International Journal for Quality in Health Care Advance Access published April 4, 2011

International Journal for Quality in Health Care 2011; pp. 1–11 10.1093/intqhc/mzr008

Indigenous cultural training for health workers in Australia

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Accepted for publication 6 March 2011

Abstract

Purpose. Culturally inappropriate health services contribute to persistent health inequalities. This article reviews approaches to indigenous cultural training for health workers and assesses how effectively they have been translated into training programmes within Australia.

Data sources. CINAHL PLUS, MEDLINE, Wiley InterScience, ATSIHealth and ProQuest.

Study selection. The review focuses on the conceptual and empirical literature on indigenous cultural training for health workers within selected settler-colonial countries, together with published evaluations of such training programmes in Australia.

Data extraction. Information on conceptual models underpinning training was extracted descriptively. Details of authors, year, area of investigation, participant group, evaluation method and relevant findings were extracted from published evaluations.

Results of data synthesis. Six models relevant to cultural training were located and organized into a conceptual schema ('cultural competence, transcultural care, cultural safety, cultural awareness, cultural security and cultural respect'). Indigenous cultural training in Australia is most commonly based on a 'cultural awareness' model. Nine published evaluations of Australian indigenous cultural training programmes for health workers were located. Of the three studies that assessed change at multiple points in time, two found positive changes. However, the only study to include a control group found no effect.

Conclusion. This review shows that the evidence for the effectiveness of indigenous cultural training programmes in Australia is poor. Critiques of cultural training from indigenous and non-indigenous scholars suggest that a 'cultural safety' model may offer the most potential to improve the effectiveness of health services for indigenous Australians.

Keywords: indigenous, Australia, cultural safety, equity in health care, cross-cultural issues

Purpose

While each nation has its own unique history and heritage, there is increasing evidence that health disparities between indigenous and non-indigenous populations are associated with social determinants of health which encompass geographic, economic, political and cultural factors [1]. In Australia, health disparities between the indigenous and non-indigenous populations are well documented. Many scholars argue that reducing these health disparities will entail addressing underlying social and economic disparities that are the 'ongoing legacy of colonization' [2, 3]. In recognizing the link between social and economic factors and the health of indigenous Australians, there has also been a growing interest in exploring the role played by socio-cultural factors in health service provision. Thomson [4] describes the cultural differences between health service providers and indigenous Australians as a 'cultural chasm' that has acted as a barrier to effective health outcomes for indigenous peoples, the impact of which has been recognized since the 1970s [5, 6].

Moreover, a recent study documents the racism reported by indigenous Australians living in a major Australian city when accessing health services, and the effect of this on their reports of poor health and wellbeing [7]. Non-indigenous health workers also acknowledge this gap; Lowell [8, p. 34] cites a survey of Northern Territory health department staff which found that '82% [of those] who have contact with Aboriginal clients reported some difficulty in their interactions'. In Canada [9], Aotearoa/New Zealand [10] and the USA [11], research has demonstrated the

untoward impact of racist or ethnocentric health service provision on the health of indigenous communities.

Evidence of institutional and interpersonal racism in the Australian health system continues to be documented [12, 13]. In attempting to address racism and bridge the cultural chasm that indigenous Australians face when accessing health care, most policy-makers have turned to indigenous cultural training for health workers [14, 15]. Cultural training in health and education also forms a key aspect of the Australian's government's Close the Gap campaign [16].

This review examines the conceptual models that inform contemporary indigenous cultural training. Two issues are central to this review: the way in which the aforementioned 'cultural chasm' is conceptualized by the dominant health system discourses and the extent to which this conceptualization translates into effective indigenous cultural training in the Australian context.

Data sources

Databases including CINAHL PLUS, MEDLINE, Wiley InterScience, Aboriginal and Torres Strait Islander Health Bibliography—ATSIHealth and ProQuest were searched using a range of search terms, including 'cultural training', 'cultural awareness', 'cultural competence', 'cultural safety', 'cross-cultural', 'culturally appropriate', 'inter-cultural', 'training', 'education', 'diversity training', 'trans-cultural nursing', 'health professionals', 'health', 'Aboriginal', 'Aboriginal and Torres Strait Islander', 'indigenous' and 'Australia'. In total, ~120 articles were accessed.

Study selection

Studies were selected if they: (i) included models that are currently used to inform cultural training; or (ii) evaluated indigenous cultural training programmes in Australia. This review focuses on countries with a history of settler-colonialism, including Aotearoa/New Zealand, Canada and the USA. Cultural training policies deploy a wide range of concepts and terminology. Throughout this review, the term 'indigenous cultural training' will be used to describe training that is concerned with assisting health workers to provide health care that is accessible, meaningful and useful to indigenous/other minority groups in terms of their social, emotional and cultural wellbeing as well as physical health.

Results of data synthesis: cultural training models

There are six major models through which cultural training can be conceptualized: 'cultural awareness, cultural competence, transcultural care, cultural safety, cultural security and cultural respect'. These models are located within the diagram depicted in Fig. 1 based on their relative emphasis on: (i) individual versus systemic behavioural change (individual/systemic axis); and (ii) training health workers to develop an understanding of their own culture and processes of identity versus understanding the culture of others (process/knowledge axis).

Cultural awareness

In Australia, most indigenous cultural training designed for health workers focuses on developing 'cultural awareness' [4, 17]. While each individual training programme varies, cultural awareness training (also known as 'intercultural' or 'cross-cultural awareness training') generally aims to increase participants' awareness of 'cultural, social and historical factors applying to Aboriginal and Torres Strait Islander peoples generally, and to specific Aboriginal and Torres Strait Islander groups and/or communities', as well as promoting participants' self-reflection on their own culture and 'tendency to stereotype' [4, p. 3]. The assumption underpinning such training is that such knowledge will assist health workers to become more 'tolerant' and, accordingly, adjust their practice with people from other cultures [1999 cited 18, p. 88]. Like cultural competency, cultural awareness can lie across the process/knowledge axis of Fig. 1 depending on the degree to which it focuses on encouraging health workers' self-awareness. In practice, however, the literature located in this review suggests that cultural awareness training focuses on 'indigenous culture' [for example, see 19], with little consideration of the broader health service or system and thus falls close to the 'knowledge' end of the axis in Fig. 1.

Cultural competence

The concept of 'cultural competence' was first popularized by Terry Cross's cultural competency continuum (1989) and has since been used widely in the USA, and to a lesser degree in the UK [20, 21] and Australia [22]. Cultural competence has a range of definitions but generally focuses on creating a 'set of congruent behaviours, attitudes and policies' that will prevent the negative effects that may arise from disregarding culture in the provision of health services [11, p. 182]. Training for cultural competence (similar to 'diversity training', 'cross-cultural training' or 'multicultural training') aims to improve health workers' awareness, knowledge and skills so that they can 'manage' cultural factors in relation to health service interventions. This understanding of cultural competence places it near the 'individual' and 'knowledge' ends of the axes in Fig. 1. In more recent literature, however, there also appears to be a growing focus on stimulating health workers to engage in a process of self-awareness and reflexivity [17], and a focus on 'organizational values, training and communication' [23, p. 8 of 10], which would tend to place cultural competence towards the opposite ends of both axes.

Transcultural care

Transcultural care (along with 'cultural sensitivity') features predominantly in the literature from the UK. Leininger [24,

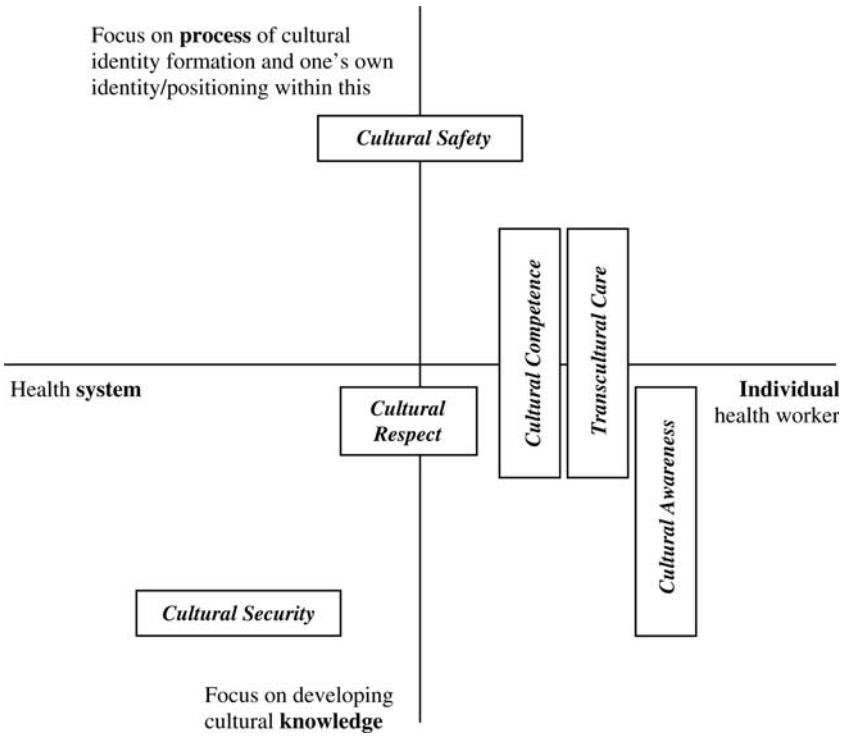

Figure 1 A comparison of theoretical models underlying indigenous cultural training.

p. 342] who has been credited with introducing the concept, defines transcultural care as:

> formal areas of study and practice in the cultural beliefs, values and life ways of diverse cultures and in the use of knowledge to provide culture-specific or culture-universal care to individuals, families and groups of particular cultures.

This model responds to a growing recognition of the inadequacies of 'passive statement[s] of good intent' by focusing on issues of power relations, racism (institutional and interpersonal), and the conceptualization of identities [25, 26]. While earlier transcultural nursing literature covers 'ethnospecific knowledge', contemporary literature tends to emphasize a process of self-awareness as well as knowledge and acceptance of cultural 'differences', rather than developing practice in reference to a 'catalogue of [cultural] knowledge' [27]. Within the schema of Fig. 1, this model is located towards the 'individual' end of the individual/system axis, and across the process/knowledge axis, reflecting its relative emphasis on self-awareness and understanding the processes implicated in the creation of cultural identity.

Cultural safety

Contrary to transcultural nursing or cultural competence, the 'cultural safety' model was developed in an indigenous health care context and has been taken up within the broader context of culturally diverse health care. Developed in Aotearoa/New Zealand, cultural safety was designed to address the way in which colonial processes and structures shape and negatively impact Maori health [28]. Cultural safety is increasingly being utilized in both Canadian and Australian contexts [29, 30–33].

Cultural safety aims to directly address the effects of colonialism within the dominant health system by focusing on the level of cultural safety felt by an individual seeking health care. The responsibility to recognize and protect a person's cultural identity (and hence maintain their cultural safety) lies with the health service. Emphasis is placed on assisting the health worker to understand processes of identity and culture, and how power imbalances or relationships can be culturally unsafe (and thus, detrimental to a person's health and wellbeing) [34].

This model eschews catalogues of culture-specific beliefs, instead encouraging health workers to be more aware of the social, political and historical processes that influence health practice [35]. Cultural safety training also places an emphasis on the health worker understanding their own culture and identity, and how this manifests in their practice [36]. Thus, cultural safety is concerned with both systemic and individual change with the aim of examining processes of identity formation and enhancing health workers' awareness of their own identity and its impact on the care they provide to people from indigenous cultural groups. In Fig. 1, cultural safety is positioned towards the 'process' end of the process/knowledge axis, and across the systemic/individual axis.

Cultural security

The 'cultural security' model was developed in Australia as a response to cultural awareness [17], emphasizing that the

responsibility for the provision of culturally secure health services lies with the system as a whole, rather than individual health workers [4]. This model contends that culture greatly affects access to health services and aims to help the health system and its workers 'incorporate culture in their delivery' of these services [37, p. 4]. With a greater focus on systemic change, cultural security seeks to create interactions between health workers and health service users that do 'not compromise the legitimate cultural rights, views, values and expectations of Aboriginal people' [38, p. 3].

There is currently little guidance on how the cultural security model can be achieved. For example, the Northern Territory approach to Aboriginal Cultural Security argues for an improved understanding of 'what Aboriginal people value and how we can work with these values to achieve better services, outcomes and more satisfied clients' [37, p. 7]. However, the recommended policy is implemented through 'improving the knowledge base' of health workers and departmental staff [37, p. 10]. Thus, despite its broader systemic approach, cultural security still appears to rely on cultural training that will teach participants about 'indigenous culture', placing it towards the 'systemic' and 'knowledge' ends of the respective axes in Fig. 1.

Cultural respect

Similar to cultural security, the 'cultural respect' model emerged in Australia with the aim of developing health services that are more accessible to indigenous Australians through change at a systems level. The 'Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009' identifies the goal of cultural respect as 'uphold[ing] the rights of Aboriginal and Torres Strait Islander peoples to maintain, protect and develop their culture and achieve equitable health outcomes' [39, p. 7]. Indigenous cultural training is advocated on the basis of reaching this goal. However, as with 'cultural security', none of the available cultural respect literature provides direction on how cultural training will achieve this goal. Because of its dual focus on systemic and individual health worker behaviour change, a cultural respect model sits across the individual/systemic axis, and towards the 'knowledge' end of the process/knowledge axis in Fig. 1.

While 'cultural awareness' focuses specifically on the knowledge, awareness and attitudes of health workers, 'cultural respect' and 'cultural security' take a more systematic approach to translating cultural knowledge and awareness into attitudinal and behavioural change for individual health workers as well as changing policy and practice for health care systems. However, despite significant differences between the models, each one advocates for indigenous cultural training in order to develop health workers' knowledge of 'indigenous culture'. This indicates that while models have evolved to match our growing understanding of the 'cultural chasm', notions of indigenous cultural training in the Australian context have generally not progressed beyond a cultural awareness model.

Results of data synthesis: Australian indigenous cultural training programmes

This section focuses on indigenous cultural training programmes for health professionals in Australia for which there are published evaluations. Due to the dearth of such evaluations, we also discuss research pertaining to health professionals' perceptions of cultural training programmes. Located studies are detailed in Table 1.

Using a locally developed survey delivered before and after the training course to both an intervention and control group, Mooney *et al.* [40] found no change in knowledge or attitudes among participants. Mathews *et al.* [19] utilized structured written evaluations designed by the authors after each day of the 5-day course. Participants reported an appreciation of what they had learnt about 'cultural issues' and that they would now 'do things differently' in their work. Participants in Mak *et al.* [41] wrote a reflective journal, were interviewed midway and after the training, and completed a locally developed survey following the training. The findings indicated that they gained a strong awareness of the complexities relating to promoting and protecting remote indigenous health.

Three studies described findings from surveys or written feedback following an indigenous cultural training programme. Participants felt that training would improve their knowledge and attitudes [42], that they could apply such knowledge to provide culturally secure health care, communicate more appropriately with Aboriginal people [43] and that their practices would change as a result of the course [44]. For all studies, participation in the training course was voluntary (as opposed to a compulsory programme mandated by an employer).

A final group of three studies used interviews to determine general views on indigenous cultural training. Watts and Carlson [45] reported a positive change in participants' knowledge and attitudes associated with indigenous cultural training they had previously attended (this was not related to a specific training course). Mak *et al.* [41], Paul *et al.* [43], Watts and Carlson [45] and Johnstone and Kanitsaki [31] found that participants were confused about the concepts of cultural competence and cultural safety and its role in nursing practice while Westwood [46] concluded that there was insufficient evidence to provide an assessment as to the efficacy of indigenous cultural training.

Conclusion

The international literature on cultural training for health professionals provides some confidence that such training can effectively improve knowledge, attitudes and skills. However, it is very clear that there is currently a paucity of studies in this field and a lack of methodological rigour, strong study designs or knowledge of effective training elements [47–50]. Moreover, virtually nothing is known

Table 1 Australian indigenous cultural training programmes

Study	Area of investigation	Participant group	Evaluation method	Relevant findings
Mooney *et al.* [40]	Evaluation of indigenous cultural awareness training	84 non-indigenous health workers from the South Western Sydney Area Health Service	Control and intervention group responses to statements on a five-point Likert scale in a locally developed survey before and immediately after attending a cultural training programme	Evaluation of the questionnaires revealed very little change in participants' responses to the statements following their attendance of the training; it was concluded that the workshop 'did not appear to have a major influence on perceptions or attitudes of health care staff towards Aboriginal people' (p. 23)
Mathews *et al.* [19]	Evaluation of 'an introductory programme on Aboriginal culture and health for non-Aboriginal health staff'	25 NT health service staff members, 15 of whom worked in remote communities	Participants completed structured written evaluations designed by the authors after each day of a 5-day indigenous cultural training programme	Participants' most positive responses were to 'cross-cultural sessions', as they especially appreciated the opportunity to listen to Aboriginal people talk about 'cultural issues' (p. 23) Participants felt that such training should be compulsory for all health workers and health service staff
Mak *et al.* [41]	A review of a pre-vocational public health medicine and primary health care training programme in 'remote Aboriginal Australia'	Four pre-vocational medical practitioners (PMPs)	Participants wrote a reflective journal, were interviewed midway and after their training. They also completed a locally developed survey following the training	'By the end of the [training] Programme all evidence pointed to the conclusion that PMPs had developed an acute awareness . . . that there are no easy solutions to the complexities of promoting and protecting health (p. e152)

(*continued*)

Table 1 Continued

Study	Area of investigation	Participant group	Evaluation method	Relevant findings
Paul *et al.* [43]	The early effect of an indigenous health curriculum into an undergraduate medical course	181 medical students	Participants' responded to statements on a five-point Likert scale in a locally developed survey, following their completion of the course	Responses to the survey demonstrated that on completion of their undergraduate course, 56% of participants felt they could 'apply knowledge of Aboriginal health to provide culturally secure health care' while 61% reported that they could communicate appropriately with Aboriginal people (p. 524)
Valadian *et al.* [42]	How cultural awareness training could be best used to address 'issues encountered by staff when working with Aboriginal clients'	191 randomly selected staff members from the South Australian Department of Human Services	Evaluation of participant responses to a locally developed survey (method of analysis not specified)	86.9% of respondents thought indigenous cultural training would 'improve the skills and knowledge of their staff in working with Aboriginal clients' (p. 156). 62.3% of respondents would prefer indigenous cultural training in the form of workshops; 45% would prefer the Internet or written materials and 13.6% would prefer formal lectures (multiple responses were allowed). 37.7% of respondents would prefer a specific subject covered in half a day, 28.3% would prefer a one day course and 7.3% would prefer an intensive two day course
Kowal and Paradies [44]	Report and evaluation of a workshop designed to encourage health professionals to consider ways they approach 'indigenous ill-health'	21 people from the Menzies School of Health Research, the Northern Territory Department of Health and Community Services, and other organizations	At the conclusion of the workshop, 15 of the participants provided written feedback discussing their experience of the workshop and what they had learnt	Many participants described the workshop as useful. A number of participants commented that they felt their practices would change as a result of the workshop (p. 32)

Johnstone and Kanitsaki [31]	Health worker perceptions of 'cultural safety' and 'cultural competence'	145 purposefully recruited health service staff members from Victoria	52 individual interviews and 28 focus groups, utilizing a qualitative exploratory descriptive (QED) approach	Most of the participants interviewed . . . had not [previously] heard of the term 'cultural safety' (p. 100). '[H]ealth service providers lack . . . knowledge and understanding of the nature and implications of cultural safety and cultural competence in health care . . . ' (p. 103)
Watts and Carlson [45]	Investigating effective strategies for the development of culturally appropriate practice	Eight occupational therapists working with indigenous people in Queensland were recruited	Semi-structured interviews, analysed by the authors using inductive thematic methods	Therapists were found to report that cross-cultural training workshops had assisted them in gaining appropriate skills and knowledge, including an awareness of their own culture
Westwood [46]	A review of a New South Wales area health service cross-cultural awareness training	An area health service department in NSW—an unspecified group of departmental staff were interviewed	Departmental staff members were interviewed and departmental documentation was accessed and reviewed by the author	It was found that a clear guiding policy was absent, and what while there was an identified need for training, sessions had been poorly attended, and that the very limited recorded evaluation of these programmes provided only ambiguous results

about any changes in health and wellbeing that follow from improved knowledge, attitudes and/or skills [51–53].

In Australia, there is scant evidence for the effectiveness of indigenous cultural training. Two of the three studies assessing change at multiple points in time suggested positive changes but these were assessed in relation to satisfaction with training and very general behavioural intentions. The only study to assess knowledge and attitudes before and after training with a control group found no effect. Three studies also documented positive post-training reports but it is unclear if this relates to any change in practice as a result of the training. No information was available with which to assess systemic differences between the programmes that did and did not produce (perceived) changes. It is not yet clear to what extent indigenous cultural training for health professionals is effective in improving practice or which factors (in terms of content, setting or duration) make for effective training [54].

While more comprehensive evaluations of indigenous cultural training programmes are needed, one drawback of existing cultural training programmes may be their limited conceptualization of culture and identity. As this review demonstrates, indigenous cultural training based on a cultural awareness model tends to focus on teaching participants about the 'other cultures' of people seeking their care. The culture of participants (health workers) and the culture of the health system itself remain unexamined, and are thereby implicitly positioned as the norm. Those who do not identify with this culture then are relegated to the 'other' group—the ones who are different.

Indigenous cultural training informed by a cultural awareness model has been criticized for its tendency to 'essentialize' indigenous cultures [55, p. 42]. Essentializing risks the development and perpetuation of the false perception that there is a unified entity called 'indigenous culture' that can be described, taught and understood. By providing such information, there is a risk that participants of such indigenous cultural training can reinforce stereotypical and even negative understanding of what 'indigenous culture' is, what it means for indigenous Australians and how it will be an 'issue' in the health care setting [56–58].

By generating a false sense of 'cultural knowledge', this kind of indigenous cultural training may encourage health workers to make assumptions about the people they are caring for. As Dreher and MacNaughton [59, p. 183] comment, 'we cannot assume that a patient is not making eye contact because he is Korean [or Koori]'. Thus, health workers may unquestioningly ascribe or attribute misunderstandings to cultural difference, and curtail or alter their clinical practice on this basis [30]. For example, a person's non-adherence to preventative medical practice on the basis of their 'beliefs, values, preferences and behaviours' is a common discourse employed when discussing 'the many root causes of disparities' [60, p. 294].

Further, in the context of a society where indigenous peoples have suffered oppression and discrimination, it may be difficult to distinguish 'indigenous culture' from these conditions. Ramsden [61, p. 6], for example, argues that nurses in New Zealand 'confus[e] the cultures of indigenous people with the culture of poverty into which the indigenous people have been driven'.

The essence of this critique is that indigenous cultural training informed by a cultural awareness model has limited potential to create a culturally safe health care system. In order to respect and protect a person's cultural identity, health workers must be able to understand the processes by which cultural identity is created and shaped. Thus, the question is how are we to provide training that addresses these concerns without returning to a designation of a 'non-dominant culture' and a dominant system?

Cultural training based on a cultural safety model may provide the answer [56]. As it is informed by post-colonial theory, a cultural safety framework works to explicitly and critically explore issues of power imbalance and social inequality. An integral aspect of training for cultural safety focuses on exposing the way in which power relations play a part in shaping health care relationships. Indigenous Australian authors continue to argue [including 6, 18, 62, 63], that the shifts required to effect meaningful changes in indigenous health are greater than simply teaching health workers some indigenous language or as indigenous Australian leader Puggy Hunter puts it, learning to 'hug a blackie' [18, p. 88]. Unlike the other theoretical models that have been discussed, cultural safety explicitly works to effect systemic change, by exposing and confronting the discourses and assumptions that are used by the dominant structures and systems.

Smye *et al.* [64] provide one example of the potential for systemic change that a cultural safety approach endorses. In a remote Canadian First Nations community nurses had been routinely giving mothers' cream for their babies' nappy rash. It was only when the nurses decided to ask more about the seeming 'pervasiveness of the nappy rash, did they realize it was most likely caused by the lack of clean water available to the people living in the community' [64]. They conclude:

> [t]he outcome was two-fold: . . . the formation of an alliance with the community (mothers, elders, and Aboriginal governance structures) to advocate for clean water; and this shift in the nurses' focus dislocated the health issue from any thoughts that the mothers might be at fault. [64, p. 145]

The approach to cultural identity offered by a cultural safety model also has the potential to overcome the limitations of a cultural awareness model. As discussed above, a culturally safe environment aims to ensure that a person does not feel any 'assault, challenge or denial of their identity, of who they are and what they need' [65, p. 214]. Only the person seeking health care can judge whether their identity is being respected and is safe; thus, a cultural safety model ensures no other person, discourse or organization can ascribe a particular identity to that person. As such, training advocated by a cultural safety model does not focus on learning a culture, but rather focuses on assisting health workers to practice the reflexivity needed to examine their own identity and cultural

beliefs, and the way in which these might manifest in their interactions with those they are caring for.

Rigorous high-quality research is required to assess the effectiveness of indigenous cultural training based on a cultural safety model when compared with other alternative models [54, 56]. Despite the limitations of indigenous cultural training in its current form, its very existence is a step towards a culture of the health service that is more aware of cultural safety and the barriers to achieving it.

Cultural training cannot make a meaningful contribution to the health of indigenous Australians while it remains situated within the models that produce the very chasm it attempts to bridge. By shifting the focus of training away from trying to teach about 'indigenous culture', toward examining processes of power imbalance and identity [54], a cultural safety model appears to be our best option for delivering indigenous cultural training that will produce lasting change among health staff and systems.

Acknowledgements

The first author would like to thank Rosemary Tipiloura for her mentorship on the Masters thesis which informed this article. The second author is supported by a National Health and Medical Research Council (NHMRC) Australian Training Fellowship for Aboriginal and Torres Strait Islander Health Research (#454813). The third author is supported by a University of Melbourne McKenzie fellowship.

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