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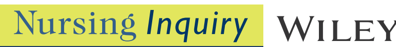

'Maybe what I do know is wrong…': Reframing educator roles and professional development for teaching Indigenous health

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Abstract

Settler colonisation continues to cause much damage across the globe. It has particularly impacted negatively on Indigenous peoples' health and wellbeing causing great inequity. Health professional education is a critical vehicle to assist in addressing this; however, non-Indigenous educators often feel unprepared and lack skill in this regard. In this qualitative study, 20 non-Indigenous nursing, physiotherapy and occupational therapy educators in Australia were interviewed about their experiences and perspectives of teaching Indigenous health. Findings from the inductive thematic analysis suggest educators require skill development to: identify their discomfort in teaching cultural safety; contextualise the sources of this discomfort and; reflect on how this understanding can improve their teaching. Additionally, educators require professional training to become practitioners of cultural humility and to be facilitators and colearners (rather than experts) of the Aboriginal-led curriculum. Of relevance to this is educator training in how to decentre non-Indigenous needs and perspectives. Educators can also renew their teaching practices by understanding what a dominant settler paradigm is, identifying if this is problematically present in their teaching and knowing how to remedy this. Crucial to improved cultural safety teaching is institutional support, which includes Indigenous leadership, institutional commitment, relevant policies, and well-designed professional development.

KEYWORDS

health education, health inequity, Indigenous health

1 | INTRODUCTION

Globally, Indigenous[1] peoples experience well-documented and persistent health inequities compared with non-Indigenous people (Anderson et al., 2016; Jones et al., 2019; Royal College of Physicians and Surgeons, 2019; United Nations, 2007). These inequities are frequently underpinned by colonisation, which negatively impacts health outcomes and contemporary experiences of healthcare (Allen, Hatala, et al., 2020; Jones et al., 2019; Larson et al., 2007; Paradies et al., 2015; Priest et al., 2020; Truth and Reconciliation Commission of Canada, 2015). Settler-colonial processes commonly inform healthcare, education and research in Australia (Fredericks, 2009; Naidu, 2021). This form of colonialism involves outsiders occupying Indigenous peoples' land with the intent to eliminate the original peoples and their cultures via a variety of methods (Tuck & McKenzie, 2014; Wolfe, 2006). It differs from other forms of

[1]The term Indigenous in this article refers to Indigenous people globally.

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colonialism as settlers come with the intent to make their home on Indigenous lands, creating overtime a '…sense of belonging, home, and place enjoyed by the non-Indigenous coloniser/migrant but based on the dispossession of the original owners of the land and the denial of our rights…' (Moreton-Robinson, 2015, p. 3). Settlers commonly normalise settler colonisation processes and do not interrogate the benefits they derive from it (Durey et al., 2016; Moreton-Robinson, 2015). This ultimately means that healthcare is predominantly informed by settler epistemologies and ontologies.

Internationally, leading health professional bodies have committed to addressing racism in healthcare and ensuring stakeholders understand how settler colonisation processes link to contemporary health inequities for Indigenous people (Australian Health Practitioner Regulation Agency, 2020; Canadian Association of Schools of Nursing, 2021; Canadian Nurses Association, 2020; Occupational Therapy Board of New Zealand, 2022; Royal College of Physicians and Surgeons, 2019). In many settler-colonised countries, this commitment is reflected in the inclusion of cultural safety in health professional practice requirements (Australian Health Practitioner Regulation Agency, 2020; Canadian Association of Schools of Nursing, 2021; Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, 2017; Milligan et al., 2021). Cultural safety requires acknowledgement of inherent power imbalances that arise between provider and patient and is determined by the recipients of healthcare (Coffin, 2007; Ramsden, 2002). Importantly, it is incumbent upon health professionals to remain critically conscious of their own worldviews and act to prevent negative impacts on healthcare provision (Curtis et al., 2019). Health professional education is a critical vehicle for implementing these enhanced requirements targeting health inequities (Anderson et al., 2016; Canadian Association of Schools of Nursing, 2021; Curtis et al., 2019; Jones et al., 2019). Many health professions courses in countries where settler colonisation occurred (such as Australia, Canada and New Zealand) are now mandated to include a curriculum on Indigenous health and cultural safety (Aboriginal Nurses Association of Canada, 2009; Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, 2017; Jones, 2011; Virdun et al., 2013). However, the presence of educators skilled to teach this curriculum is critical.

Recommended educator capabilities relate to what to teach and how. For instance, how to teach students to critically examine their knowledge and beliefs and how to take action on this reflection to improve cultural safety (Department of Health, 2014; Fildes et al., 2021; Jones et al., 2019; Universities Australia, 2017; West et al., 2022). Also recommended are skills to teach students how to recognise and respond to power imbalances, such as teaching how privilege is constructed and maintained and how to mitigate resultant harm to patients (Freire, 2000; McLaughlin, 2013; Nixon, 2019; Pease, 2010; Williamson & Dalal, 2007; Wolfe et al., 2018). Further educator capabilities involve being able to teach students about problems arising in healthcare from racism and entrenched settler-colonial epistemologies and ontologies (Bullen & Flavell, 2021; Moreton-Robinson, 2015). These types of capabilities require educators to: understand these concepts; know how to teach about them; equip students to act to improve cultural safety in healthcare. However, this is currently not translating well into practice (Vass & Adams, 2020). Non-Indigenous educators are often relied upon to teach Indigenous health and cultural safety. However, studies indicate that they commonly feel intimidated by this task (Bullen & Flavell, 2021; Vass & Adams, 2020; Wolfe et al., 2018). Educators experience uncertainty, tension and discomfort when teaching at the cultural interface where Western and Indigenous epistemologies and ontologies intersect (Bullen & Flavell, 2021; Nakata, 2007; West et al., 2022; Wolfe et al., 2018). Educators describe a lack of skill and knowledge to teach topics such as antiracism, privilege and cultural safety (Diffey & Mignone, 2017; Vass & Adams, 2020; West et al., 2022). These deficits likely relate to educators being trained and immersed in healthcare institutions that have been informed by settler colonisation. Particularly problematic is that these environs often promote learning at odds with what is required for effective teaching of Indigenous health and cultural safety (Bullen & Flavell, 2021; Bullen et al., 2021; Vass & Adams, 2020; Wolfe et al., 2018). For instance, they can lack learning related to generating divergent thinking, intellectual humility and capacity to navigate uncertainty (Bullen & Flavell, 2021). There is no doubt that non-Indigenous educators require upskilling to improve teaching in this area (West et al., 2022). However, understanding non-Indigenous educators and how they can bring problematic settler colonisation processes into their teaching requires further analysis (Bullen & Flavell, 2021; Fleming et al., 2019; Vass & Adams, 2020; Wolfe et al., 2018).

This study aims to further understand non-Indigenous educators' perspectives and experiences of teaching Aboriginal and Torres Strait Islander[2] (herein Aboriginal) health and cultural safety to health professional students in Australia within the context of ongoing settler colonisation.

2 | METHODS

2.1 | Theoretical framework

This Australian study was designed with a social constructivist approach (Andrews, 2012) that considers knowledge production as occurring through an individual's social, historical and cultural norms (Creswell & Poth, 2018; Denzin et al., 2008; Schwandt, 2007). The authors aimed to investigate how educators construct knowledge to teach about cultural safety and Aboriginal and Torres Strait Islander peoples' health. The researchers identified, during data analysis, that educator narratives included settler colonial processes. For instance, educators at times described their experiences as the norm or usual, such as referring to themselves as 'typical Aussies'. Hence, study findings were interpreted and discussed within the context of settler colonisation and its processes.

[2]Aboriginal and Torres Strait Islander people in this article refer to Indigenous people in Australia.

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2.2 | Study design

This qualitative study utilised semistructured interviews to describe a range of participants' perspectives and experiences of teaching Indigenous health (Gergen, 1999; Patton, 2015).

The research question was: What are non-Indigenous higher education educators' experiences and perspectives of teaching Indigenous health to entry-level health professional students in Australia? The study was conducted within a university faculty in South-Eastern Australia on the unceded lands of the Kulin Nation. At the time, an interprofessional Indigenous Health Curriculum Committee (IHCC), led by Aboriginal academics and informed by the Aboriginal and Torres Strait Islander Health Curriculum Framework (herein called the Framework) (Department of Health, 2014), coordinated the implementation of Indigenous health curriculum and educator professional development resources. Human Research Ethics approval was granted for this study by the Monash University Human Research Ethics Committee (approval # 14738).

2.3 | Standpoint and reflexivity

Researchers' standpoints influence all aspects of the research process, including how they see themselves in relation to others and society (Walter, 2014). As such, it is important to declare the authors' backgrounds. This included Anglo-Saxon heritage (Author 1); South East Asian heritage (Author 2); and Aboriginal (Author 3). The authors have a range of professional backgrounds including physiotherapy (Author 1), optometry and public health (Author 2) and public health and nurse education (Author 3). Author 3 provided a senior supervisory research role. Author 1 conducted the interviews and was an insider with existing professional relationships with some participants. This positioning could have impacted participants' responses and interpretation of findings. For instance, participants may have felt more comfortable or more cautious in sharing information. Tensions were also associated with potentially critically interpreting colleague responses.

During the research, the authors reflected on their sociocultural positioning and discussed this regularly (Patton, 2015). For example, the research team discussed and considered the risks associated with non-Indigenous researchers studying the perspectives of non-Indigenous educators. Particularly, the risks of absenting or diminishing Indigenous perspectives while simultaneously privileging non-Indigenous worldviews (Denzin et al., 2008; Funnell et al., 2020; National Health and Medical Research Council, 2018; Whop et al., 2019).

2.4 | Participants

Participants were non-Indigenous educators in a large university health faculty in South East Australia. Participants were included if they had involvement in Aboriginal health and cultural safety curriculum within the last 3 years with Nursing/Midwifery, Physiotherapy and Occupational Therapy students. This teaching could include a lecture, a tutorial or a unit. The focus on non-Indigenous participants was informed by literature review findings (Francis-Cracknell et al., 2019). This indicated more needs to be known regarding this group teaching Indigenous health and cultural safety curriculum. Included disciplines were selected based on the researcher's professional affiliations and a desire to provide better professional development for these groups. All participants identified as either Anglo-Saxon or of European background.

2.5 | Data collection

Convenience sampling (Creswell & Poth, 2018) was utilised. Heads of Nursing and Midwifery, Physiotherapy and Occupational Therapy schools emailed a study flyer to educators known to be teaching Aboriginal health curriculum. The Faculty's IHCC also emailed the flyer to its membership. Interested educators contacted Author 1 to obtain a study explanation and arrange an interview time. Twenty non-Aboriginal educators participated in 45–60 min interviews. Four were male and 16 were female. Seven educators were from Occupational Therapy, seven from Physiotherapy and six from Nursing and/or Midwifery. Open-ended interview questions were developed collaboratively by the research team members with both Aboriginal and non-Aboriginal standpoints. Interview questions were informed by a literature review (Francis-Cracknell et al., 2019) and social constructivism. Interview questions explored: how prepared educators felt; thoughts on curriculum, professional standards and graduate attributes. Interviews were audio-recorded, transcribed verbatim and checked for accuracy by Author 1. All interviews occurred between January and July 2019 and were conducted with informed consent. Reflective notes were taken after each interview (Author 1) and discussed with the research team.

2.6 | Data analysis

Inductive analysis was undertaken to identify, analyse, interpret and describe patterns of meaning or themes using Braun and Clarke's phases of thematic analysis (Braun & Clarke, 2006; Clarke & Braun, 2017). Throughout this process, the active role of the researchers was acknowledged along with the impact that the researcher's theoretical and epistemological position brings to this analysis (Braun & Clarke, 2006, 2013). The research team continued to include reflexivity during data analysis via in-depth reflective discussion between the authorship team (Braun & Clarke, 2021; Creswell & Poth, 2018; National Health and Medical Research Council, 2018; Schwandt, 2007). This involved reflection on the authors' perspectives of the analysis (Braun & Clarke, 2021; Creswell & Poth, 2018; Schwandt, 2007) and discussion of this in relation to researcher positionality. As part of this reflection, the

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research team collaboratively identified that settler colonisation was influencing educator narratives and thus considered this within the analysis.

Transcripts were checked for accuracy and familiarisation while taking notes (Author 1). Two researchers independently generated codes for one transcript (Authors 1 and 3) which allowed comparison of consistency and consensus on discrepancies. Further coding was generated and reviewed at several meetings (Authors 1 and 3). Codes were grouped into subthemes and themes; these themes were then defined and mapped with illustrative quotes for key points (all authors). NVIVO 12 software was used to manage the data (QSR International Pty Ltd, 2018).

3 | RESULTS

In keeping, with social constructivism these results provide a descriptive interpretation of non-Aboriginal educators and the knowledge that informed their teaching at the time. Five themes were identified in this study. The themes were mapped into two distinct groupings of educators' perspectives regarding learning and teaching (Themes 1–3) and educator perspectives regarding their own learning (Themes 4 and 5). To discuss the complexity of study findings, this paper focuses on the later grouping. These included educator teaching tensions and educator attributes and professional development (see Table 1).

3.1 | Educator teaching tensions

Many educators described tensions and uncertainties regarding their role in teaching Aboriginal health. Educators questioned their knowledge, authenticity and suitability to be teaching this topic as a non-Aboriginal person. For instance:

> …I didn't feel I had the knowledge that was authentic… and I didn't want to be like a fraud, saying this is how it is and actually finding out it actually isn't how it is… (Participant 14)

Educators described systemic issues with curriculum, such as the lack of clarity regarding curriculum coordination and noting a disconnection across courses and year levels.

> …where does any of that content sit in the context of the full curriculum? …does it get covered somewhere else, or what has come before that the students can build on? And that's not been clear to me… (Participant 13)

Some responses indicated less alignment with recommendations for teaching Aboriginal health. For instance, endorsing undergraduate learning of knowledge, rather than higher-order learning, such as critical reflection and evaluation.

> …I can learn health outcomes—I can learn that from a report…Do [students] need to have a deeper understanding of what that actually is in order to go and do their professional job, I don't know…" (Participant 17)

On the other hand, higher-order learning was acknowledged as important, but educators expressed uncertainty about how to achieve this:

> …I don't know how you teach insight. I don't know how you teach people to question. You've got to be ready to do it so it's a difficult one… (Participant 2)

Some were looking for a clear delineation of right and wrong or standardised responses to feel comfortable with this teaching.

TABLE 1 Themes: Educators' perspectives of teaching Aboriginal health

	Themes	Subthemes	Example quotes
1	Educator teaching tensions	Tensions about learning and teaching	'…I don't know how you teach insight. I don't know how you teach people to question. You've got to be ready to do it so it's a difficult one…' (Participant 2)
		Tensions relating to the educators' role	'…I think that sort of discomfort and tension about am I the right person to teach it?' (Participant 13)
		Experiences of what works and what doesn't	'…Sometimes what they need and what they want might be a little bit different…. people sometimes look for generalisations that they can apply, which is not always the case. …' (Participant 8)
2	Professional Development	Educator self-perceptions	'…Yeah, and you've got to reflect and go, well maybe I don't know, or maybe what I do know is wrong, possibly…' (Participant 10)
		Personal and professional attributes	'…I didn't feel I had the knowledge that was authentic…and I didn't want to be like a fraud, saying this is how it is and actually finding out it actually isn't how it is…' (Participant 14)
		Preparedness	'…I think [educators] need to have a level of cultural sensitivity training because you can't teach students how to be culturally sensitive unless you know yourself…' (Participant 4)

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Whereas others acknowledged that diverse situations require critical consciousness, reflection and action to respond.

> …Sometimes what they need and what they want might be a little bit different…. people sometimes look for generalisations that they can apply, which is not always the case… (Participant 8)

Others had questions about the need for Aboriginal-specific content altogether or assertions that teaching should focus on cultural differences. This absented settler colonisation impacts and power imbalances and racism in healthcare. Sometimes educators wished to challenge these assumptions, but found it difficult to articulate this. For instance:

> …The discussions I've had with some people, it's around 'why do we have to have a separate Indigenous unit… Why aren't we teaching it from all cultures, because we're such a diverse cultural population?…I have to take a big breath and think about what I'm going to say… (Participant 15)

Participants often desired the presence of Aboriginal educators to augment their teaching and centred this need around their teaching discomfort. This was often accompanied by a lack of awareness of educational resources and recommendations developed by Aboriginal people to support non-Aboriginal educators:

> … So, some of those sort of big picture content pieces, whether it's lectures or something else, actually delivered by Aboriginal people would be really good. If I knew…delivery was co-constructed with Aboriginal people, then I think I would feel more confident… (Participant 13)

These educator tensions and uncertainties suggest there is an inconsistent understanding of recommendations to inform teaching practices.

3.2 | Professional development

Participants articulated a lack of skills for teaching Aboriginal health and cultural safety, despite recommendations for educators about how to address skills deficits (Department of Health, 2014). For instance, participants focussed on having a dearth of expertise, feeling ineffective, inauthentic and being fearful of causing offence by saying the wrong thing.

> …I have no authority to speak for the Indigenous population and I can only speak about the Indigenous population. And I find that uncomfortable. (Participant 16)

In contrast, other educators recognised a gap in their skills and took action to address this that was aligned with recommendations (Department of Health, 2014). For instance, by being self-aware, reflecting on what they needed to address skill deficits and taking action to improve their teaching.

> …here you're teaching that unit and then you go oh my God I've no idea, I don't know enough about any of this. It's been a very steep learning curve… (Participant 1)

Some participants positioned themselves more as facilitators of learning, rather than an expert, gaining scholarships alongside students.

> …and accepting the feeling that I wasn't an expert, and I think that's a huge thing, especially in academia, we're meant to be [experts]… (Participant 10)

Educators also provided constructive descriptions of recommended attributes (Department of Health, 2014), such as active listening, reflective thinking skills, adaptability, curiosity and humility.

> …the skills that are needed are respectful communication, listening, and a lot of it is thinking about your thinking. I don't know if that's a skill. That's sort of like the meta-cognition thing. And reflective skills. You need to have reflective skills… (Participant 3).

Most participants thought addressing a lack of skills and knowledge required University structures to support their teachings, such as enhanced resources and further professional development.

> …I think it would be fair to describe myself as fairly unprepared for teaching in that context. But also open to learning as well… (Participant 11)

Educators positioned their need for professional development in various ways. For instance, some thought they needed to be experts first to teach:

> …I think [educators] need to have a level of cultural sensitivity training because you can't teach students how to be culturally sensitive unless you know yourself… (Participant 4)

In contrast, others modelled lifelong learning acknowledging they had more to learn and were on the learning journey with their students:

> …Yeah, and you've got to reflect and go, well maybe I don't know, or maybe what I do know is wrong, possibly… (Participant 10)

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Some thought professional development required a combination of theory and practice.

> …I think its lack of exposure to the population, lack of formal education, as in training and that kind of preparedness, the academic preparedness. Then probably the opportunity as well to actually put it in to practice … (Participant 19)

Participants also discussed useful factors that contributed to their professional development that cultivated confidence and led to feeling more prepared.

> …understanding what cultural safety is, what that means for Aboriginal people and why they don't feel safe in mainstream healthcare… (Participant 14)

> …Educators are no different to our students…whilst they would be able to articulate the correct words around inclusion & equity, the cognitive component to responding to this…I don't think is often there…" (Participant 6)

Participants saw value in opportunities for ongoing learning, peer discussion and having access to support resources. Some educators also described the significance of understanding their own culture, privilege and worldviews.

> …So you need to have cultural awareness—awareness of your own culture, awareness of your own prejudices and aware of your upbringing… (Participant 18)

4 | DISCUSSION

This study aimed to understand non-Aboriginal educators' perspectives on teaching Aboriginal health to health professional students. Two key themes were identified: tensions experienced by non-Aboriginal educators and educator attributes and professional development considerations. Results align with existing evidence and provide new insights into educator experiences and professional development needs.

4.1 | Grappling with layers of tensions and uncertainty

Similar to previous studies (Bullen & Flavell, 2021; Diffey & Mignone, 2017; Vass & Adams, 2020; Wolfe et al., 2018), non-Aboriginal educators described experiences of tensions and uncertainty regarding teaching Aboriginal health. However, this study identified that educators experienced this personally when interacting with learners and within the institution they work in. Additionally, educators did mention some potential impacts of their experiences on Indigenous students, patients and academics. However, largely this was centred around their own circumstances and needs. This indicates that educator professional development models would benefit from the inclusion of skill development in how to decentre non-Indigenous needs and perspectives. This is essential to ensure Indigenous needs and perspectives are given proper and equitable consideration and action.

Educators described feeling uncertain about their authenticity in their role and concerned about saying the wrong thing. Participants at times expected binary, right or wrong solutions to teach more credibly, rather than describing the critical thinking required. This may reflect socially reinforced expectations of how knowledge is produced rather than the complexity required for interrogating colonial norms (Mackey, 2014). Educator discomfort and uncertainty can result from engagement with a curriculum that challenges a normalised dominant settler paradigm (Pease, 2010). If this discomfort is not addressed, then non-Aboriginal educators will promote problematic pedagogies, which feel more comfortable and less challenging to teach (Bullen & Flavell, 2021; Milligan et al., 2021). Identifying this discomfort is also important (Mackey, 2014) as it provides a valuable opportunity for educators to engage with cultural humility (Zanussi, 2018). Consequently, educator professional development would be enhanced by enabling educators to: identify discomfort; contextualise the sources of their discomfort; reflect on how this understanding can improve their teaching.

At the educator–learner interface, educators were commonly beset by tensions of inauthenticity. Educators could work toward addressing this by positioning themselves as facilitators and colearners of Aboriginal-led curriculum (rather than experts) and towards being practitioners of cultural humility (West et al., 2022). Becoming a practitioner of cultural humility requires discarding ego (Foronda et al., 2015). It also requires committing to self-evaluation with the goal to improve skills in mitigating power imbalance and preventing paternalistic interaction (Foronda et al., 2015; Tervalon & Murray-Garcia, 1998). However, educators will require institutional support to do this (Fleming et al., 2020; West et al., 2022). Without this shift to active cultural humility, culturally unsafe teaching remains a risk.

Educators faced several institutional challenges including lack of curriculum alignment, inadequate professional development and teaching in isolation. These posed barriers to cultural safety teaching and reinforced teaching of dominant settler epistemologies. Therefore, better institutional support and financial commitment to uphold cultural safety and cultural humility in teaching practice are needed. Important to this is Indigenous leadership, relevant policies and well-designed professional development (McKivett et al., 2021). One professional development design with promise is a cultural humility community of praxis inclusive of pedagogies of discomfort (Boler, 2004). These will likely support educators to better integrate theory into practice (Allen, Hay, et al., 2020; Anderson & Freebody, 2012; Brookfield, 2017; Freire, 1968; Wenger, 1998).

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4.2 | Rethinking educator roles and professional development

Most participants in this study described themselves as feeling unprepared to teach Aboriginal health, despite the critical need (Geia et al., 2020). Educators described themselves as lacking knowledge and mainly focussed on wanting more knowledge about cultural differences. However, Indigenous scholarship recommends against an epistemology of Indigenous people as objects of study and instead points to critical reflexivity that requires developing self-awareness of one's own position, recognition of power differentials that exist and consideration of the conditions of existence in the settler colonised context (Moreton-Robinson, 2015; Walter, 2014). Indeed, Indigenous people's sovereignty can be erased when non-Indigenous educators claim knowledge of Indigenous people's perspectives and can reflect a wider settler colonial narrative. Instead, educators can renew their teaching practices by understanding what a normalised dominant settler paradigm is, identifying if this is present in their teaching and remedying this (Smith, 2012). Without this educators will face barriers to adequate teaching (Tuck & Yang, 2012), which will likely have negative impacts on Indigenous peoples' lives (Jones et al., 2019; Moreton-Robinson, 2015; Nakata, 1997; Pease, 2010; Rigney, 1999; Smith, 2012; West et al., 2022).

4.3 | Strengths and limitations

There are risks when non-Indigenous researchers interview non-Indigenous people regarding Indigenous matters. For instance, by privileging and centring non-Indigenous perspectives and needs while simultaneously decentring and absenting Indigenous perspectives and needs. While the authors practiced reflexivity to mitigate this, it still remains a limitation. Focusing upon selected disciplines of physiotherapy, occupational therapy and nursing/midwifery participants and a single university sample is also a limitation. Further information regarding study participant's roles in teaching Indigenous health may offer further context regarding capacity for teaching. Other experiences and perspectives not captured by this study may also exist. These study limitations may impact the generalisability of the findings.

5 | CONCLUSION

Educators experienced tensions and uncertainty impacting their experiences of teaching Indigenous health. Tensions arose personally, during learner interactions and within their institutions. The findings suggest that educators require skill development to: identify their discomfort in teaching cultural safety; contextualise the sources of this discomfort; reflect on how this understanding can improve their teaching. Additionally, educators require professional training to become cultural humility practitioners and to be facilitators and colearners (rather than experts) of Aboriginal-led curriculum. Of relevance to this is educator training in how to decentre non-Indigenous needs and perspectives. Educators can also renew their teaching practices by understanding what a dominant settler paradigm is, identifying if this is problematically present in their teaching and knowing how to remedy this. What will assist in better cultural safety teaching is institutional support. Important to this are Indigenous leadership, institutional commitment, relevant policies, and well-designed professional development.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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