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Article 3

Shifting Nursing Students' Attitudes towards Indigenous Peoples by Participation in a Required Indigenous Health Course

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Shifting Nursing Students' Attitudes towards Indigenous Peoples by Participation in a Required Indigenous Health Course

Cover Page Footnote

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Positionality

Nursing with cultural humility is vital to ensuring access to health care and improved health care outcomes for Indigenous Peoples (Rozendo et al., 2017; Wittig, 2004). In this article, the term Indigenous refers to all persons in Canada identifying as First Nations (status or non-status), Métis, or Inuit; however, this does not suggest that these groups have the same history, culture, identity, beliefs, and knowledge. The first author (RC) is of Red River Métis descent on the paternal side. Born and raised on Treaty One Territory, homeland of the Red River Métis, RC has always identified as being Indigenous but did not learn about the culture until adulthood because of colonialism. The second author (KM) identifies as a third-generation Canadian-born white female descendent of British, Scottish, and Ukrainian settlers to Winnipeg and Selkirk, Manitoba, Canada in the early 1900s.

Introduction

Nurses who are aware of the sociopolitical history of colonialism and have cultural humility in their beliefs and practices with Indigenous Peoples can use care approaches that support Indigenous clients to receive culturally safe care as an outcome determined by the client (First Nations Health Authority [FNHA], 2022). Nurses are professionally well positioned to respect Indigenous cultures and ways of life to help achieve a balance between traditional healing and the approaches of modern medical care (Wittig, 2004). The Canadian Nurses Association's *Code of Ethics* (2017) states that nurses must include ethically minded cultural care in all domains of their nursing practice while acknowledging and respecting the sociopolitical history and interests of Indigenous Peoples. Research shows that health outcomes improve when health care providers are sensitive and responsive to cultural issues (Kirmayer, 2012). As a result, there have been initiatives in Canadian schools of nursing to include the concepts of intercultural competence and cultural safety in curricula, with emphasis on the Indigenous Peoples in Canada (Canadian Association of Schools of Nursing [CASN], 2013; Rowan et al., 2013). (See Table 1 for definitions of cultural competence, cultural humility, and cultural safety.) The Truth and Reconciliation Commission (TRC) Call to Action 24 implores all Canadian nursing schools to incorporate a course addressing Indigenous health issues. This course is expected to include content related to colonization such as residential schools, Indigenous rights, Indigenous teachings and practices, and anti-racism (Martin et al., 2018; TRC, 2015).

Nurses who want to achieve the practice of cultural safety through cultural humility should be familiar with the diversity in Indigenous Peoples' attitudes, beliefs, and values; be sensitive to patients' needs related to cultural issues; and practice relationally (FNHA, 2022; Zou, 2016). A culturally safe environment acknowledges and respects all aspects of a person's life and does not diminish "or ignore that person's identity, uniqueness, or power as a human being" (Kurtz et al., 2018, Introduction). Cultural safety education increases students' readiness to advocate for and communicate with Indigenous Peoples. Learning how to provide culturally safe support with Indigenous Peoples can prompt transformations within students and motivates advocacy towards making changes to improve Indigenous health as a newfound personal priority (Kurtz et al., 2018). Therefore, there is an urgent need to explore perceptions, skills, knowledge, and attitudes within undergraduate nursing students about the ongoing societal and systemic impacts of colonialism and the resulting impacts of racism on Indigenous health and nursing practice (Coggins, 2019).

Increasing evidence shows that Indigenous Peoples experience greater health disparities than non-Indigenous Canadians (Bourque Bearskin, 2011) and this gap is widening due to the

social determinants of health, racism, poor housing, lack of clean water, colonialism, and imposed poverty (Enns, 2019). Due to negative stereotypes, racism, and the harms experienced by Indigenous Peoples, past and present, this population tends to receive a lesser quality of health care or avoids seeking medical attention altogether (O'Sullivan, 2013). Cultural safety is an outcome determined by the client that can address health gaps between Indigenous Peoples and non-Indigenous people. Feeling culturally safe has been found to empower patient decision-making and results in a relationship where patients and providers work together towards effective care. The need to educate health care professionals about Indigenous culture, history, and culturally safe care has never been more relevant (Yeung, 2016). Cultural competence, cultural humility, and cultural safety definitions are presented below (Table 1).

Table 1

Definitions

Cultural Competence	**Cultural Humility**	**Cultural Safety**
Cultural competence is "developing the knowledge, skills, and attitudes for working effectively and respectfully with diverse people. It's about reducing the number of assumptions we make about people based on our biases. Cultural competency does not require us to become experts in cultures different from our own" (Northern Health, 2022).	**(Process of nursing care)** "Cultural Humility is a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience" (FNHA, 2022).	Cultural safety is about identifying the barriers to access to health care arising from the inherent power imbalance between provider and patient. It seeks to attain improved care through awareness of differences, decolonization, considering power relationships, implementing reflective practice, and allowing the patient to determine whether a clinical encounter is safe (Papps & Ramsden, 1996; Ramsden, 2002).

Students enter nursing school with varying impressions and knowledge regarding the history of Indigenous Peoples (Aboriginal Nurses Association of Canada, 2009). Within nursing curricula, mandatory courses that address the need for equitable health requirements as well as the history of the Indigenous population within Canada are rare (Rozendo et al., 2017). Both western and Indigenous Knowledges are essential components of nursing practice, yet often only the former is present within nursing education (Pijl-Zieber & Hagen, 2011; Zeran, 2016). Incorporating Indigenous ways of knowing shows students how to shift their focus away from western medicine and incorporate a strength-based perspective to address Indigenous Peoples' health. To develop this strength-based approach, nursing programs must build student knowledge of the history and sociopolitical context of Indigenous Peoples' health, their relationships with Canadian society both past and present, and identify how the Canadian history of genocide has impacted the health of Indigenous Peoples in the present (Stansfield & Browne, 2013).

Review of the Literature

Systemic factors such as colonization and racism have impacted the development of Indigenous health curricula in nursing programs. The current premise is that interculturally competent curricula should improve practitioners' knowledge, skills, and attitudes about Indigenous culture and colonial history, which can then influence client outcomes and address health equity. Health equity is unlikely to be achieved unless major challenges within educational institutions are addressed (Pitama et al., 2018)

Research confirms that negative perceptions of Indigenous Peoples with respect to their adverse health outcomes continue because of a hidden curriculum in educational programs (Durey et al., 2013; Pitama et. al., 2018). Hidden curriculum can be defined as "culturally acquired unintended lessons" (Raso et al., 2019, p. 989). Hidden curricula can mar student attitudes toward and their response to Indigenous patients through perpetuating negative health stereotypes about Indigenous Peoples. Presenting only negative images of Indigenous health to students risks leaving the perception that Indigenous health issues can be blamed on individual choices rather than on the systemic inequities perpetuated within colonial systems. To avoid this hidden curriculum messaging, course content can be developed to show the ongoing effects of colonization, racism, and systemic biases from an Indigenous viewpoint. Presenting Indigenous content from this perspective can have an impact on learner perceptions (Pitama et al., 2018; Rowan et al., 2013). Similarly, the extent to which nursing students are exposed to Indigenous health topics in their curricula are also part of the hidden curriculum as educational policy and pedagogical changes that integrate Indigenous perspectives have continued to be devalued (Pitama et al., 2018).

Inadequate inclusion of Indigenous leadership in nursing curricula also needs to be addressed. According to Pitama et al. (2018), curriculum involving Indigenous health initiatives have not included Indigenous expertise, leadership, or knowledge in the past. Kurtz et al. (2018) supports the importance of cultural safety education for student attitudes and behavioral change in nursing; however, the importance of a respectful two-way partnership with Indigenous Peoples is crucial for effective program delivery and sustainability. Research shows that to ensure a successful partnership, genuine support by faculty and administration is critical. Additionally, it is vital to maintaining respectful relationships with Indigenous leaders and communities to promote deeper understandings of Indigenous Peoples (Kurtz et al., 2018).

Inclusion of content in nursing curricula examining Canadian history and its impacts on the social determinants of health in Indigenous Peoples results in increased understanding and knowledge (Rowan et al., 2013). In their systematic review, Pitama et al. (2018) identified that a barrier to the development of Indigenous health courses as part of the core curriculum was insufficient time and resources to support these activities; the Truth and Reconciliation Commission of Canada (TRC, 2015) challenges this barrier as Indigenous health content is now prioritized for nursing education. Organizational support at all levels of department leadership in providing time, resources, strategic planning, and policy within the post-secondary setting are vital for effective "curriculum delivery, ongoing community engagement, positive student experiences, and increased interest in advocacy, health equity, and actions to improve health [within] Indigenous communities" (Kurtz et. al, 2018, Discussion).

Method

As a result of these challenges, this research employed a one-group pre- and post-test survey to evaluate if student attitudes towards Indigenous Peoples and their knowledge of

Indigenous cultures and history improved within a context where undergraduate nursing students experienced a required Indigenous health course.

Course Description

The course is taught in the third year of one Western Canadian accelerated baccalaureate nursing program in a city that, according to 2016 Canada Census data, had the highest Indigenous population in Canada (Anderson, 2019). The learning outcomes of this course include discussion of:

1. Why Indigenous history and health concerns are important for nurses and other health professionals.
2. Cultural sensitivity and cultural safety and their practical application in the health care system.
3. Social and health demographics of Canada's Indigenous population and how they compare to Canadian demographics.
4. The rich culture and history of Canada's Indigenous Peoples pre-contact/colonialism.
5. Historical policy decisions as the government's response to social and health concerns.
6. Analysis of major social and health issues of Indigenous Peoples today in relation to the historical context.
7. The appropriateness of Canada's health system and the biomedical model in meeting the needs of Indigenous Peoples.
8. Indigenous role models/leaders and their initiatives to evoke positive change in physical, emotional, mental, and spiritual wellbeing.
9. Current social and health strategies.

The course topics cover the Indian Act, residential schools, the Truth and Reconciliation Commission, traditional ceremonies, racism, determinants of health, and cultural safety. The course also examines Indigenous organizations that help to better the health of Indigenous Peoples. Both instructors involved in teaching the course during the 2019–2020 academic year are of Métis descent. This study was initiated by one of these instructors (RC) and methodological, statistical, and writing support were supplied by the second author (KM).

Sampling Methods

Over the 2019–2020 academic year, 190 students were enrolled in three sections of the course Health, Wellness, and the Indigenous Population of Canada. Students completed a survey asking them to rate items assessing their knowledge of Indigenous culture and history and their perceptions toward Indigenous Peoples. Consent to use their questionnaire responses as study data was received from 84% of students enrolled in three sections (160 students).

Data Collection and Instruments

Two previously validated instruments were used to measure student perceptions, interest in Indigenous issues, and knowledge of Indigenous history and cultures. These measures were used as study data and acted as a pedagogical reflective tool for students to self-assess their change

in thinking about Indigenous Peoples from the beginning to the end of the course. Throughout the course, students also wrote reflections describing the impact of the course content on their learning and attitudes for two classes of their choosing. These reflections were also included as data. The Term 1 and Term 2 surveys were completed in person during class time. The Term 3 data collection was disrupted by institutional closures to in-person instructional activities due to the COVID-19 pandemic; therefore, data in Term 3 was collected electronically.

Perceptions About Indigenous Peoples Scale

This is a 16-item Likert-format questionnaire, ranging from 1 (strongly disagree) to 5 (strongly agree), was used to ask students to rate their perceptions about Indigenous Peoples (Keith, 2020). The scale asked students to rate their understanding of their own beliefs and values about Indigenous Peoples, recognition of the impacts of history on the present, their willingness to examine their own biases, and their comfort level with people of different cultural backgrounds. Cronbach's alpha for the Perceptions about Indigenous People Scale in this study was .85.

Questionnaire Exploring Knowledge of Factors Impacting Indigenous Health and Interest in Indigenous Issues

A two-part Likert format questionnaire developed by Shah and Reeves (2015) was used to measure: 1) student knowledge of factors impacting Indigenous health including their existing knowledge of the Indian Act, government policies, residential schools, determinants of health, health outcomes, Indigenous culture, and understanding of cultural safety (hereafter referred to as Knowledge of Factors Impacting Indigenous Health); and 2) student interest in topics related to Indigenous Peoples including their interest in Indigenous Peoples' culture and wellbeing, their interest in being culturally safe with Indigenous patients, and their interest in advocacy and empowerment work with Indigenous Peoples (hereafter referred to as Interest in Indigenous Issues). For the Knowledge of Factors Impacting Indigenous Health scale, a 6-item questionnaire was used with categories ranging from 1 (very poor) to 5 (excellent). For the Interest in Indigenous Issues scale, a 3-item questionnaire was used, ranging from 1 (strongly disagree) to 5 (strongly agree) (Shah & Reeves, 2015). Cronbach's alpha for the Knowledge of Factors Impacting Indigenous Health and Interest in Indigenous Issues Scales were .82 and .82 respectively.

Demographic Questionnaire

We developed an instrument to gather data on demographic and personal characteristics such as gender, previous education, previous Indigenous education, the year started in the nursing program, age, race, and previous health care experience.

Student Reflection Assignment

The student was asked to choose two topics that were taught throughout the course that resonated with them and answer the following questions.

1. What was my knowledge about this class before the presentation?
2. What are two facts I learned after taking this class?
3. What insights did I gain about myself/what did I learn about myself as a result of gaining knowledge in this class?

4. Provide an example of a time when you took care of an Indigenous patient in your BN student nurse clinical experience. How did this class help you or how it could have helped you take better care of your Indigenous patient?
5. How will this class shape my future nursing care?

Ethical Approval

Ethical approval was obtained from the research ethics board at the instructional institution and study participation was voluntary. The data collected for the study were components of educational activities requested of students over the term. The study surveys were given to students as a reflective activity at the start and finish of the course. Students were also asked to write reflections on various topics within the course content as part of their academic activities. Students were offered two bonus marks for choosing to include their survey and reflections as part of the research study. Any student who did not wish to include their questionnaire responses in the research study was offered an alternative option to obtain the bonus marks. Because the lead author was one of the two course instructors in the 2019–2020 academic year, data collection processes were implemented to create a separation between this instructor's role as teacher and her role as researcher. The second author, who was not involved in evaluating students in the program, introduced the study to the students and held the questionnaires on behalf of the lead instructor until all grades were submitted. The data were not examined until the end of the academic year after course grades had been assigned.

Data Analysis

Statistical analysis was conducted using the Statistical Program for the Social Sciences (version 25). Statistical tests included: descriptive statistics, T-tests, mixed between-within groups analysis of variance (ANOVA), and hierarchical linear regression. As the questionnaires were completed as part of course credit, very little missing data were observed ($< 1\%$). Any missing responses to the Perceptions about Indigenous Peoples, Knowledge of Factors Impacting Indigenous Health, and Interest in Indigenous Issues Scales were replaced by inserting the participants' average score of all completed items for that scale.

Results

The demographic characteristics for the entire sample are presented in Table 2 ($N = 160$). The three course sections that provided data were equally represented. Table 3 presents the data for pre- and post-course responses to the Attitudes about Indigenous Peoples, Knowledge of Factors Impacting Indigenous Health, and Interest in Indigenous Issues Scales and indicates that the students showed a highly significant change from pre- to post-course on all variables assessed ($p < .001$).

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Table 2

Demographic Characteristics of the Sample N = 160

Variable	Category	n(%)
Gender	Male	16(10.0%)
	Female	144(90.0%)
Highest Level of Education	High School	84(52.5%)
	Completed Diploma	31(19.4%)
	Bachelor's Degree	44(27.5%)
	Master's Degree	1(0.6%)
Race/Ethnicity	White	88(55.0%)
	Indigenous	13(8.1%)
	Asian	38(23.8%)
	African	9(5.6%)
	Other	12(7.5%)
Year Started in Nursing Program	2015	9(5.6%)
	2016	24(15.0%)
	2017	81(50.6%)
	2018	37(23.1%)
	2019	4(2.5%)
	Missing	5(3.1%)
Previous Experience Working in Health Care	Yes	77(48.1%)
	No	83(51.9%)
Previous Indigenous Education	Yes	57(35.6%)
	No	103(64.4%)
Term Per Term	Term 1	57(35.6%)
	Term 2	55(34.4%)
	Term 3	48(30.0%)
Age	Mean (SD) Age n = 137	26.1(4.8)

Table 3

T-Test Exploring Change in Perceptions About Indigenous Peoples, Knowledge of Factors Impacting Indigenous Health and Interest in Indigenous Issues Between T1 (pre-test) and T2 (post-test) N = 160

	T1 M(SD)	T2 M(SD)	*t* df = 159	Mean Δ *t* (95% CI)	*p*
Perceptions about Indigenous Peoples	61.0(7.1)	69.8(5.8)	–16.8	–8.8 (–9.8 - –7.8)	<.001
Knowledge of Factors Impacting Indigenous Health Scale	17.4(4.2)	25.1(2.7)	–21.5	–7.6 (–8.4- –7.0)	<.001
Interest in Indigenous Issues Scale	11.8(1.9)	13.1(1.8)	–9.3	–1.3 (–1.6- –1.1)	<.001

Relationship Between Select Demographic Variables and Perceptions about Indigenous People, Knowledge of Factors Impacting Indigenous Health, and Interest in Indigenous Issues from Pre- to Post-Course

A mixed between-within subjects analysis of variance (ANOVA) was conducted to assess differences in *Perceptions about Indigenous Peoples*, *Knowledge of Factors Impacting Indigenous Health*, and *Interest in Indigenous Issues* from pre- to post-course based on four student characteristics: previous health care experience, previous Indigenous education, term in which the Indigenous Health course was taken, and the dichotomized variable of race (White compared to all other races). These results are presented in Table 4. The term the students took the course was of interest mainly because each term presented different teaching contexts with Terms 1 and 2 being taught by a different instructor than Term 3 and Term 3 having taken place in an online environment due to the COVID-19 pandemic. The results for the term of instruction demonstrated that all groups showed a main effect statistically significant change in Perceptions about Indigenous Peoples ($F = 280.4$; $p < .001$), Knowledge of Factors Impacting Indigenous Health ($F = 453.2$; $p < .001$), and Interest in Indigenous Issues ($F = 89.8$; $p < .001$) for improvement over time but group and interaction effects were non-significant.

The remaining demographic characteristics (previous health care experience, previous Indigenous education, and race) all demonstrated a significant effect for improvement over time in all groups with a large effect size. Few statistically significant differences emerged in these categories for interaction effects or group differences. Significant interaction effects for group differences and changes over time were identified for Perceptions about Indigenous Peoples based on student self-reported race ($F = 7.7$; $p = .006$) (White or not White) with White students experiencing a larger increase in Perceptions about Indigenous Peoples from pre- to post-course compared to all other races. Differences were detected on self-reported Knowledge of Factors Impacting Indigenous Health for students with previous Indigenous education reporting a higher starting knowledge score ($F = 10.2$; $p = .002$) than those without previous Indigenous education, and non-White students reporting a lower knowledge score at time 2 than White students ($F = 4.0$; $p = .05$).

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Hierarchical Multiple Regression

As reflected in Table 5, three hierarchical models were built to assess the ability of participant characteristics as well as their T1 scale scores (Perceptions about Indigenous Peoples, Knowledge of Factors Impacting Indigenous Health, and Interest in Indigenous Issues) to predict the student's T2 scores on each of the three scales. At Step 1, age, gender, previous health care experience, previous Indigenous education, highest level of education, and race were entered as control variables. Their T1 scores were entered at Step 2. The variables entered in Model 1 explained 31% ($p < .001$) of the variance in Perceptions about Indigenous Peoples scores at T2 (end of course). Only Perceptions about Indigenous Peoples at T1 (*beta* = .42, $p < .001$) and Interest in Indigenous Issues at T1(*beta* = .23, $p < .05$) made a statistically significant contribution to the T2 Perceptions about Indigenous Peoples score in the final model. The variables entered in Model 2 explained 15% ($p < .01$) of the variance in Knowledge of Factors Impacting Indigenous Health scores at T2. The demographic characteristic of race (*beta* = -.24, $p < .01$) and Knowledge of Factors Impacting Indigenous Health score at T1 (*beta* = .29, $p < .05$) made a statistical contribution to the T2 Knowledge of Factors Impacting Indigenous Health score in the final model. The variables entered in Model 3 explained 31% ($p < .001$) of the variance in Interest in Indigenous Issues at T2. In the final model, only Interest in Indigenous Issues at Time 1 (*beta* = .45, $p < .001$) made a statistically significant contribution to the T2 Interest in Indigenous Issues score.

Table 4

Mixed Between-Within Subjects ANOVA for Perceptions about Indigenous Peoples, Knowledge of Factors Impacting Indigenous Health, Interest in Indigenous Issues Score by Previous Health Care Experience, Previous Indigenous Education, Term Course Taken, and Race

		T1 (pre-test) M(SD)	T2 (post-test) M(SD)		Wilks' Lambda	*F*(df)	*p*	Partial eta squared[1]
Perceptions about Indigenous Peoples								
Previous Health Care Experience	Yes (n = 77)	60.1(7.3)	68.9(5.9)	Time x group interaction effects	1.0	<.001(2,158)	.98	<.001
	No (n = 83)	61.9(6.9)	70.6(5.6)	Main effect across time	.36	281.3(1,158)	**<.001**	.64
				Main effect by group		3.8(2,158)	.053	.024
Previous Indigenous Education	Yes (n = 57)	61.1(7.6)	69.6(6.4)	Time x group interaction effects	.99	.13(2,158)	.71	.001
	No (n = 103)	61.0(6.8)	69.9(5.4)	Main effect across time	.38	255.2(1,158)	**<.001**	.62
				Main effect by group		.006(2,158)	.94	<.001
Term Course Taken	1 (n = 57)	60.9(7.3)	69.1(6.6)	Time x group interaction effects	.99	.30(2,158)	.75	.004

	2 (n = 55)	62.2(7.0)	71.3(4.7)	Main effect across time	.36	280.4(1,158)	**<.001**	.64
	3 (n = 48)	59.9(7.1)	68.9(5.8)	Main effect by group		2.5(2,158)	.09	.03
Race	White (n = 88)	59.7(6.8)	69.7(5.8)	Time x group interaction effects	.95	7.7(2,158)	**.006**	.05
	All Others (n = 72)	62.7(7.2)	69.9(5.9)	Main effect across time	.36	283.1(1,158)	**<.001**	.64
				Main effect by group		3.4(2,158)	.07	.02
Knowledge of Factors Impacting Indigenous Health								
Previous Health Care Experience	Yes (n = 77)	17.1(4.3)	24.9(3.0)	Time x group interaction effects	1.0	.07(2,158)	.79	<.001
	No (n = 83)	17.7(4.1)	25.2(2.5)	Main effect across time	.26	457.2(1,158)	**<.001**	.74
				Main effect by group		.99(2,158)	.32	.006
Previous Indigenous Education	Yes (n = 57)	18.8(4.5)	25.0(3.3)	Time x group interaction effects	.94	10.2(2,158)	**.002**	.061
	No (n = 103)	16.6(3.7)	25.1(2.4)	Main effect across time	.28	408.6(1,158)	**<.001**	.72
				Main effect by group		85.6(2,158)	**.015**	.04
Term Course Taken	1 (n = 57)	17.6(3.7)	25.0(2.8)	Time x group interaction effects	.99	.17(2,158)	.84	.002
	2 (n = 55)	17.1(4.9)	25.1(3.0)	Main effect across time	.26	453.2(1,158)	**<.001**	.74
	3 (n = 48)	17.5(3.9)	25.1(2.7)	Main effect by group		1.3(2,158)	.92	.001
Race	White (n = 88)	17.7(4.2)	25.5(2.7)	Time x group interaction effects	.99	.13(2,158)	.72	.001
	All Others (n = 72)	17.0(4.1)	24.5(2.7)	Main effect across time	.23	451.5(1,158)	**<.001**	.74
				Main effect by group		4.0(2,158)	**.05**	.03
Interest in Indigenous Issues								

Previous Health Care Experience	Yes (n = 77)	11.6(2.0)	12.9(1.8)	Time x group interaction effects	1.0	<.001(2,158)	.99	<.001
	No (n = 83)	12.0(1.9)	13.3(1.7)	Main effect across time	.65	85.2(1,158)	**<.001**	.35
				Main effect by group		2.7(2,158)	.10	.02
Previous Indigenous Education	Yes (n = 57)	11.6(2.1)	12.8(1.8)	Time x group interaction effects	.99	.22(2,158)	.64	.001
	No (n = 103)	11.9(1.9)	13.3(1.7)	Main effect across time	.68	76.0(1,158)	**<.001**	.33
				Main effect by group		1.7(2,158)	.19	.01
Term Course Taken	1 (n = 57)	11.9(1.8)	12.7(1.9)	Time x group interaction effects	.96	2.9(2,158)	.06	.04
	2 (n = 55)	11.8(2.2)	13.3(1.8)	Main effect across time	.64	89.8(1,158)	**<.001**	.36
	3 (n = 48)	11.6(1.9)	13.3(1.5)	Main effect by group		2.3(2,158)	.65	.005
Race	White (n = 88)	11.6(2.1)	13.2(1.9)	Time x group interaction effects	.98	2.9(2,158)	.09	.02
	All Others (n = 72)	11.9(1.7)	13.0(1.5)	Main effect across time	.66	82.9(1,158)	**<.001**	.34
				Main effect by group		.06(2,158)	.80	<.001

[1] Partial eta squared: effect size small .01, moderate .06, large .14

Table 5

Hierarchical Regression Results for Models Predicting Perceptions about Indigenous Peoples at T2, Knowledge of Factors Impacting Indigenous Health at T2, and Interest in Indigenous Issues at T2

	Total Attitudes about Indigenous Peoples Scale Time 2		Total Knowledge of Factors Impacting Indigenous Health Scale Time 2		Total Interest in Indigenous Issues Scale Time 2	
	ΔR^2	β	ΔR^2	β	ΔR^2	β
Step 1	.050		.05		.03	
Age		.05		.06		-.05
Gender		.03		-.002		-.03

Previous Health Care Experience		.078		-.01		.02
Previous Indigenous Education		-.03		.03		.08
Highest Level of Education		.01		-.07		.004
Race		-.01		-.24**		-.12
Step 2	.26***		.11**		.28***	
Total Perceptions about Indigenous Peoples Scale Time 1		.42***		.29*		.17
Total Knowledge of Factors Impacting Indigenous Health Scale Time 1		-.14		.07		-.05
Total Interest in Indigenous Issues Scale Time 1		.23*		.05		.45***
Total R^2	.31***		.15**		.31***	

* <.05 ** <.01 *** <.001

Qualitative Analysis of Student Journals

Three major themes were developed from the students' reflections: knowledge about Canada's history and Indigenous Peoples; developing cultural humility skills; and positive insights gained by learning about Indigenous history, culture, and health. The qualitative reflective writing samples were viewed through Campinha-Bacote's (2002) framework, which describes cultural competence as gaining an in-depth understanding of cultural knowledge and addresses health beliefs, cultural values, cultural skill (the ability to collect data relevant to clients' concerns), and cultural awareness, which is about self-examination of one's own cultural background. This process involves the recognition of one's biases, prejudices, and assumptions about individuals who are different (Campinha-Bacote's, 2002; Wittig, 2004).

Knowledge about Canadian History and Indigenous Peoples

The sociopolitical history between Indigenous Peoples and non-Indigenous people in Canada is a starting point for understanding concepts such as cultural safety, ethical space, and relational practice and is a strength-based approach to learning about Indigenous Peoples' health. In their reflections, students wrote about their increases in knowledge on the topics covered in the course, how their assumptions were altered, and how their previous education had not gone deep enough to facilitate abandoning previously held preconceived stereotypes of Indigenous Peoples. As one student said, "I realized the value of learning in depth about this topic because we tend to learn about Indigenous Peoples in a surface-level way that provides leeway to make uninformed judgements about them." Another student spoke about how her assumptions of Indigenous Peoples changed, "After taking this class, I learned that I made assumptions about the Aboriginal population when I should have been educating myself and seeking more information about their history and traditions." Increasing their knowledge offered nursing students the opportunity to shift their focus from a Western medicalization viewpoint of Indigenous Peoples' health towards reframing with strength-based perspectives acknowledging how colonial systems had impacted the health of Indigenous Peoples.

Developing Cultural Humility Skills

Students wrote about how learning to think and behave with cultural humility impacted their perspectives on their practice and future relationships with Indigenous clients. The students acknowledged that they had an increase in their confidence to provide care with cultural humility with Indigenous Peoples and would be more likely to provide care with cultural humility in their future nursing practice. One student wrote:

> I plan to focus my attention on the areas affected by cultures like communication, concepts of family, education, environment, and historical experiences and understand the connection culture may have on them. Doing so, I will be able to see through a more transparent lens and use these categories to guide me when seeking to understand my patient's health and wellness. I believe I will be better prepared to create a safer environment built on mutual respect. I can do so by inquiring about their values, beliefs, and traditional practices and building trust by working to assist them better access them.

A key element to culturally safe practice was recognized in creating a trusting relationship with the patient. Students also recognized that care interactions were influenced by the ability to self-reflect:

> While I understand that this is a skill that is not learned overnight and the ability to provide culturally safe care comes with practice, experience, and self-reflection. I now have the proper tools needed to carry on within nursing to practice culturally safe care.

Another student reflected on what cultural safety practices looked like from their perspective:

> Taking time to self-reflect to ensure I am constantly working on recognizing my unintentional biases. This may involve taking a step back during a shift to reflect on how I am treating others. Perhaps even after a shift, where I can take time to journal and reflect on my actions. I will continue to strive and ensure I meet every client's needs by communicating with them and asking them questions about their culture. I will listen to my clients, along with understanding their values, beliefs, concerns, resources, abilities, and motivations.

Positive Insights Gained by Learning About Indigenous History, Culture, and Health

Students recognized within their reflective writing how understanding their own biases and where those biases had originated in their own personal histories helped them to develop empathy toward Indigenous patients. One student wrote:

> I am grateful for the education I have gained and the knowledge I now have to change my thought process. I have learned that I did have some biases about the Indigenous population. I often associated Indigenous people with addictions, homelessness, and failure to take responsibility for their health. Understanding what led to their poor health outcomes and engaging in genuine conversations will help me be a better nurse and a better human being.

Many students realized that their perceptions were formed because of their environment or upbringing. Some acknowledged the racism within their own families and friend circles, which they would be more conscious of in future interactions.

> I grew up in an, at times, very racist environment where my parents would often make comments specifically directed at the Indigenous population. As a result, this manifests at

> work and in my social life, when an individual I am talking to makes an insensitive, negative remark about an Indigenous person, I don't say anything to challenge the person on their remark.
>
> There have been times where I have let my friends say hurtful things about someone just of the individual's race. I am not proud of it and am appreciative of the insights this class has given me. Now that I am more aware of the silent types of racism, I will be more conscious with how I respond in certain situations.

Discussion

The findings of this study demonstrate that the required course, Health, Wellness, and the Indigenous Population of Canada, evoked a positive change in student self-reported Knowledge of Factors Impacting Indigenous Health, Interest in Indigenous Issues, and Perceptions about Indigenous Peoples. This finding is similar to the survey data reported by Hunt et al. (2015) in the Australian nursing education context. Our study's analysis expands upon Hunt's findings by exploring possible differences in student attitudes towards Indigenous Peoples based on personal characteristics such as previous health education, previous health care experience, and self-reported race (White or non-White). Unsurprisingly, students who reported previous Indigenous education reported increased Knowledge of Factors Impacting Indigenous Health at the start of the course when compared to students who reported no previous Indigenous education. For the students who had reported previous learning about Canadian and Indigenous history, culture, and ways of knowing, the course may have provided positive reinforcement of their previous learning or introduced them to new concepts related to the health care context that had not been part of previous courses they had taken. Having previous health care working experience did not demonstrate significant differences in Knowledge of Factors Impacting Indigenous Health, Interest in Indigenous Issues, or Perceptions about Indigenous Peoples. As students who reported previous health care working experience were working in a hospital environment with significant exposure to Indigenous patients, those exposures did not seem to impact their perceptions of Indigenous Peoples in a noticeably positive or negative way. White students reported significantly lower cultural perceptions and higher Knowledge of Factors Impacting Indigenous Health than their non-white classmates at the start of the course, but their perceptions matched their non-white classmates at the conclusion of the course. We can conjecture that a possible reason for this identified group difference is related to students' experiences with negative stereotypes and/or substandard education about Indigenous history earlier in their lives; however, these issues were not specifically explored within this current study. We acknowledge this would be an important line of inquiry in a future research design.

Student responses to the surveys at pre-course were the strongest contributors to their post-course response on each of the Perceptions about Indigenous Peoples, Knowledge of Factors Impacting Indigenous Health, and Interest in Indigenous Issues scales according to the regression analysis. Race was the only demographic variable that statistically significantly predicted the post-course score on the Knowledge of Factors Impacting Indigenous Health Scale with White race predicting greater knowledge. Therefore, exposing students to content teaching them about systemic factors and determinants of health that impact the health outcomes of Indigenous Peoples results in student nurses being broadly knowledgeable about Indigenous Peoples' contexts, health, wellness, illness, access to health care services, and Canadian history.

The qualitative analysis of the student's reflections supports the quantitative data by

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illustrating the specific features of the course that contributed to their newly developing, often transformative, perspectives on Indigenous health. Students described an increase in knowledge of Indigenous history within a colonial context in Canada. They also gained an understanding of the consequences of colonization and government policies on the health status of Indigenous Peoples. These findings are similar to those presented in Hunt et al. (2015) who reported that learning the history and culture of Indigenous Peoples, and their resultant mistrust toward Westernized perspectives of medicine, impacted how students perceived these past injustices and their contribution to present health outcomes. Analyzing the student reflections revealed how students recognized the ability of the course to help them learn to provide care with cultural humility. This is an important finding because culturally safe care empowers patients and allows for open communication (Hunt et al., 2015). Douglas (2013) observed that nurses who implemented culturally safe care are good listeners who consider others' values, beliefs, and concerns. The "sharing of mutual power can be achieved by engaging in active listening, being willing to help, taking time to understand, and being present" for the patient (Bourque Bearskin, 2011). In a culturally safe environment, a patient can direct their own care and express concerns about nursing care that he or she may deem unsafe (National Aboriginal Health Organization [NAHO], 2006).

The students in their self-reflections also acknowledged the role of reflective practice in implementing cultural safety. Reflection results in meaningful learning and integration of new knowledge into identity (Martin et al., 2018). Nurses who practice cultural humility will engage in self-reflection about how their cultural background contributes to bias, prejudice, and assumptions about people who are different (Douglas, 2013). Reflection allows nurses to engage in practices that demonstrate an understanding of what the patient believes is important to health and wellbeing (Smye et al., 2010) and creates recognition of how their caregiving activities can impact all future interactions an Indigenous person might have with the health care system (Harder et al., 2018). Our study results corroborate the findings of previous studies. Pitama et al. (2018) also identified that a key impact on students who experienced an Indigenous health education course was how knowledge of Indigenous colonial history resulted in motivation to improve their practice. Hunt et al. (2015) reported that including knowledge of factors impacting Indigenous health in nursing curricula increased cultural sensitivity, changed attitudes towards Indigenous Peoples, reduced racism, and improved health outcomes.

Limitations

This study is limited by self-report data, which was collected as course credit during the Health, Wellness, and the Indigenous Population of Canada course. As the reflective materials were written for grades, social desirability bias may have impacted how the students phrased their thoughts about the course material and how they responded to the pre- and post-course surveys. This study was a scholarship of teaching and learning initiative where the course instructor (RC) desired to examine the impact of her course content on student change in attitude about Indigenous Peoples. Scholarship of teaching and learning has the underlying objective to understand the impact of teaching practices on learning with the goal to improve those teaching practices. For example, the reflective question assigned in the course did not ask students to reflect on their own ethnicity (e.g., whiteness) and its positionality with respect to the knowledge they were learning. Students often need to be reminded that the course was intended to help them approach the care of Indigenous Peoples with a new sense of humility and not to make them feel guilty. An important first step in that humility was to gain awareness of past harms and understand how those past harms

were impacting the determinants of health and the care of Indigenous Peoples to the present day.

This study examined student self-reported gains in their knowledge and interest in Indigenous health content. It did not measure if the gain in knowledge resulted in a sense of cultural humility or if those gains in knowledge would translate into patients now perceiving care from that student as culturally safe. We acknowledge this is also a limitation of this research and an important area for future study.

Implications for Teaching Indigenous Content in Nursing Programs

The findings of this present study are impacted by the context of the nursing program where it was taught. Given this limitation to generalizability in this scholarship of teaching and learning investigation, we can suggest several considerations for nursing programs that wish to develop a specific Indigenous health course within their curriculum.

1. In the context of the study reported, the Indigenous health course is located approximately 2/3 of the way through the nursing program. Programs must carefully consider where in the nursing program curriculum the course should be located. Students will have had heavy exposure to Western modes of thinking about health care in many programs. The drive in an Indigenous-specific course should be to close health equity gaps between Indigenous and non-Indigenous Peoples, address the shortage of educated practitioners, and to provide care with humility to Indigenous Peoples (Kurtz et al., 2018). While programs can and do distribute this information throughout their programs, the Australian experience reported in Hunt et al. (2015) demonstrates that a piecemeal approach to teaching Indigenous content is inadequate; however, neither should a single course be considered a "cookbook approach" to Indigenous education (p. 466). Thus, we recommend programs consider an individual course approach with repeated reinforcement throughout a program. Decisions about where in a curriculum such a course should be situated will depend on local contextual factors and current curriculum structure. Future research in this area could include an environmental scan of Canadian schools of nursing identifying how many have an Indigenous health course, the format of integration of Indigenous material into the nursing curriculum, the involvement of Indigenous faculty or community members in the teaching of the material, and the degree to which that content meets all the requirements of the Truth and Reconciliation Commission Calls to Action. We understand from the editors of this special section that a scoping review with this objective is currently underway.
2. The course presented in this research was taught by faculty members of Indigenous heritage with knowledge of Indigenous traditions. However, most faculty who teach within nursing programs do not have knowledge of Indigenous ways of knowing, being, cultural background, and traditions, which are necessary to create a culturally safe environment (Harder et al., 2018). Therefore, the non-Indigenous instructor, who is an expert in nursing content, may be a novice instructor when it comes to teaching Indigenous curricula and can face challenges and fears (Verdun et.al., 2013). Van Bewer et al. (2020) suggest that one way to address this issue is for non-Indigenous faculty members to build relationships with Indigenous nursing scholars to gain a better understanding of Indigenous perspectives. Indigenous perspectives may allow faculty to create a stronger link with the discipline's core values of relationality, individual-centered care, and holism (Van Bewer et al., 2020). These authors advise that "schools of nursing interested in weaving Indigenous perspectives into their curricula and pedagogy must focus on the Indigenous context, including Indigenous values, culture, tradition, language, and

community" (Van Bewer et al., 2020, p. 18). The priority, however, should be to hire Indigenous faculty to address this gap.

3. The instructor for the course described in this study has built a relationship with Elders currently and formerly employed at the institution where this research took place to ensure that what is being taught is culturally safe and appropriate. Stansfield and Browne (2013) suggest that an Indigenous Community Advisory Committee or an Elders Committee should be included in curriculum planning to support educators or Schools of Nursing that want to include Indigenous Knowledge in their nursing curriculum. Battiste (2013) recommends a co-developed curriculum as the ideal approach. Stansfield and Brown (2013) also recommend professional development preparation that allows educators to critically reflect on their assumptions, biases, blind spots, viewpoints, and need for learning related to Indigenous Knowledge.
4. The reflections analyzed in this study revealed that students can have a significant emotional response to developing insights about harms experienced by Indigenous Peoples in a colonial context, past and present. Faculty teaching Indigenous content to students should be sensitive to the emotional nature of the material taught in Indigenous health courses. This sensitivity applies equally to Indigenous students who may have lived this history through their families, immigrant students who may have lived traumas in their own countries, and white students as they confront recognition of racial biases and past racist thoughts or actions toward Indigenous Peoples (Hunt et al., 2015). Cultural learning will not always be comfortable (Kurtz et al., 2018). Faculty need to create a non-judgemental space to reflect on these awakenings or potential for retraumatization as a necessary step toward facilitating the kind of personal transformations that will lead nursing practice that is informed by cultural humility in the clinical environment.

Making a clear connection between the theory and praxis of Indigenous health in a culturally safe environment is a gap in the literature on this topic and future research needs to connect how learning Indigenous content impacts patient care. Greater insight into how students' attitudes toward Indigenous populations evolve as they grow into their nursing professional identities is critical. Understanding the long-term effectiveness of Indigenous health education is important as there are ambitious expectations that such education will lead to reduction in health inequities and improve access to care for Indigenous populations (Pitama et al., 2018).

Conclusion

The purpose of this project was to evaluate if nursing student attitudes towards Indigenous Peoples, knowledge of Indigenous culture, and their cultural perceptions improve through participation in an Indigenous Health course. This study revealed that the data for pre-and post-course responses to the *Perceptions about Indigenous Peoples*, *Knowledge of Factors Impacting Indigenous Health*, and *Interest in Indigenous Issues Scales* indicate that the students showed a highly significant change from pre- to post-course on all variables assessed. We also sought to evaluate through examining student reflections if students reported the impacts the course might have on their future ability to provide care with cultural humility. The reflective writing completed in the course also revealed some of the transformative nature of learning about Indigenous history and health.

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