriginal studies (ways to mutually discuss and move forward agendas in an online forum) (Riley, Mooney, Howard-Wagner, & Kutay, 2015). Importantly online forums must facilitate reciprocal community relationships (note the narrative approach in Figure 5). The cultural praxis learning model would be appropriate to consider in an online community of practice.

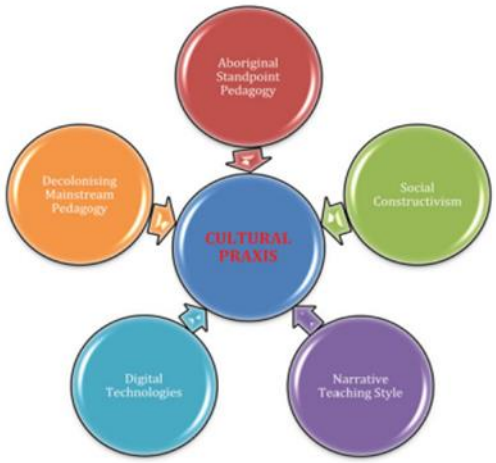


Figure 4: Cultural Praxis (Riley, Mooney, Howard-Wagner & Kutay, 2015)

CSU Values in cultural education

As mentioned earlier, Indigenous Australian cultural competence is both a philosophy and a pedagogy (Sherwood, 2013). The praxis of knowing, being and doing requires the consideration of values and behaviours in our implementation of Indigenous Australian cultural competence and thus our influence as educators in student learning. Making the value visible through practice will be important for cultural competence development particularly in the online learning space. Table 1 provides some ideas on how we can “live” our values through cultural competence education within the health sciences.

Table 1: CSU Values

CSU Values	Value summary	Ways to "live" the value through cultural competence education within health sciences
Impactful	• Consistent • Constructive • Student first, practical and useful	• Develop formal relationships with peak bodies to support cultural competence development • Operationalise a model of external and internal consultation that unearths and values the voice of key stakeholders. This should include online consultation • Define cultural competence as a faculty • Measure our strategies • Celebrate and share our success • Add SMART cultural related indicators into EDRS performance outcomes • Add cultural related benchmarks into our annual work plans
Inclusive	• Accessible • Versatile • Easy, warm and welcoming	• Build a central online platform for cultural competence/capabilities development. This recommendation has been consistently reported yet a higher education institute is yet

		to move on the idea. This would enable competence development making it accessible to LHDs and regional communities across Australia. • Give staff and students the permission to remove the “shame” associated with cultural competence learning. Leaders in the FoS have influence and respect. They can make a difference.
Insightful	• Respectful • Perceptive • Knowledgeable, wise and open minded	• Ongoing prioritisation of broad online cultural competence training. • Use branding to support students and staff stories • Project and strategise consumer needs. For example, it is clear that Local Health Districts will struggle to receive cultural safety accreditation. CSU can lead in this area and offer online education to support LHD staff development. • Create an online micro course for regional health services

		• Build a diverse health academic workforce • Make ‘culture’ a priority in the FoS strategy
Inspiring	• Rigorous • Creative • Leading, imaginative and solid	• Invest in cultural competence-based research • Support staff to network with key stakeholders to develop “ground up” innovative research • Create an Indigenous health stakeholder group/COP • Prioritise evidence-based tools that measure curriculum cultural competence development

Consultation as Strategy

.The Australian Institute of Aboriginal and Torres Strait Islander Studies (2012) suggests that relationships should be ongoing, mutually beneficial and enable Aboriginal self-determination. Universities’ core business is education and this presents many opportunities to consult widely and meaningfully with community members on curriculum development and resources. In addition, we have a professional responsibility to ensure that consultation is remunerated in a way that is responsive to the principles of reciprocity. We have many areas that we can build our networks and it is acknowledged that many individuals and small teams at CSU have extensive networks that are drawn upon when building curricula.

Some key stakeholders in the area of cultural competence include local Aboriginal Elders (represented from each campus), community working party groups, Local Health District staff, Aboriginal health executives, and Aboriginal Community Controlled Health organisations. To further expand our approach, it is imperative to

engage with culturally and linguistically diverse community groups. Building a Faculty of Science (FoS) engagement plan that is responsive to local community needs across all of our campuses would ensure that we are not adding to the cultural load of communities and consulting in a meaningful, ongoing and responsive manner (refer to implementation plan). Considering the First Nations Unit at Griffith University (refer to graphic) as a foundational approach may be appropriate in ensuring that FoS staff are involved in building a plan that is paramount not only to ensure staff 'buy in' but most importantly to ensure that the plan is responsive to local community/discipline needs. Of course in doing this we should strive to maintain standards in our consultation approach: https://www.pmc.gov.au/sites/default/files/publications/best-practice-consultation.pdf.

Sharing our approach to cultural competence with the wider community is the 'flip side' of consultation. CSU has extensive governance and literacy relating to cultural competence. This will prove to be important to health services as they move to reporting and operationalising cultural safety key performance indicators. CSU Faculty of Science could be a leader in this field, developing business savvy models (e.g., a MOOC/micro course) that are made available to health service staff. This approach would require collaboration between a number of internal stakeholders and should be led by Aboriginal and Torres Strait Islander staff who have the appropriate workload allocation to prioritise this objective.

Figure 5: First Nations Unit Engagement model

Comprehensive evaluation

As mentioned earlier, we have to further our leadership in the area of cultural education. To enable us to move forward, we should measure[1] our success Consideration should be given to the experiences of all

[1] Measuring using both quantitative and qualitative methods

stakeholders. National findings show that a lack of evaluation in cultural education is a fundamental floor in most health curriculums (Commonwealth of Australia, 2014).

Some tools that should be considered:

1. The Ngaa-bin-nya framework, which is one of only a few program tools developed specifically to reflect Aboriginal and Torres Strait Islander people's context (Williams, 2018).
2. The Organisational Commitment and Health Professional Program Readiness Assessment Compass (OCHPPRAC) has been developed to assist the HPP to identify the readiness of their environment for implementing The Aboriginal and Torres Strait Islander Health Curriculum Framework: https://www1.health.gov.au/internet/main/publishing.nsf/Content/72C7E23E1BD5E9CFCA257F640082CD48/$File/Health%20Curriculum%20Framework.pdf

How to make this happen?

These four focus areas have led to the following recommendations:

- A shared understanding that cultural competence needs to be supported by change management and leadership frameworks;
- A commitment to community consultation that is supported through organisational strategy and policy;
- Build our internal capacity. Invest in training, online resource development and activities that will enhance understanding on cultural competence. This is evidenced as impacting students' learning experiences (Biles, 2017);
- Redefine our institutional understanding of the philosophy of cultural competence. Currently cultural competence is practised as Indigenous Australian cultural competence at CSU and in the NSW health system. Institutional understanding should reflect this;
- Strategise how we can generate impact through a shared understanding of regional communities, workforce, and leadership.
- Work to embed CSU values across all domains of cultural education (CSU, 2020). CSU values align with the journey of cultural competence.

- Develop an online Community of Practice that will support staff and students in building a safe environment that is supportive of their learning needs (Zuniga, 2003). Invest in an online platform for health sciences focused on cultural competence resources and short courses available for external stakeholders. This aligns with health service accreditation requirements and would align with a market orientated approach.
- Discrete university funding for cultural competence/capability research. Rally and support LHDs to allocate resource and research funding to support online cultural competence development and cultural safety. CSU health academics to be the conduit between LHDs and university. Academics need to drive this agenda and support LHDs to implement their ideas.

These recommendations have been further refined to an implementation plan to reinvigorate cultural competence within the Faculty of Science. It is useful to note that cultural education is largely reliant on a number of systems. Therefore, the plan will extend beyond teaching and learning initiatives.

Suggested Implementation Plan to reinvigorate cultural competence in the Faculty of Science

Suggested Campaign name: Reinvigorating cultural competence in the Faculty of Science

The purpose of this plan is to reinvigorate the Faculty of Science's approach and commitment to cultural competence development specifically in relation to health courses. As CSU is a leader in online education, this plan will focus on online initiatives/strategies.

Assumptions and Constraints

This plan assumes extensive consultation with communities with CSU footprint, Aboriginal staff and students and other key stakeholders. This plan assumes collaboration between Senior Leadership Teams, the Division of Learning, PVC Indigenous, staff and community groups within the footprint of Charles Sturt University. This plan is a draft. As mentioned previously consultation has not occurred in the development of these ideas due to the COVID 19 pandemic.

1. Project Organisation

This project/campaign can be implemented within the structure of the Faculty of Science. It is suggested that the project be administered in the footprint of the learning and teaching portfolio but include objectives across the faculty.

2. Management Overview

Ideally, this project should be allocated a project manager at a 0.2 FTE for two years. However, given the current budgetary constraints associated with COVID-19 impact to higher education, a creative approach to management may be more appropriate. A few viable options have been detailed below:

1. Each health-related school be allocated a small FTE to work on project outcomes.
2. Using a strengths-based approach, each Health HoS consider a KPI that aligns with the overall strategy and the faculty work together to achieve a common outcome.

3. Major Tasks

Table 2: Translating objectives into practice

Major Objective	Strategies to achieve the objective
A shared understanding in cultural competence	Internal consultation with all health staff through the following modes: 1. Generate baseline data such as an online survey aimed to determine CSU's understanding of CC; Organisational

	Commitment And Health Professional Program Readiness Assessment Compass: 2. Build the OCHPPRAC into curriculum design processes Build on current knowledge/understanding through face-to-face faculty meetings.
A commitment to community consultation	Build on current CSU health networks and develop a model of online external community consultation. Consider working towards a sustainable renumerated model that involves key representation from each campus and disciplines. A sustainable model will build relationships, model reciprocity and 'live' the CSU values. This model would be become an important mode for community consultation. This would also enable CSU to serve our communities, ensuring that our research and teaching is responsive to the communities that we serve. . Consider the Griffith University First Nations model as an exemplar. Some steps to implement this idea include: 1. Form a First Nations led working party to build on community networks. 2. "Work up" a membership description. 3. Ensure the membership model renumerates community members' time (Government community consultation regulations suggest $40/hr as fair and equitable) 4. Co-create terms of reference and a model of best practice. 5. Invest in technology (iPads) to ensure that the group have the capacity to virtually meet.
Build our capacity through our institutional strength. Invest in	1. Ensuring that ICCP 1 and 2 are mandatory for both staff and students.

the development of training, online resource development and activities that will enhance understanding on cultural competence for: **1. CSU staff and students** **2. CSU health partners**	2. Building on ICCP and considering ways that we can normalise cultural development within CSU. 3. Develop MOOCs and focused micro courses 4. Consider authentic and meaningful ways to deliver content and normalise conversations. One example, is the Different Dialogues framework focused on diversity and inclusion https://www.youtube.com/watch?v=_cfOWW5gUOE. Importantly this framework provides a safe space for dialogue that stimulates growth through conversations and relationships (Zuniga, 2003). More information can be found via this link: https://igr.umich.edu/. I am currently in conversation with an academic at Georgetown University to implement this program as a cross institutional study. This project aligns with Australian HEPPP funding.
Redefine our understand in the philosophy of cultural competence e g all encompassing, religions, cultural, minority groups,	Historically, cultural education has been included in higher education courses within Australia to combat racially motivated behaviours in health services (Universities Australia, 2012). Despite ongoing investment in the preparation of undergraduate health students, incidences of racism in healthcare remain (Paradies et al., 2015). Terminology has changed over time, for example, cultural awareness, cultural competence, cultural empathy, and cultural safety leading to confusion. Spending time unpacking “CSU’s understanding of cultural terminology” will enhance our approach to practice and responsiveness.
Understand how we can generate impact through a	1. Develop an **online** teaching and learning Community of Practice that will support staff, students and external stakeholders in

shared understanding particularly impact for regional communities, workforce, and leadership.	building cultural competence (this could be an extension of the existing Indigenous curriculum working group) 2. Build on our partnership with the Australian Indigenous HealthInfoNet across health science disciplines in the Faculty of Science.
Work to embed our values into the capability framework across all domains (CSU, 2020). CSU values align with the journey of cultural competence.	As discussed earlier in this report, cultural competence is largely change management. Focused our attention towards value/behaviour led change that will support the narrative of cultural competence at CSU.
Discrete university funding for cultural research. Rally and support LHDs to allocate resources and research funding to support online cultural competence development and cultural safety. CSU health academics to be the conduit between LHD and university.	Given the impact of COVID-19 internal compact funding is not a viable option. Instead, funding bodies that support cultural research should be focused towards diversity, inclusion and equity grants inclusive but not limited to the following: 1. National Centre for Student Equity in Higher Education 2. NSW Health translational research grants 3. Ian Potter grant 4. NHMRC 5. ARC Indigenous discovery grant 6. National Indigenous Australian Agency Community Led grants 7. The WACE International Research Community Grants
Invest in an online platform for health sciences focused cultural competence resources and short courses available for external stakeholders. This	Invest and become leaders in online health education. With local health districts now needing to demonstrate cultural safety in formal accreditation it is an opportune time for CSU to showcase its capacity and leadership in online cultural safety education. It is recommended that we invest in online learning such as micro

aligns with health service accreditation requirements and would align with a market orientated approach.	courses and /or MOOC. Alternatively, platforms such as: https://utsindigenoushealth.com/

4. Implementation Support

Ultimately this plan requires a financial investment by the Faculty of Science of 0.2 FTE for two years along with operating costs to bring recommendations to fruition. However, the current financial challenges associated with COVID-19 have generated a challenging landscape for higher education creativity and innovation. Therefore, it is proposed that health sciences staff collaborate with industry and national peak bodies to fund initiatives through competitive grants.

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Appendix 1. Student Equity in Higher Education Research Grants Program 2020

https://cdn.csu.edu.au/__data/assets/pdf_file/0009/3483981/Appendix-5-Student-Equity-in-Higher-Education.pdf

Appendix 2. Translational Research Grant Submission and example of how cultural competence can align with workforce development

https://cdn.csu.edu.au/__data/assets/pdf_file/0008/3483980/Appendix-4-NSW-Health-Translational-grant-submission-.pdf