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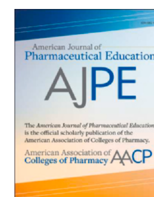

Qualitative Research

Exploring First Nations' and Cultural Safety Content of Pharmacy Curricula With Academics in Australia

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ABSTRACT

Objective: This study aimed to explore academics' views on Aboriginal and/or Torres Strait Islander Health and Cultural Safety content in pharmacy school curricula to inform recommendations for future curricula.

Methods: All 18 Australian pharmacy schools were contacted, and interviews were conducted with consenting heads of school and/or their delegate(s). The interviews covered what the school was doing with respect to the First Nations theme in the revised accreditation standards and further ideas for improvement. Audio recordings of interviews were transcribed verbatim via an online transcription service. Transcripts were thematically analyzed and coded according to the framework approach and mapped to the Aboriginal and Torres Strait Islander Health Curriculum Framework. Coding was facilitated using NVivo software.

Results: All 18 schools consented to participate and a total of 22 interviews were conducted. The pharmacy accreditation standards were well known to most educators, however, the dissemination of the Aboriginal and Torres Strait Islander Health Curriculum Framework, introduced in 2014, appeared to be poor. Many interviewees (n = 14) expressed that the current content regarding Aboriginal health and cultural safety/competence was lacking and cited barriers that have led to a lack of development such as a lack of First Nations staff and expertize.

Conclusion: While cultural safety/competency was taught in all Australian pharmacy schools, it is apparent that pharmacy schools are at various stages in their development of Aboriginal and Torres Strait Islander Health curriculum design and implementation. Future resources should be developed and made available.

1. Introduction

We acknowledge Aboriginal and Torres Strait Islander People as the traditional custodians of the country known as Australia and that sovereignty was never ceded. Three authors study/work on Gadigal land, two authors work on Ngunnawal land, and one lives on Wurundjeri Woi Wurrung land. These lands are Aboriginal, and education and practices have been provided by First Nations people for tens of thousands of years.[1] The phrase First Nations people(s) (Aboriginal and Torres Strait Islander Australians) will be used throughout this paper except when quoting from resources or transcripts that have used alternative terminology.

Historically there has been a lack of awareness of First Nations people's histories and cultures or an understanding of the impact of colonization on health. Today, however, acknowledgment of history with cultural awareness and safety mandates are included in health policies.[2–5] However, there is still work to be done to translate policy into education and meaningful effects on health outcomes, such as the 9-year difference in life expectance of First Nations peoples.[3,6,7] The intersecting reasons for disparities, including dispossession, transgenerational trauma lead to socio-economic disadvantage, and discriminatory practices within mainstream health care.[8,9] In fact, First Nations people have not always felt safe seeking health care. A study surveying 755 Aboriginal Victorians in 2013 reported that 97% of respondents had experienced at least 1 incident of racism in the preceding 12 months in a health care setting,[2] and a 2017 evaluation of services found that people continued to experience hospitals as sites of trauma.[2] A lack of health professionals' awareness of, or reflection about, the rich

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cultural traditions that shape beliefs and values in First Nations peoples is a key factor.[2] This likely leads to many First Nations people being less satisfied with imposed norms of mainstream health care. It is therefore important that health care providers are trained to provide a culturally safe environment for First Nations peoples.

Within the pharmacy setting, there is a lack of research outlining the role pharmacists play in assisting First Nations people,[10] and perhaps the lack of research and service provision is further compounded by the small percentage of First Nations pharmacists. Current statistics state that out of 34,000 registered pharmacists in Australia, only 0.31% identify as First Nations.[11] This is alarming, as First Nations people are 3.2% of the general population.[12]

The accreditation standards for Pharmacy Degree Programs in Australia (2020) now state that program planning, design, implementation, evaluation, review, and quality improvement processes are to be carried out in a systematic and inclusive manner,[4] mandating First Nations people are consulted stakeholders when designing or reviewing a degree program.[4] Further, program design, content, delivery, and assessment are to specifically emphasize and promote First Nations cultures, cultural safety, and improved health outcomes.[4]

Cultural competence is a key strategy for reducing inequalities in health care access and improving the quality and effectiveness of care for First Nations people.[7] Cultural competence is more than cultural awareness, it is the set of behaviors, attitudes, and policies that come together to enable a system, agency, or professionals to work effectively in cross-cultural situations.[7] To become more culturally competent, awareness of one's own cultural values and world views and their implications for making respectful, reflective, and reasoned choices, including the capacity to imagine and collaborate across cultural boundaries, are required.[13] Cultural safety occurs when cultural competence is put into practice. Cultural safety is the principle underpinning programs and policies to address the remnants of colonial outlooks in health systems.[6]

Learning about how to provide culturally safe health care starts with preregistration training. The Cultural Respect Framework 2016–2026 has 6 domains, with domain 3 (*Workforce development and training*) and domain 5 (*Stakeholder partnership and collaboration*) stating that cultural competence needs to be integrated into health care training.[5] Not only is inclusion of First Nations health content mandatory in pharmacy degrees according to the Australian Pharmacy Council (APC),[4] but cultural competence is also articulated as a university graduate outcome across several universities.[14,15] Despite these proactive and affirmative policies, little is known about how cultural competence/safety has been integrated into pharmacy curricula. Further, exploration of hidden curriculum and its impact on students, and strategies to address systemic, institutional racism may be required. The hidden curriculum, defined as the unwritten "rules, regulations, and routines" of the institutional environment is more "concerned with replicating the culture of the profession/society rather than with the teaching of knowledge and techniques."[16] A study conducted by Roberts and colleagues[17] exploring barriers to learning about culture, race, and ethnicity, found that students perceived institutions were failing to provide a learning environment encouraging constructive discussion about culture. They recognized that cultural competence was essential for their future professional practice but felt that their school placed lower priority on these learnings.[17]

The Aboriginal and Torres Strait Islander Health Curriculum Framework (the Framework) was created to help support tertiary education providers in implementing First Nations health curricula across degrees.[18] The Framework aims to facilitate the provision of culturally safe health services to First Nation's people through development of cultural capabilities. Underpinning this Framework are 8 key principles for implementation (Table 1).

This study aimed to explore pharmacy heads of schools and/or delegates' views on how First Nation's health topics are taught in Australian pharmacy schools, using the Framework as a benchmark to inform future curriculum design and resources.

Table 1
The Aboriginal and Torres Strait Islander Health Curriculum Framework Principles.[12]

	XXX	XXX
Principle 1	Leadership at all levels is key to supporting effective implementation of Aboriginal and Torres Strait Islander Health curricula. • Organizational leadership, commitment, and accountability at all levels, including the executive level, supports full implementation of Aboriginal and Torres Strait Islander Health curricula • Undertaking cyclical organizational assessments provides opportunities to enhance and support more effective curriculum implementation • Building leadership capabilities in graduates to be advocates and agents of change in their chosen health profession is key to transforming health practice	
Principle 2	Respectful partnerships and collaboration with shared responsibility between Aboriginal and Torres Strait Islander and non-Indigenous people are required in curriculum design and implementation. • Meaningful involvement of local Aboriginal and Torres Strait Islander peoples in the development and implementation of curricula is essential • Curriculum content and the learning process must emphasize learning 'from' and 'with' rather than 'about' Aboriginal and Torres Strait Islander peoples • Shared responsibility between Aboriginal and Torres Strait Islander and non-Indigenous staff for leading and dealing with Aboriginal and Torres Strait Islander matters is critical	
• Principle 3	• The process of learning is equally as important as content. • Transformational teaching and learning approaches that favor adult learning principles and enable a critically reflexive learning experience while caring for the wellbeing of students is essential • Aboriginal and Torres Strait Islander pedagogies should be integrated into teaching practice • Strengths-based learning1 incorporating innovative, experiential and practice-based examples should be emphasized	
Principle 4	Self-reflexivity and humility develop respectful health care practice. • Self-reflexivity and critical analysis of one's own cultural values and privileges are integral to respectful health care practice • Development of humility and respectful person-centered health care practice involves recognizing and understanding the feelings and experiences of Aboriginal and Torres Strait Islander peoples	
Principle 5	Holistic health service delivery is essential. • Aboriginal and Torres Strait Islander peoples have unique health needs shaped by the local context and colonial history, which requires responsive, effective person-centered health services • Health services should be informed by comprehensive primary health care principles and models of interprofessional2 practice, these elements are integral in the education of health graduates	
Principle 6	Local context and diversity must be recognized. • Curriculum content and the teaching and learning process should reflect the local Aboriginal and Torres Strait Islander context and the diversity of Aboriginal and Torres Strait Islander People	
Principle 7	Development of intercultural capabilities is a lifelong learning journey. • Foundational content on Aboriginal and Torres Strait Islander Health should be introduced in the first year of study and then built on through horizontal and vertical integration throughout HPPs • The development of cultural capabilities is a lifelong journey, extending beyond formal education and practice	
Principle 8	Ongoing professional development and professional support for Aboriginal and Torres Strait Islander and non-Indigenous	

(*continued on next page*)

Table 1 (*continued*)

	XXX	XXX
	educators is essential. • HPPs should offer ongoing cultural learning and professional development opportunities for all levels of staff • Support needs to be provided for Aboriginal and Torres Strait Islander and non-Indigenous educators, recognizing the emotional load encountered while teaching in this context • • Educators should have strong theoretical and practical understanding of Aboriginal and Torres Strait Islander pedagogical principles that support safe and effective transformational learning.	

2. Methods

The research team brought a variety of identities and perspectives to this study. Team members were both internal and external to the pharmacy program and included faculty members and APC collaborators. The team represented diversity through the lenses of race, gender identity, immigration status. This diversity was deemed important to ensure data were interpreted through lenses that represented target populations (See Supplementary Appendix 1).

Ethical approval was obtained through the Human Research Ethics Committee of The University of Sydney reference number 2020/526. A list of all Australian pharmacy schools and key contacts was obtained from the APC website.[19] Emails were sent by AB inviting heads of schools or delegates to take part in interviews in August 2021. Heads of school were chosen, as it was expected they would have a general overview of curriculum taught in their institution. If, however, they identified an additional teacher/coordinator, the investigator allowed for a represented delegate to take part instead, or in addition to, the head of school. Follow-up emails were sent 2 months later in October and final emails were sent in February 2022 to nonrespondents. All interviews were completed by March 2022. Interviews were conducted by AB using the Zoom video-conferencing application.

Interview questions focused on what the pharmacy school curriculum currently included regarding First Nations health and cultural safety (Supplementary Appendix 2). Interviews were audio recorded and transcribed verbatim via a third-party transcription service (Rev.com). Transcripts were uploaded to NVivo where quotes were coded according to themes derived from the Framework. In addition, quotes within the 8 Framework themes (Table 1) were further coded using the framework analysis approach of Ritchie and Spencer,[20] with validation of coding by RM. Discrepancy in coding between AB and RM was discussed until consensus was reached. Ritchie and colleagues[20] state the framework analysis is suited to research aiming to uncover new phenomena, and is useful in assessing policies and procedures from the people affected[20] (in this case, academics from Australian pharmacy schools). The framework analysis allows one to explore data through 4 frames: (1) contextual (what is happening); (2) diagnostic (the reasons for or against doing something); (3) evaluative (does it work?); and (4) strategic (new plans). Using these 2 frameworks, a matrix of quotes was developed (Table 2). In addition, some inductively derived concerns presented across the matrix of themes and are reported.

3. Results

Interviews were conducted with at least 1 representative of all 18 Australian pharmacy schools. In total, 22 interviews were conducted, with 4 schools offering 2 representatives (head of school and teaching academic). Of the 22 participants, 2 identified as First Nations. Table 2 reports the main study findings with specific quotes mapped against the Framework[12] and the 4 frames of Ritchie and Spencer.[20]

3.1. Mapping to Frameworks

When looking at the Framework, the 8 principles were broken down into 3 key areas: (1) Expert Involvement: Who are pharmacy schools hiring to teach this content and who are they consulting when organizing curriculum design? (principles 1 and 2); (2) Processes used: How are pharmacy schools going about teaching this content, what are the processes that they are using when creating this content? (principles 3–5); (3) Preparing for future success: How are pharmacy schools setting up students, academics, and First Nations people for success when they go out into the field, teach and design curricula? (principles 6 and 7).

3.2. Expert Involvement

Principle 2 describes the need for involvement of First Nations people in developing and teaching content. Participants identified the need for and the importance of First Nations people playing a role. Often, external stakeholders were reported to be brought in to help teach content, however, few participants mentioned the importance of hiring First Nations people and having them in positions of leadership (principle 1). A participant from one school mentioned that people made redundant during the COVID-19 pandemic were those casually employed which often included First Nations people. When discussing barriers that prevented the implementation of principles 1 and 2, funding was described as a key barrier to employing people to help implement, teach, and evaluate. *"Money is definitely an issue. Most academics I know work 70 h a week. Since COVID and all the international students disappearing, it's got worse."* An area where participants noted that improvements could be made, was working with First Nations people in creating case studies or bringing community into classrooms to talk about issues they have faced. Some participants noted that there should be opportunities for First Nations people to become permanent staff members.

3.3. Processes Used

Covered by principles 3, 4, 5, and 6, this was an area where many schools struggled. Principle 3 focuses on the way content is delivered. Interestingly, many participants indicated that while relevant content was often included, approaches to how this should be taught and assessed were rarely discussed. Similarly, there appeared to be some lack of consideration of what content could be delivered by a First Nations person so that the First Nations experience is embedded into student learning. principle 5, about holistic health, did not map to many response quotes as participants did not talk about this point, ie, ideas around how an individual perceives their health. Therefore, the data suggest that few looked at this principle from a First Nations perspective. Further, most schools believed they should be doing more and often cited specific barriers to lack of content but also ideas on future improvements "*I was really inspired by the medicine course last year… they have a welcome to the course which involves more of a cultural immersion.*"

In the cases where the head of school and other nominated staff were interviewed, there were conflicting accounts of what they reported. In one case, the head of school was concerned as they did not believe they were doing enough to meet accreditation standards "*I know that we are going to struggle this year*" and when asked about how adequately they were preparing students for First Nation's needs "*It's pretty woeful…we don't have any experts in that space*" this was contradicted by one of their staff members who believed that they were preparing students adequately. In another school a similar situation occurred where a staff member believed what they were doing was *"adequate,"* but the head of school thought it was inadequate "*Why do I say it's not adequate? Because it's not…normalized. It's out there as a separate thing and it should be just embedded*" they also had a very clear picture of what was included and where and how they wanted the school to progress "*If*

Table 2
Selected Quotes Mapped to Aboriginal and Torres Strait Islander Health Curriculum Framework and Framework Analysis of Ritchie and Spencer.[20]

XXX	Contextual	Diagnostic	Evaluative	Strategic
Principle 1. Leadership at all levels is key to supporting effective implementation of Aboriginal and Torres Strait Islander Health curricula.	• "We don't have any Aboriginal academics on staff. So, we did have one, but she's somewhere else now. But we had Aunty X, who was based in the nursing field … but we haven't had anyone replace and she's been gone for about 3 years now." • "I Think one of the best things that the uni did was that they employed at the university level a[*n*] Aboriginal women who is overlooking all of the teaching, learning activities and supporting all the teaching and learning activities"	• "We lost a lot of First Nations staff because unfortunately a lot of our First Nations staff were the ones who were casual" • "My default position is that universities as a whole, health courses as a whole, don't generally do this stuff well. Part of the problem of course, is that there's not enough Aboriginal and Torres Strait Islander Academics leading this space"	• "The issue is having the capacity of Indigenous staff to teach it because it should be taught by them" • "I think we need more access to Indigenous academics to help us with better content, better focus in our program"	• "Just more Indigenous staff, is what the university needs" • "I think we definitely need more representation. That's the resource we need the most, is more academics that know this stuff"
Principle 2. Respectful partnerships and collaboration with shared responsibility between Aboriginal and Torres Strait Islander and non-Indigenous people are required in curriculum design and implementation.	• "We also have some people a[*s*] pharmacists who work with Aboriginals in various communit[ies], talk to students about those things that they do, and as white people relating with First Nations people" • "So, I'm moving into an aspect where I try to get stuff that's been authored or written or videos by Aboriginal people to use, to illustrate points rather than me speaking on their behalf, because I think that's not appropriate anymore"	• "I would love to get another academic to teach it. Ideally, I would get more input from First nations academics, but unfortunately X university, many universities have very much a lack of Indigenous academics" • "The ongoing issue is having access to Aboriginal people who are not burnt out by having to do 10 billion of the same things everywhere, and I totally understand that we have a very small population of Aboriginal people and an even smaller population of them who are willing and able to actually deliver training like this"	• "[I] don't think we've done enough local engagement and that's something I think we need to change, and it's just trying to find that balance" • "As non-Aboriginal people… We have to be careful that we're not doing things that we think are right, rather than things that they think are right"	• "I'd like time. I'd like some money, because I would like input from Aboriginal health academics. And I would like input from perhaps some Indigenous health workers" • "I think it would be much better if we had an Aboriginal person deliver it" • "It would be really good if we had… This is just a pipe dream, I suppose. But we need Indigenous people with education backgrounds included in our curriculums"
Principle 3. The process of learning is equally as important as content.	• "So, we always teach from a deficit model, and I think we need to move on from a deficit model" • "The indigenous content is solely lacking in our course, and we are certainly trying things to rectify this"	• "To be fair, mostly it comes down to money resources" • "There's been no specific resources… we do need some pharmacy-specific resources" • "I think that is the challenge, actually building on content"	• "I think the best way to assess it is to actually see them try and do it in practice" • "The universities aren't going to let us do that… They're not going to let us fail someone that's clinically capable, but we judge [a]s culturally unsafe"	• "Making it sort of as a learning experience rather than I'm doing it for the sake of doing it or I need to do it" • "Proposing a new course where… about 1/3 of content will be focussed on Indigenous health, as opposed to 1/10″ • ·"Set really challenging assessment tasks… you need 80% of the knowledge even to get 50% marks or you make the pass mark 65 or 70 for a student to pass"
Principle 4. Self-reflexivity and humility develop respectful health care practice.	• "I guess my own training is more an awareness of my lack of knowledge and the need to ask questions of the appropriate people" • "We have values, beliefs and attitudes sessions, where the students delve into their own personal values, beliefs and attitudes"	• "I think a lot of us were worried about doing the wrong thing" • "A lot of students… have to unlearn what they've learnt about our history. So, there's a lot of unlearning that has to take place before they actually learn. And that's why I think it's really important that start because our history's not taught in schools"	• "Depends on what they've learnt before they've come. If they've come with an open mindset, that's fine. If they've come with a closed mindset, no way. It takes years for that to happen" • "People do lots of cultural awareness training. It doesn't mean they can create a culturally safe space" • "I hope it's enough, but I don't know. I'm saying I hope it's enough because I hope that our broad approach to	• "I don't think what many of us call learning ball about the exotic other is the solution. I think it's more about turning the gaze inwards, thinking about themselves and how their views, attitudes, beliefs, assumptions impact on Aboriginal [and] Torres Strait Islander people when they're providing care." • "So, I think that you need to approach the curriculum with a purpose. And that is, if you understand the

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Table 2 (*continued*)

XXX	Contextual	Diagnostic	Evaluative	Strategic
			thinking about broad culture and broad cultural differences, is enough that they're getting enough skill that they should be able to apply that to anybody of any culture, regardless."	background, then you will become a better health care practitioner"
Principle 5. Holistic health service delivery is essential.	• "The lens of these are Aboriginal people who have cultural values, beliefs, language, customs first. Not seeing them as sick people who need health services" • "I think the only point that I haven't got across… we're the sovereign people of this country. We're not an afterthought and we're not waiting to be saved. We're actually deserving of care. We're human beings. We have basic human rights, not only to health, but to self-determination in our lives and within our choices around health"	• "It's probably not a money area, no one's done the research" • "There's an emphasis on Aboriginal and Torres Strait Islander cultural background, but I think we're still neglecting that larger cultural aspect and its effects on health care"	• "Cultural safety skills are implicitly linked with clinical safety. So, I think a really good understanding of what cultural safety is and how it applies to their own practice is a really important skill" • "What I think it does is prepare them to engage with the person to find out what they need" • "I want people to feel safe to be able to talk to me about cultural issues. And I also would like to feel safe to talk about cultural issues with others"	• "I say this to any of the disciplines I work with… on a placement consider going regional remote, you will learn so much more. And I think it makes you a better practicing clinician" • "Provide a space… where people of any culture… can feel safe and comfortable, and also have their culture recognized as an important part of their health philosophy"
Principle 6. Local context and diversity must be recognized.	• "I do think there are some students that show genuine commitment, genuine self-reflection and a genuine desire for the right reasons to go and spend time in a black space to build their skills" • "Our students get exposed not all of them, but a number of them get exposed to the Aboriginal Health Services that are in our region. And all of our students go on remote placements at least once in their 4-year degree"	• "I'd love to have some money to bring mob into the classroom or to take people out, students out on country" • "Understanding how to find out about their local group, rather than a generic thing that applies to all Aboriginal people, because that wouldn't be appropriate" • "If those universities determine that there's a significant body of work for clinicians to do in that environment that relate to health and wellbeing of indigenous Australians, then it should be a stronger feature in the programs"	• "I also push in my subject the need to get them to reflect on statistics. Statistics can be useful. They can tell a story, but are they telling the whole story" • "Are the learning experiences of the students more important than the risks we put community out by just rushing in and sending students out"	• Speaker 1: "should [placements] be made mandatory" speaker 2: "I think you can argue it both ways. I think you need to do it in a way that it's not a burden [on] community and it's not going to be unsafe" • "I would rather see them go on a placement to an Aboriginal health clinic"
Principle 7. Development of intercultural capabilities is a lifelong learning journey.	• "We weave cultural competence or diversity competence throughout the whole curriculum" • "At the university, all new students have to complete an indigenous stud [y] as a central unit, which is a zero-credit bearing unit"	• "APC Accreditation standards only say that you must have that there. They don't really provide a framework for the content" • "You don't want to just drop an activity around First Nations health and Cultural Safety into a subject when it just doesn't fit… the students pick up on, well, they've just shoved that in randomly"	• "If we are training people appropriately in the right context and they're learning it and they understand what they're learning… Then it should stay with them, and they should draw upon it when it's needed"	• "The importance of Aboriginal and Torres Strait Islander voices and perspectives. So sometimes with just a little bit of thought and creativity, you can find places where content can go" • "I think what they need is a little of the high-level stuff, but they need actual actionable advice, skills, pieces of knowledge, that allow them to apply their broader knowledge around primary care and of delivering quality pharmaceutical services to that specific population"
Principle 8. Ongoing professional development and professional support for Aboriginal and Torres Strait Islander and non-Indigenous educators is essential.	• "I don't use the word cultural competence because I think competence suggests that there's a finite set of skills that you need to learn, and you reach an end point. And I don't believe that's the case in cultural safety. I think it's about a	• "I think people try, but I don't, I think it can be done better because I think people, again, in the same way, people are still on this learning journey" • "I think the thing that sort of worries my team, the ones that who are doing it is we don't want to do it wrong; we	• "If they go into a black space and they innocently do something really stupid or really racist, and one of our mob has a go at them about it" • "Then we turn them away from working in Aboriginal health forever"	• "I do think we need some very specific skills for teachers in the classroom around anti-racism and being able to deescalate conversations that start to get a bit racist"

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Table 2 (*continued*)

XXX	Contextual	Diagnostic	Evaluative	Strategic
	lifelong learning and constant reflection” • “I've done about three or four cultural competence workshops, that and my own interest and reading, but nothing more formal and just general”	don't want to come across as being tokenistic. But then at the same time, well, we don't know how to do it”	• “I think that's a skill that you build over time by learning from patients, but also from attending training. I don't think anyone can go, “right now I'm competent.” I don't think it's an endpoint, I think it's just something you continue to build”	• “I actually think the boards could do more, I actually think Boards could update their standards a bit more often”

we could pull our resources in terms of creating cases and learning materials that we could share and use together, I think that would be really helpful, of common pharmacy-related scenarios that we could embed… and other people could embed it where it would work for them.” Furthermore, most stakeholders either did not believe they were adequately preparing students to meet First Nations consumer needs, or they believed that they could be doing more “*I would say, at the moment, we're not meeting needs, but we're trying. And I guess that's just from my point of view, but I'm sure it's probably the same around many universities*.” With respect to the structure of how and when First Nations health content should be delivered, there seemed to be a majority opinion. Fifteen interviewees favored an integrated approach that had been built upon in all the years “*Integrated, obviously. Embedded. Because if you have a unit that's just Aboriginal… ”Okay, I've covered Aboriginal, it's in that unit, I don't have to worry about it.” “Then students silo things.*” One interviewee, however, favored a discrete unit where these outcomes form the basis of a separate unit of study “*It works for us having a discrete unit because we know the people who are teaching it really well.*”

Three interviewees favored an approach where a discrete unit introduces concepts in early years and builds upon them in later years via an integrated approach “*Look, I think there's a middle ground for most things… And I think that having some standalone units, which are particularly focused on that… And then it's integrated later on.*”

Many interviewees (8) wanted to see an eventual move to mandatory placements for students in either a First Nations community or a rural setting where a higher percentage of First Nations people resided “*I would love to see that, because rural placements seem to change students. I've seen really quite apathetic students come back completely changed from a rural experience.*”

Five interviewees however noted that this could be troublesome and did not favor this approach, as it could be seen as a form of “*cultural tourism*” and if students who are not culturally safe go into communities, they could do damage “*I don't hear enough conversation about risk management for community.*”

The issue of assessment was also raised. Some interviewees noted that “soft skills” such as cultural safety/competence would be difficult to assess “*So, these things where you are assessing things that are not necessarily very tangible…it's this ability to communicate and connect and actually make a difference*.” To combat these issues, interviewees wanted to move to skills-based assessments “*but can we have an OSCE [Objective Structured Clinical Exam]… specifically around addressing Indigenous health needs?.that's something that we're looking at,*” supplemented by reflections “*We do have a big priority regarding reflection in our course in general, and so we definitely want students to be examining their own worldview. So, there's learning outcomes to do with examining their own cultural worldview and values and describing implications for health care practice*.” The consensus was that there should be a move away from multiple choice and short answer questions. Preparing for future success covered by principles 7 and 8, schools understood that they had shortcomings and had ideas about how these could be addressed in the future such as designated roles for First Nations people or increased funding to make employment viable, however, there were many disagreements about outside roles and even internal conflicts that could hamper this effort.

Interviews revealed clear variations between “what” and “how” First Nations' content was delivered. Often, there was acknowledgment by participants that the inclusion of Aboriginal health content in pharmacy curricula is in its infancy. Participants identified that they were at various stages of the accreditation cycles, with some accredited against new standards and others still waiting to undergo evaluation. Some schools had recently undergone curriculum reform allowing them to have a more structured approach to the inclusion of First Nations' health. One interviewee stated “*You're right, it could mean that one might have a lot and one might have hardly any. Having said that, that's the strength of our higher education system and the differentiation between the different universities.*” Further into this idea, was how much schools

should adapt the accreditation standards of the APC. Some interviewees felt that accreditation standards were a good starting place but more effort from the school was needed to go above and beyond. Some schools however felt that APC standards were adequate in helping them develop the minimum standard to teach to.

When asked about the role of the APC, some schools wanted them to take a more active role in providing resources to help reach accreditation standards and some felt that the standards do not go far enough, and more emphasis on First Nations health should be provided. This was not the opinion of some stating, "*I think that it is probably… stepping outside the bounds of the accreditation to mandate how much it should be because they are not the pedagogy experts.*"

To see a more comprehensive look at how the framework and analysis were used see Table 2.

4. Discussion

This study explored key academic views on how First Nations health topics are taught in Australian pharmacy schools, using the Framework[12] as a benchmark of what institutions should be achieving. All current pharmacy schools in Australia were represented, therefore this study has gathered a national census of opinions. The study highlighted that all pharmacy academic institutions include some content around First Nations health and culture, with a large variety of ways and amounts of teaching. Overall, most academics expressed keenness to include this topic more comprehensively and strongly desired deeper involvement of First Nations teachers.

As identified, the individual schools were at various stages of the accreditation process meaning some had implemented changes while others had not. Similarly, a study by Onyoni and colleagues[21] was conducted in the United States of America and Canada which found that curriculum change committees recognized that cultural competence needed to be added to curriculum, but not all respondents had implemented changes in their schools. It should be noted that it takes time to develop and renew curricula so implementation change needs to occur thoughtfully over time allowing one to create more awareness of issues, such as the plight of First Nations people. Further, political change can also drive curricula. For example, the current curriculum at some Australian pharmacy schools may have predated political changes. For example, in 2007, the then Prime Minister's approach to First Nations affairs was very different.[22] In 2007, the government was refusing to apologize for the stolen generations of First Nations peoples and the government made it harder to claim native title.[22] This time also predated the 'closing the gap' strategy, implemented after "the national apology" of 2008.[3] Looking at this example, it could be a reason why variation between pharmacy schools exists.

Although it was positive to see schools teaching some content, what was troubling was a lack of standardization, and what one was doing may not be replicated in another. Within some schools it appeared that First Nations issues were seen as an afterthought with 1 participant saying: "*sometimes with just a little bit of thought and creativity, you can find places where content can go.*" Although the interviewee may mean well, this is indicative of the current culture in that First Nations issues find itself in. This is not a problem unique to pharmacy. A study in contemporary nursing noted that one of the weaknesses of the nursing curricula was the minimal inclusion of First Nations health and the disparity in how it was covered in curricula.[23] The authors of this paper took the approach of incorporating key aims from the Graduate attributes into a school's curriculum.[23] They made sure to effectively embed First Nation's content and made it the business of non-First Nations people to teach this content. They noted that the lack of explicit responsibility for the development and teaching of Indigenous elements by non-Indigenous academics can manifest as weak engagement or interest in either developing students or dealing with unacceptable behavior.[23] Encouragement of all academics to be involved and engaged in the teaching of this content may be one way to ensure at least some standardization and integration into all curricula.

A problem seen throughout the interviews was an undertone of racism. The academic who stated: "*that's the strength of our higher education system…*" perpetuates the idea that cultural safety content is less "important" than the competition between schools. Ideas such as these may foster structural racism, still very prevalent in Western society. Structural and systemic racism can be further seen in the lack of First Nations leadership throughout the pharmacy education sector. None of the interviews mentioned the input of a First Nations pharmacist nor did any school, at the time of interview, employ a First Nations pharmacist. While some universities had input from First Nations health care professionals, documents they provided "had to be adapted" by non-Indigenous persons to fit the pharmacy curricula. Although some schools were doing better than others, it is hard to make a link that advances were due to the input of First Nations staff. This lack of First Nations leadership adds to hidden curriculum, sending undertones of a lack of importance of First Nations content. This was further exemplified when it was uncovered that First Nations staff were mostly casual employees and as such were the first to be "laid off" during the COVID-19 pandemic. While many schools noted that the lack of First Nations leadership was concerning, none commented on possible solutions. Many participants noted a lack of funding to employ people, however, these sentiments again display a culture of school's unwillingness to spend money on First Nations workforce development.

In contrast, nearly all participants wanted to have more engagement and employment of First Nations people. This cultural shift and restructure of how educators deal with the damage hidden curriculum can cause is needed. The notion of just ticking a box to show cultural safety has been included with ad hoc implementation of content vs a dedicated effort to make sure staff and students understand the content, its importance, and the conscience effort to include First Nations people at all stages of curriculum development was recognized by some as the only way forward. Strategies to move forward include doing more to advertise pharmacy to First Nations high school students through outreach programs, the creation of alternative entry pathways, the possible reduction of university entry marks into pharmacy, and the creation of dedicated roles for First Nations pharmacists to enhance the creation of a strong First Nations workforce.

The issue of assessment was also raised by participants. As stated, most wanted to see a switch to the assessment of soft skills such as interview techniques. However, pharmacists are experts in medication management and can easily assess a student on medication content, but when talking to a patient of a First Nations background, only a person from that background can make an accurate determination of culturally safe provision. Pharmacy schools need to be making conscious efforts to have First Nations people perform assessments with students. A review from Nguyen and colleagues[24] reported that when consumers are used in the education and assessment of students, not only do the students report improvements in self-confidence and communication skills, but consumers also report higher satisfaction from sharing lived experience with students.

Although this study explored what schools were doing currently, it did not specifically go into every individual unit of study but asked for a general overview. Because of this general approach, some important information and key areas of improvement could have been missed. When multiple people in the school were asked the same questions there were sometimes conflicting opinions, which should be further explored. Therefore, this study can be used as a template for adaption to individual schools to take a "deep dive" into their own curricula to identify areas of improvement. In addition to using a similar method within individual schools in Australia, the approach could also be applied to other countries with First Nations people such as the United States of America and Canada where accreditation standards are undergoing review. This article may therefore provide schools with some advice/pathways for identifying curricula gaps, systemic racism, and hidden curriculum.

5. Conclusion

This study explored what was being taught in Australian pharmacy schools regarding First Nations health and cultural safety and uncovered potential gaps and barriers to meeting the Aboriginal and Torres Strait Islander Health Curriculum Framework. The fact that many schools see this as an area that must be taken seriously was promising. Resources including funding and involvement of First Nations people in design and teaching were identified as key facilitators to meet standards. Further studies into individual school's curricula will be needed to explore their specific gaps in meeting accreditation requirements and the health needs of First Nations' peoples.

Author contributions

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Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.ajpe.2023.100605.

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