

Review of the Flinders University Master of Public Health Program

**National Curricula Review of Core Indigenous
Public Health Competencies Integration into
Master of Public Health Programs**

Public Health Indigenous Leadership in Education Network



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*This national review is a component of the Indigenous Public Health
Capacity Building Project funded by the Australian Government
Department of Health*



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THE UNIVERSITY OF
MELBOURNE



Flinders
UNIVERSITY



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Definition

Within this report, the term Indigenous is used to refer to both Aboriginal and Torres Strait Islander peoples.



Sharing knowledge – a community learning circle around the campfire

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Foreword

I thank the PHILE Network for the opportunity to contribute to this timely national project. In particular, I recognise the contribution of the review team. With the care shown by the team in its capture and analysis of Flinders University's mode of delivering Indigenous health content within its Master of Public Health (MPH) programs, I have no doubt that insights arising from our specific experience of developing, embedding, and teaching such curriculum will be usefully integrated into any national enhancements of approach.

This review highlights how the combination of Indigenous perspectives shaping curriculum and pedagogical leadership – arising particularly through the Poche Centre for Indigenous Health and Well-Being, Adelaide – and the Discipline of Public Health collaboration and commitment has successfully forged a stronger and more coherent role for Aboriginal and Torres Strait Islander health-related issues in the preparation of Flinders MPH graduates. It also, helpfully, details constraints and areas for improvement. Given the lag between data collection and publication, however, this Foreword will also serve to augment the review with a range of challenges, and other issues of significance, which have arisen since the original data-gathering phase was concluded.

The Adelaide-based Poche Centre teaches across a number of areas in the (now re-named and re-configured) Faculty of Medicine, Nursing and Health Sciences at Flinders University. Recent Centre evaluations of teaching, allied with pedagogical research, points to a crucial role for pedagogy, as much as curriculum content, in successfully preparing effective, culturally safe practitioners. No matter what the discipline, there is evidence of a spectrum of student response to Indigenous health and cultural safety content. Such content sufficiently challenges numbers of students to lead to pedagogically significant levels of resistance among several identifiable cohorts.

Given the incompleteness of the evidence base within this still-emerging discipline of Indigenous health, it is crucial that the teaching strategies employed are those most at promise of becoming good practice. Our approach to such teaching specifically aims to maximise the engagement of all students, even when the material challenges numbers of those students, through ensuring core status of a major topic [or course subject], ensuring Indigenous leadership of content and pedagogy, and allowing sufficient time (optimally a semester) for the running of a major topic, along with other content that is integrated throughout the course.

Nationally, significant budgetary constraints have emerged within public health training. These have resulted in both direct effects – a diminished funding base – and indirect effects – increased intensity of competition for students driving calls, in the name of enhancing choice and flexibility, for fewer core topics and greater numbers of smaller electives. In times of funding stringency, there are even indications of a 'Realpolitik' mind-set emerging. Where such a narrowing of that-which-is-considered-feasible occurs, it acts as a significant threat to institutional acceptance of the necessity to actively incorporate the core competencies noted in this review. In particular, differing interpretations of the imperatives around the 'core' status of the Indigenous health competencies are possible in any institutional setting under pressure. A key dispute around status can arise: are they 'mandates for action' or 'just guidelines' that can be challenged as currently unaffordable or, more alarmingly – where there is little comprehension, or a discounting, of the training challenges already outlined – dismissed as 'unnecessary'?

It needs to be clearly noted that the Poche Centre, Adelaide recognises the reality of these pressures and concurs with action that is pertinent. Indigenous health has its own imperatives, however, as a national priority area. Although we are cognisant of current pressures on public health, there is no justification for degrading the efficacy of Indigenous health/cultural safety teaching and practitioner preparation. To do so flies in the face not only of the core Indigenous public health competencies, but also of the non-'tokenism', along with the 'genuine' and 'strong commitment' to both Indigenous content and a core topic.

That it has been necessary to defend strenuously both Indigenous leadership of content and the retention of core status for the flagship Indigenous Health topic is not a criticism of the many supportive colleagues at Flinders. Rather, it is a critique of national policies on public health acting to degrade health workforce preparation that concurs with Indigenous perspectives and is designed to assist the attainment of nationally mandated measures to 'Close the Gap'.



Professor Dennis McDermott

Director, Poche Centre for Indigenous Health and Well-Being, Flinders University, Adelaide
December 2013



Glossary

ANAPHI	Australian Network of Academic Public Health Institutions
AQF	Australian Qualifications Framework
HREC	Human Research Ethics Committee
IPHCB	Indigenous Public Health Capacity Building
MPH	Master of Public Health
PHERP	Public Health Education and Research Program
PHILE Network	Public Health Indigenous Leadership in Education Network
SET	Student Experience of Teaching

1. Executive Summary

The Indigenous public health competencies are a core component of the *Foundational Competencies for MPH Graduates in Australia* (ANAPHI 2009), a curriculum framework that integrates the six core competencies in Indigenous public health expected of every Australian MPH graduate. The aim of this review is to investigate the integration of the core Indigenous public health competencies into the curriculum of MPH programs nationally in order to document and disseminate examples of best practice and to find ways of strengthening the delivery of this content. This report, one in a series, relates to the curriculum review conducted at Flinders University, Adelaide in February 2012.

The review was based on a qualitative design although some quantitative data, which focused on a series of interviews with staff from Flinders University, were also collected. All interviews were recorded and transcribed for two types of qualitative analysis: a conceptual analysis using Leximancer text analytics software and a thematic analysis conducted by the researchers.

Flinders University is recognised for its expertise around the social determinants of health, and the public health principle of equity that drives the philosophy of teaching within the MPH program lends itself to inclusion of Indigenous health content. Establishment of the Poche Centre for Indigenous Health and Well-Being (Poche Centre) in the Discipline of Public Health at Flinders University also provides for a strong teaching base in this area. Additionally, the institution requires integration of Indigenous content as part of its internal five-yearly review process.

In terms of the MPH, this review found that components of both vertical and horizontal integration of Indigenous health content have been utilised by the Discipline of Public Health. However, neither model has been fully achieved. Vertical integration is evident in that the Social Determinants of Indigenous Health course is provided as a core

in four of the seven specialised streams in the MPH, due to competing content areas. Horizontal integration is also evident in several of the other courses, but this varies according to the experience and confidence of staff to teach this content.

A systematic process to map the content of the MPH against the Australian Network of Academic Public Health Institutions (ANAPHI) competencies was clearly identified as a need by interviewees to ensure this integration occurs in a meaningful way, and to ensure that all students are exposed to the necessary content during their MPH that will enable them to achieve the required competencies expected of all graduates. Staff development to improve their capacity to teach this content also needs to be ongoing.

The Social Determinants of Indigenous Health course that is provided by Poche Centre staff is an exemplar of Indigenous health teaching. Its focus on highlighting racism as a social determinant, enabling students to grasp the impact of social determinants on health, and the importance of understanding health within a social context is in line with best practice for Indigenous health curriculum. The course supports students, within a culturally safe environment, to examine and challenge their own racially based beliefs and encourages critical self-reflection. In this way, it facilitates transformative learning, an approach that is also in line with best practice.

This review also raised some general concerns about the ability of the sector more broadly to achieve the ANAPHI competencies in all graduates – both within current funding levels and with the limited number of staff with the necessary expertise to teach some of the highly specialised content areas (such as economic evaluation) included in the competencies. Their applicability to the workforce and application on graduation is also an area that needs investigation.



The review team, therefore, recommends:

- A national workforce survey of MPH graduates to assess application of the competencies and graduate outcomes and their relevance to workforce need.
- Provision of additional resourcing for public health education and professional development courses in much the same way that rural health has been supported previously.
- Review of the ANAPHI competencies to ensure they are still applicable and achievable.

To strengthen the integration of the Indigenous public health core competencies at Flinders University, the review team had the following recommendations:

- Consideration be given to extending the length of the MPH to facilitate inclusion of the Social Determinants of Indigenous Health as a core course across all streams of the MPH.
- Horizontal integration of content is treated as a priority and implemented in a systematic manner so that content clearly links to and builds on core content.
- Ongoing staff development and support for the teaching of Indigenous health content is adequately resourced and provided.
- A survey of MPH graduates is conducted to assess the relevance and applicability of the program to their workforce needs.

However, the review team also commended the MPH program staff at Flinders University for:

- Supporting the establishment and operations of the Poche Centre that provides Indigenous teaching and research expertise and support to staff throughout the Faculty.
- Demonstrating commitment to the inclusion of Indigenous content in the University's curricula through ongoing internal reviews that include Indigenous content as a mandatory Term of Reference.
- The delivery of the Social Determinants of Indigenous Health as a core course that is an exemplar of the way that the social determinants of health in an Australian context should be taught.
- The innovative transformational (un)learning approach utilised by Poche Centre staff in teaching the Social Determinants of Indigenous Health course, which provides students with the opportunity to develop culturally safe judgment skills and practices.
- The intention of teaching staff within the Discipline of Public Health to integrate Indigenous content and core competencies horizontally throughout the rest of the MPH curriculum.

2. Introduction

2.1. Public Health Indigenous Leadership in Education (PHILE) Network

Indigenous health workforce reform is a foundation plank of current policy initiatives to 'Close the Gap' in Indigenous health. The PHILE Network is a coalition of leading national academics and professionals in Indigenous public health formed from the National Indigenous Public Health Curriculum Network. This Network was established in 2003 in response to an identifiable need to provide a forum to exchange resources, ideas and develop policies and programs of relevance to teaching and learning activities in Indigenous public health. It is part of the broader Indigenous Public Health Capacity Building (IPHCB) project funded by the Australian Government's Department of Health. The strengthening of Indigenous curriculum components within MPH programs nationally is a key focus of the PHILE Network.

2.2. Indigenous public health core competencies

The Indigenous public health competencies are a core component of the *Foundational Competencies for MPH Graduates in Australia* (ANAPHI 2009), which was published in early 2010. This curriculum framework integrates six core competencies in Indigenous public health that are expected of every MPH graduate nationally. The core Indigenous health competencies that students should graduate with are:

1. Analyse key comparative health indicators for Aboriginal and Torres Strait Islander people.
2. Analyse key comparative indicators regarding the social determinants of health for Aboriginal and Torres Strait Islander people.
3. Describe Aboriginal and Torres Strait Islander health in historical context and analyse the impact of colonial processes on health outcomes.

4. Critically evaluate Indigenous public health policy or programs.
5. Apply the principles of economic evaluation to Aboriginal and Torres Strait Islander programs, with a particular focus on the allocation of resources relative to need.
6. Demonstrate a reflexive public health practice for Aboriginal and Torres Strait Islander health contexts.

The development of these core competencies, and the framework to guide their integration within MPH programs (Genat 2008), constituted an initial step of a major institutional reform in national public health curriculum.

2.3. National review of competencies integration into MPH curricula

The aim of this review is to investigate the integration of the core Indigenous public health competencies into the curriculum of MPH programs nationally in order to document and disseminate examples of best practice and to find ways to strengthen the delivery of this content.

Specifically, the research questions for the review are:

- How have MPH programs integrated the six core Indigenous public health competencies within their curricula?
- What examples of best practice and innovations have emerged within MPH programs to integrate the Indigenous core competencies within their programs?
- How can the integration of the six core Indigenous health competencies be improved?
- What numbers of Indigenous student MPH enrolments and graduations have been recorded in the past five years?

3. Review Methodology

3.1. Ethics application

The ethics application for the national review was submitted and approved by the Human Research Ethics Committee (HREC) at The University of Melbourne in October 2010: Ethics ID# 1034186.

An amendment was approved in April 2011: Ethics ID# 1034186.2 to reflect changes to the principal researcher and other members of the research team that occurred at the end of 2010. As other changes arose to the PHILE Network membership in late 2011 additional amendments were needed. After further consultation with PHILE Network members and the Chair of the HREC, it was agreed that members of the PHILE Network should be registered as independent contractors. A further amendment was approved accordingly in February 2012: Ethics ID# 1034186.3. Therefore, as new members came on board no further amendments were required and the reviews could continue for the duration of the project.

3.2. Participant recruitment timeline

Table 1 below outlines the process and timeline for recruitment of participants in the review.

3.3. Review design

The curriculum review was essentially based on a qualitative design, although some quantitative data was also collected. The review comprised the following activities.

3.3.1. Quantitative data collection

Questionnaires were distributed to the MPH Coordinator (Attachment 8.5) and Unit Coordinators (Attachment 8.6).

3.3.2. Qualitative data collection

Participation in the review involved the completion of a 45-minute semi-structured interview.

Table 1: Participant recruitment timeline

Date	Action
January – June 2010	Call for Expressions of Interest (see Attachment 8.1) sent to institutions that deliver an MPH program.
December 2010	Received 13 inquiries about review participation.
May 2011	Letter of Introduction (see Attachment 8.2) sent to the 13 institutions.
September 2011	Pilot review conducted.
December 2011	Pilot process and outcomes reviewed and modified.
End of 2011	Recruitment process to all interested institutions began, which included dissemination of a Plain Language Statement (see Attachment 8.3) and an informed written Consent Form (see Attachment 8.4) that was collected at the focus groups and interviews.
February 2012	MPH reviews commenced.

The review of the Flinders University MPH was conducted on 14–15 February 2012.

3.4. Data analysis

All semi-structured interviews were recorded and subsequently transcribed. Transcripts were then cleaned and all information relating to the interviewees was removed from the transcripts. For this reason, quotes used in this report have had cataloguing identifiers removed. However, it should also be noted that respondents were informed that due to the small sample size individuals may be able to be identified from respondent comments.

Two types of qualitative analysis were used. The first was a conceptual analysis using Leximancer qualitative content data analytical software tool, which is designed to minimise the effect of predetermined perceptions of researchers on interpretation, by assessing the semantic and relational dimensions of text (Smith & Humphreys 2006). Leximancer tool, therefore, draws out the key themes and concepts.

The cleaned transcripts were uploaded into the Leximancer software. All material relating to facilitator comments was eliminated from the analysis, as were words like 'because', 'yeah', etc., while similar words (e.g. Aboriginal and Indigenous) were combined.

Typical statements relating to each of the conceptual links (based on lexical collocation, or concepts that are frequently linked together in the text) were identified by the Leximancer software and subsequently examined using a second thematic analysis that was conducted by the researchers. A continued hermeneutic reading (Patton 2002) of the data was conducted to:

- Draw out the essential meaning of the themes and concepts identified in the conceptual analysis, informed by knowledge of the specific subject matter of the study; and
- Identify any important learning from the text that was not identified as in the key themes and concepts and was hence overlooked by the Leximancer analysis.

3.5. Report structure

A brief outline of the program offered by Flinders University is provided below. The Results section commences with summaries of the data collected through the questionnaires. This is followed by a section outlining the discussion threads (or pathways) that form the content of the Leximancer-generated conceptual pathways. Additional themes identified through the manual thematic analysis are also discussed either under the respective discussion thread sections that directly relate to these conceptual links, or separately if they had not been identified in the Leximancer analysis.

The Findings section then draws out the learning from the results that directly relates to the three research questions that have informed the curricula review.



4. MPH Program Overview

4.1. Structure

The MPH program at the Flinders University is structured:

- 1.5 years full-time or three years part-time study.
- Five core courses# (9 units each) and one (9 unit) or two (4.5 unit) electives.

Of these five core courses, two – Social Determinants of Health and Wellbeing, and Research Methods for Social Epidemiology – are common to all specialist streams. The other three core courses are relevant to the individual specialisations.

There are seven specialised streams offered within the MPH program:

- Public Health.
- Public Health Research.
- Public Health Nutrition.
- Primary Health Care.
- Health Service Management.
- Chronic Conditions Management.
- Cancer Prevention.

4.2. Delivery mode

The MPH program is offered through mixed modes of delivery.

4.3. Enrolments

4.3.1. MPH enrolments

The number of enrolments in the MPH, over the last five years, is set out in Table 2 below.

Table 2: MPH Enrolments

Year	2008	2009	2010	2011	2012 (S1 only)
MPH Enrolments	76	59	87	50	41

4.3.2. Indigenous student enrolments

It is estimated that seven Aboriginal and Torres Strait Islander students have enrolled in and completed the MPH over the past five years.

4.4. Indigenous staff

Flinders University hosts the Poche Centre for Indigenous Health and Well-Being. There is one Aboriginal staff member who is a teaching partner for the Discipline of Public Health and the MPH program.

5. Results

5.1. Mapping of integration of core competencies

Flinders University's MPH program has Social Determinants of Indigenous Health as a core course. This course covers all but one of the six Indigenous health core competencies, the exception being: 5. Apply the principles of economic evaluation to Aboriginal and Torres Strait Islander programs, with a particular focus on the allocation of resources relative to need.

Additionally, a review of the objectives and content of six other courses (two cores and four electives) confirmed that the Indigenous core competencies are also embedded elsewhere. The results of this mapping of the competencies in the seven courses, including Social Determinants of Indigenous Health, are summarised in Table 3 below.

From the questionnaires it was reported that the areas of Indigenous health content covered include:

- Community engagement and empowerment strategies.
- Comprehensive primary health care services in Indigenous settings.
- Cross-cultural models of working.
- Ethics in Indigenous health research.
- History of Indigenous research.
- Indigenous health issues.
- Indigenous health politics and policy.
- Indigenous health practice.
- Indigenous health promotion frameworks.
- Indigenous leadership in Australia.
- Indigenous research methodologies.
- Social determinants of Indigenous health and inequalities.
- Use of oral histories and data.

Table 3: Indigenous health core competencies covered in courses

Integrated Indigenous Health Core Competencies	No. of courses	
	Yes	No
1. Analyse key comparative health indicators for Aboriginal and Torres Strait Islander people.	3	4
2. Analyse key comparative indicators regarding the social determinants of health for Aboriginal and Torres Strait Islander people.	3	4
3. Describe Aboriginal and Torres Strait Islander health in historical context and analyse the impact of colonial processes on health outcomes.	3	4
4. Critically evaluate Indigenous public health policy or programs.	2	5
5. Apply the principles of economic evaluation to Aboriginal and Torres Strait Islander programs, with a particular focus on the allocation of resources relative to need.	0	7
6. Demonstrate a reflexive public health practice for Aboriginal and Torres Strait Islander health contexts.	4	3



5.2. Analysis of interview content

As shown in Figure 1, the Leximancer conceptual analysis drew out 12 key themes in order of frequency, with 'health' as the most frequent and 'time' as the least. Within the 'health' theme, 'Aboriginal' and 'health' are the most frequent key words contained in this concept. Taking the key words most frequently occurring within the Leximancer conceptual analysis, and those most relevant to the research objectives, the following five conceptual links were created:

- Health to communities.
- Health to content.
- Health to course.
- Health to competencies.
- Health to student.

The additional themes identified through the thematic analysis are described following the outline of the five conceptual pathways:

- Teaching approaches.
- Need for curriculum development support and resources.
- Funding of public health education programs.

5.2.1. Health to communities

This conceptual pathway linked a series of key words including 'health', 'Aboriginal', 'people', 'work' and 'community'. The key statements from the Leximancer discussion thread particularly relate to who is involved in teaching, and in contributing to, the course.

5.2.1.1. People involved in teaching

There was frequent discussion regarding the appropriateness of Indigenous versus non-Indigenous people teaching Indigenous health content. Although some non-Indigenous staff did not feel it was their place to be teaching this content, others felt quite confident or indeed believed they had an obligation to include such content in their courses, as illustrated in the divergent quotes below.

*Because quite frankly I wouldn't want to teach it because I don't have an **Indigenous** background and I don't think I'd ever pretend that I was an expert in the area. So fortunately we've got... an expert... teaching that topic and we're really, really happy about that.*

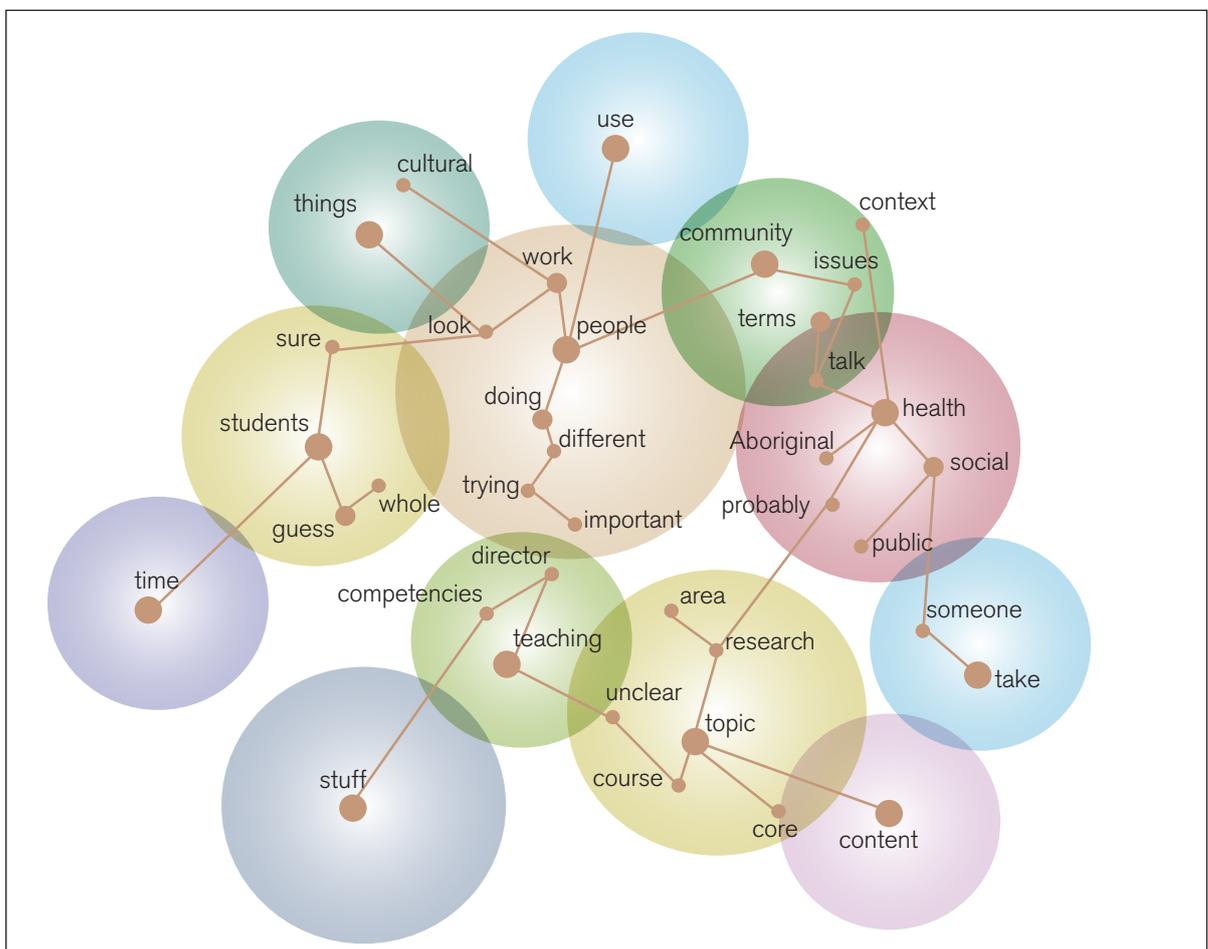


Figure 1: Concept map showing themes from interviews at Flinders University

For myself, I did a lot of Indigenous health when I was doing my Fellowship. So I'm really quite **confident**... – well I cannot say I'm a specialist in Indigenous health, but I am always familiar with the issues of Indigenous health.

I have been taught by the **Ngarrindjeri Elders** as a race relations and cultural education philosophy that it's got to come from **non-Aboriginal** as well as **Aboriginal [people]**. It can't possibly always be **Aboriginal people's** responsibility to teach **non-Aboriginal people**.

Non-Indigenous staff who have taught Indigenous health content referred to the advice they have sought from Indigenous colleagues and/or community members to ensure their content was appropriate.

Another **Aboriginal woman** came in to teach it. Then for a couple of years there were **no Aboriginal people** there teaching it. It needed to be converted to distance [mode], and so I volunteered to do it and what I basically did was took some advice from **Aboriginal colleagues**... So I was trying to navigate being someone who was there to look after it in the most respectful way possible. I haven't done any work, I've no formal long-term engaged work, with Aboriginal communities. I'm **non-Aboriginal** and so we decided it wasn't my role to go in and change things but try and take some **judicious advice** here and there.

Aboriginal staff in the hospital – we did what you normally do – you **identify someone**, go and talk to them, sit down. We didn't have an advisory committee, we just at various points said we need advice, go and find someone and talk to them and take the **advice**.

The importance of the Poche Centre being located at Flinders University, and the contribution of the staff to teaching in the program, was also acknowledged.

I also think **it works** because there's a **Poche Centre here**. I don't think the topics work well unless they're the face of something or there's some research and practice underneath it.

The contributions of Aboriginal people teaching into the program were also acknowledged including community leaders and Elders.

Daryle Rigney came to talk about the importance of country to Ngarrindjeri. So he's really well versed on looking at the

sorts of things that his community is doing to assert some governance. He's been an integral part of the NRA, the Ngarrindjeri Regional Authority, which has brought together a number of different Ngarrindjeri groups who [have been fractured by the] processes of colonisation and processes of history.... Now that the NRA has got some legs, government is starting to listen because they can look at a system of governance that they feel they can work with. So it was great. **Steve Hemming**, who's also been a crucial part of setting up the NRA, came in as well with Daryle.

My idea is to try and expose people to the **Aboriginal leaders** in their area and to encourage them to seek out the Aboriginal leaders in their own area when they go back.

Yes, we try to make sure that people like **Uncle Tom** come in and talk to students, and **Aunty Helen**.

Other topic experts with experience working in or relevant to the Indigenous health sector are also invited as guest lecturers.

Mostly I will be talking about theories and practices of health promotion, but also I will invite **different practitioners**. I have so far planned to invite someone who has a lot of **experience** in community engagement and how to empower the community. So empowerment strategies including strategies which work for **Indigenous communities** would be taught. I'll also invite people who are in obesity prevention, particularly in health promotion. So issues of policy development, policy and practice, [and] policy analysis would be also attached. I'll invite someone from the Health in All Policies [area of the SA Government]... that is really good, because it recognises that the **other sectors** have to be responsible as well. So I will have someone from Planning who will **provide examples** of how planning is essentially [about] health promotion.

5.2.1.2. Work In Aboriginal communities

While the previous discussions refer to who is teaching Indigenous health content, the next set of discussions refer to the use of personal experience to inform the content. Participants often referred to drawing on their own work in communities when preparing their lectures.

I used the example of the **work** I've done on dengue with **Aboriginal** and non-Aboriginal people in **Northern Australia**, and talked



about how that process was collaborative but also what the limitations or challenges of it were for them as well.

Similarly, they draw on the work of others in the field to add a practical context to their course content.

*Then you connect it to other things such as... hearing loss. There's some **recent work** on that. I don't know if you've come across it from the **Northern Territory**, by a **non-Indigenous psychologist** called Damien Howard. When he and an **Aboriginal audiologist** looked at people in Alice Springs Gaol and Darwin Gaol, they found that 90 per cent of all **Aboriginal prisoners** in the **Northern Territory** had significant hearing loss – 90 per cent! In Damien's previous work he's looked at the connection between mental health, particularly anxiety and depression, on hearing loss.Where does the hearing loss come from... We try to make those **connections** to say [that] we can't look at [the] effects of incarceration without factoring in hearing loss.*

*I'm on an ARC [Australian Research Council] grant with her, where there's an **Indigenous health** lens in two of the studies. She's got a long **history in this field** and we use a text – an article called 'In Our Own Backyard'. [It's] an analysis of experiences of racism and discrimination and marginalisation of **Aboriginal people in Adelaide** and she's one of the **lead authors** [of] that text.*

5.2.2. Health to content

This conceptual pathway also linked a series of key words including 'health', 'topic', 'core' and 'content'. The key statements from the Leximancer discussion thread relate to the place and type of Indigenous content within the MPH program. The following items in this section outline the structural issues of Indigenous content within the program.

5.2.2.1. Indigenous health as a core

Traditionally, the Flinders program went for an integration model but recently decided to make Indigenous health a core course.

*We've traditionally always tried to **integrate** it in all the topics but we thought: hang on, why don't we actually put a major topic up there, course **core topic**, right across the streams and get someone who really knows what they're talking about.*

*It's a **debate** we've always had both in this course and in the medical course and that is – how do you teach Aboriginal health? Do*

*you have a unit on it, and is that all you do? Or do you **distribute** it through [the MPH]? If you distribute it through do you lose it? The debate went along these lines and we resolved that we think it's okay to have as **core topics** [both] Social Determinants of Health [and Wellbeing] and Social Determinants of Indigenous Health... – it's inescapable.*

Although this was reportedly a unanimous decision at the time, it should be noted that the support expressed during the interviews has not led to uniform application of the core topic, as will be discussed in Section 5.2.2.3.

*This **isn't about tokenism** anymore; this isn't about chucking in a lecture here or there. This is a core topic. If you want to do public health you do the Indigenous stuff; you must know this stuff. I loved the message that that was sending, apart from the fact that students would do that. It was such a strong message. We're not toying with this stuff. It's a core topic, everyone has to do it. We were all **thrilled** about that decision. It was **unanimous** and it was quick. It was a really quick decision.*

*I **felt really strongly** that we'd made a **commitment** to making Indigenous content a **core topic**. I felt strongly that we had **all** felt strongly about it when that decision was made.*

*I suppose... what's become crystal clear to me in public health is that there's a very, **very genuine** and **strong commitment** to Indigenous content. I don't know how else to refer to it, so I'll just make it that.*

Creating the core course on Indigenous health even required the removal of other courses in the program to make way for it, further demonstrating the commitment and importance given to this course.

*I must admit we actually removed topics... we couldn't fit in. But we did say that Indigenous health – you have to do that properly... **Indigenous health was the only one we introduced...***

However, the manual thematic analysis identified that support for Indigenous health teaching is not necessarily mirrored throughout the university. While there was acknowledgment given to individual champions within the institution, there was an identified need to ensure that all staff across the faculty were fully supportive.

We feel we're in a privileged space because we've got the support of both public health but also the wider [university]. I mean

we wouldn't have got this far without the **champions** that are here. It's really worth noting. Your Paul Worleys don't come round every day. Your Michael Kidds don't come round every day. Michael Kidd is not only the Executive Dean but he's responsible for negotiating... to set up the Poche Centre here, because he was previously University of Sydney where they had one. Both of them are **dedicated to Indigenous health...** That's important. We've got some great champions there, people who have worked for a long time in Aboriginal health like Associate Professor Eileen Willis. There are a number of people who have got strong runs on the board and **strong commitment**. But it's parlaying that into an overall faculty *Zeitgeist*, a culturally safe faculty.

At Flinders this is being addressed through cultural safety training for university staff.

*I think until we teach from the **top down** we might continue to have battles like diluting core topics to electives. I think that something that we're doing next week with the Nursing Faculty is running cultural safety training with the staff. I think it's really important to **educate faculty**, so we have actually done that in Public Health. [We] ran a cultural safety workshop for Public Health faculty but there was about seven or eight people there, so I'd like to make sure that that was a much more comprehensive program. It wasn't just one morning. It was something that was at least two days, possibly three, something like the program we just ran. So some comprehensive training in cultural safety [is needed, but] that's not just it. It doesn't just end there. It's something that's followed up. We have talked about a [continuing professional development] system... We'd really like to see cultural safety incorporated into that type of thing.*

5.2.2.2. Integration of Indigenous health

Indigenous health as a core course has not precluded integration of Indigenous health content in other topics, as outlined above and reiterated in the following quotes.

*That doesn't discount the fact that we, as lecturers, don't talk about **Indigenous health**. Certainly in my Research Methods topic, I like pulling out some statistics such as... there's evidence out there that suggests that 50 per cent of Indigenous people in this country have diabetes 2...*

*We also acknowledge that [it] is important to **include Indigenous health** in Health Promotion for everybody.*

However, there was also acknowledgment given that any integrated content needs to be constructive rather than focusing on the deficit model of Indigenous health.

*I am **quite careful** about that because I think there can be a situation where you're constantly reinforcing certain ideas and assumptions about health in Indigenous communities. I don't deal with alcohol, for example, because I think at the moment, it's terribly inflamed. There are some other issues that I think are really quite inflamed at the moment. But I do tend to use case studies... effectively as a **comparative approach**.*

*I'm careful to use case studies also that aren't seen to overly **reinforce certain stigmatic ideas** about health and issues in relation to Indigenous communities. I try to actually show comparative [examples].*

Indeed, the manual thematic analysis identified data that suggests the competencies may even inadvertently encourage focus on Indigenous health in a negative way, by perpetuating a sense of the 'other'.

*This whole idea of **competency** is, I think, a very interesting one. Because we have key competencies, we have all these things that people consider themselves competent in and yet I think it still perpetuates that **'othering'** gaze, and that **'othering'** approach.*

5.2.2.3. Exception for three specialisations

Although Indigenous health is a core course for most of the specialisations within the MPH, there are three specialty strands that had the core Indigenous health course removed to make room for the research dissertation project.

*We thought the most viable option was to remove the course core topic of **Social Determinants of [Indigenous] Health** from those streams, but to embed content into the topics actually talking about chronic condition management and cancer prevention. So there were examples in there that [are] all embedded in the assessment.*

The intention is that Indigenous health is integrated throughout the units contained within these streams so that all students are still taught Indigenous health content.



I also think it should go through the streams because some of the streams are taught wholly outside of our Discipline... The ones that aren't are **Cancer, Chronic Disease, and Management**. They're taught by other people who aren't in our Discipline. So if there's going to be review, if there's going to be a matrix – there should be a matrix I think in those three streams, not just in the core topics that come out of health. So, for example, if you're looking at cancer: I don't know anything about the content of the cancer and chronic disease and management stream [and] I haven't seen the topics but there should be Aboriginal coverage there I would say.

So for me it's a little **lopsided** because we've got five streams that have [Indigenous health] as a major topic and two that don't. It's not a huge issue from the point of view that those two new streams do not have large enrolment numbers – they represent about 10 per cent of the enrolment. But we feel that it would be wrong and **inequitable** not to teach Indigenous health for a number of reasons. One of the reasons would be that some students would be taught it and some students wouldn't be and that's not a good thing.

However, there was uncertainty expressed as to whether or not this had successfully been achieved and the need to ensure this occurred.

*Health Care Management and Chronic Disease... bring in the Flinders approach to self-management of chronic conditions. I know that they've done work in Aboriginal communities with it and done training but I generally **don't know whether that comes into the course** or not, in the topics. It should, [especially] the cancer subject ... Again we should be able to know in those where the Aboriginal content is.*

*We've got to work out whether that's going to be **done properly**...*

5.2.2.4. Resourcing for review and mapping of content

Staff teaching into the MPH, therefore, acknowledged that a formal mapping of content is needed to ensure that all core competencies are being covered and also to create stronger linkages between the topics.

*We do regular **curriculum planning** and one of our agenda items is to look at how much Aboriginal health is done in the rest of the areas.*

*[It would be good] to get some guidelines like what you've established, and there's medical education guidelines as well, but I think the **public health guidelines** might be even more useful, and to **review the content** as it stands and **then map it**.*

*We're happy to look at that and I think in order for people to have a think about that, saying - well these are the sorts of things you want to put in your topics over and above what [he] teaches but we have to work out how that **matches** up with [his] thing and is he going to **change** that ... To be quite honest we're a **small teaching team** and we teach quite a few topics; we've got seven streams. We don't want to be teaching the **same stuff** that [he] is teaching.*

While it was recognised as an activity that needed to be completed, the barrier to this occurring was stated as being a lack of resources to enable the mapping of content to occur in a formal way.

*In terms of the rest of the streams, we haven't actually done that yet. It's purely a lack of personnel. We're stretched a bit at the moment... It's a matter of simply **not enough time and people** to actually sit down and work out how to do that.... It's a **person power** issue. It's on the radar.*

5.2.2.5. Content links between subjects

Making the link between the various subjects and staff teaching in the program was also recognised as being important for the student learning experience, to create a program context and also the opportunity to establish relationships and networks.

*Where I think we could **strengthen** what we do is **tie in** what we do more specifically to some of the **context** of the other **public health topics**.*

*What they're getting here, I guess, is an introduction to all the **key people** in the Discipline or in the faculty [and] their key areas of interest, but specifically how they relate to social determinants. They're also getting a bit of an introduction [as] to what the Social Determinants of Indigenous Health is, which is a core topic for them to take in second semester and they're getting to meet... **specific people** who they'll [be taught by] later.*

One thing I think we probably could do a little bit – and I'm trying to do that with Social Determinants because it's really the first core topic that they get – I am trying

to promote a bit more about some of the **other topics** and, in particular... *Social Determinants of Indigenous Health* because I think that's really critical.

The next sections outline the content areas that are covered in the Flinders MPH program.

5.2.2.6. Focus on social determinants throughout content

Social determinants and the principle of equity are the foundational ethos of the program and this has had a clear impact on the integration of the Indigenous health core competencies and the framework within which it is covered in the curriculum.

We've always tried to be upfront [as to] what we're about and what we're not about. That's our... rationale for saying that our ethos is usually to stick with something which says – This is what we do and we're not teaching a general subject about Aboriginal health. I think [this] would in fact weaken the case because they would say – Well isn't that an elective then? Whereas by putting the social in, we're trying to suggest to people that this is important. It relates to our mission and that's why it's there.

When you're teaching topics, because of the nature of public health and because of the way we teach [it] and the approach that we take to public health, it's not about epidemiology. It's not about measuring here and there. It's about the values and principles that underlie public health.

When you teach them like that, you have to talk about difference and you have to talk about the whole array of the community. So what you look for are the gaps... What are people forgetting? What's falling in the holes? What are the big debates? What are the important issues here? Necessarily, the Indigenous content comes into it there.

This is an Australian core program and I can't think of another population... anywhere else in the world that has more health problems. So we make sure that we teach that right across the course; and that's where it stands at the moment but we're always tinkering around with it. We do have a large emphasis on social determinants of Indigenous health and I think we take it very, very seriously. We don't take it lightly.

Fundamental to this ethos and philosophy is the need to overcome inequities produced by privilege and power, which is a key focus of the Flinders Indigenous health course.

So it's about making sure that we are not teaching students to look at 'the other'... We're not teaching students to say: Well, you learn this course, you'll know how to work with Aboriginal people. We really don't like that approach. We want you to be aware of your own cultural identity. We want you to be aware of power imbalance right from the word go. What you bring to those relationships. What your mere presence in the community or wherever you're working, how that's impacting on the way you work – whether it be at a policy level or whether it be with clients.

I use things like historical corollaries. I talk about the Enclosures Act 1761 in the UK that pushed my ancestors off their land, that had their language destroyed, that had their families separated, the women's and men's heads shaved, put in workhouses and kids taken away. That's very recent, [only] 1761. When non-Aboriginal people hear that history... it starts to get them to understand that this isn't about race. You can tell people until you're blue in the face that there's no such thing as race, but they're hearing from everywhere else that there is. You try to talk about them [it] in sociological contexts, that there's no such thing as a social construction blah, blah, blah. Everywhere else in the world is telling them that there are races, whereas I want them to understand power and how power operates.

So we have a Sámi woman who is working with us at the moment. She gets great traction with the students because there she is, this blonde, blue-eyed Norwegian woman who's talking about the fact that her family had to hide their language and that... they still had, what do they call it, residential schools programs in the 1980s in Norway. All of these similar sorts of things that were about establishing power; that were about crushing sovereignty, that were about assuming the way to live. We deliver those things in ways that bring students with us.

Closing the Gap is a very specific and worthy laying out of targets, areas for action and indicators for getting there. Great and fabulous to see that money and that energy go into this comprehensive program. What's missing is the context in which that's applied.

So here's a set of things being done to and hopefully with Aboriginal people. Here's the wider context in which that all



happens. Who's addressing context? The context is workforce, the context is **race and discrimination**, the context is policy – a 1001 things – the **context of lives**. So that's what we try and ask people to keep in mind. Not just the initiatives and the programs, but the context in which they're delivered and sort of juggle these two things at once.

When I was tutoring in Social Determinants of Health, and I was trying to get across the concept of **equity**, the students I had were really struggling with this concept of equity. It might seem really straightforward to some, but they were really struggling. So I used the example of Indigenous communities and **resources** that are given to Indigenous communities. I used it a lot because they'd got it like that, they got it really quickly. So because the differences between Indigenous communities and the mainstream were so vast in the **examples** that we used, it just kind of hit them in the face and they got it really clearly.

Discussion of the comparison between Aboriginal and non-Aboriginal views of health and how these relate to the social determinants in Australia are also featured in the program.

*It goes through his **framework for understanding Aboriginal health**, which is different from the one which is used in the social determinants topic.*

*[We look at] how Aboriginal health fits into the **non-Western view of health** and how ... a Western view of social determinants is [the way in which Indigenous health determinants] were first developed. But in terms of how Aboriginal people look at social determinants, [you need] to include things like **land and spirit** and those sorts of things.*

*In terms of readings, they've got specific readings... [such as] Debbie Rose Bird's work on Nourishing Terrains. I find it a useful example for non-Indigenous people to engage with **ideas about country**, and the **links between country and health**. It's actually based on work that she's been doing for many years with Indigenous families, so we talk about **racism and colonialism** and so forth in that area.*

Specific examples of content relating to the Indigenous social determinants were frequently discussed during the interviews as these quotes illustrate.

*I gave a lecture on Indigenous housing... in rural and remote areas as an example of **social determinants** of health and **housing**. But I specifically took the example of Indigenous health and housing. I'm going to reprise that lecture this year, so they'll get that extra content. But there'll be others as well, so examples that are used in tutorials.*

*When I was tutoring in Social Determinants of Health, and I was trying to get across the concept of **equity**, the students I had were really struggling with this concept of equity. It might seem really straightforward to some, but they were really struggling. So I used the example of **Indigenous communities** and **resources** that are given to Indigenous communities.*

*I use quite a lot of **language** and make sure that students understand that language is still alive. It's a really common understanding in the south amongst non-Aboriginal people that there is no **culture**, that there's no language. It's something we hear in our classes every year.*

*I think [in the] third week we're talking about water as an exemplar issue of **land and country and environment**. So we start talking about well what's happening in Roxby Downs and the **water table** there and the Kokatha people. What about Northern Territory in terms of people – officially services are being designed so people go into growth towns. How does that affect the **Homelands** movement?*

*We ask them to look at – I think it's an article ... from the AMA – looking at the amount of money spent on Aboriginal versus non-Aboriginal Australia and talking about **funding**... We stress... not the failure, but the inadequacy of **pilot programs**. Not pilot programs but one-offs, and [using] **sustainability** as a catch phrase, but how do we actually build it in?*

5.2.2.7. Choice of topics

It was noted that students often choose Indigenous health topics themselves for further study, outside the set curriculum.

*That's often coming from the student [and] what they might pick up about it. They might be working in a position where they've seen resources used badly or resources used well. So they'll often highlight that in their **own assignments**.*

*With the Primary Health Care in Developing Countries I don't teach much about Indigenous [health]. I mean, yes I would maybe give some examples in the content but not necessarily [have it as] one of the objectives. It is purely for the developing countries, so that one we don't have. But we don't exclude people or **individuals interested** in Indigenous health. So if someone is interested in Indigenous health – maybe somewhere else, Canada or even other places – then I would encourage that. But it's not prescriptive.*

Support is provided by the staff at Flinders for students wanting to develop their skills in this area in their research or placement projects as well.

*In Public Health Practice and Development, that is basically an individual **selection of the topic**. Everybody develops according to the[ir] interest in [an] area of need. So, depending on the person, if a person is interested in working in Aboriginal communities or Indigenous communities then I would **help** that individual to **develop** in that area on an individual basis.*

5.2.3. Health to course

This conceptual pathway linked a series of key words including 'health', 'Aboriginal', 'topic' and 'course'. This pathway highlights conversations pertaining to the evaluation and review of the course and its content.

5.2.3.1. Five-yearly review of MPH program

Flinders University consistently reviews all programs every five years and includes Indigenous health content as one of the terms of reference for investigation, thereby demonstrating institutionalised commitment to contributing to 'closing the gap'.

*Our course is **reviewed** every **five years** and there's a **compulsory term of reference** in this university [with regard to Indigenous content]. When every course is reviewed there's a compulsory term of reference of reviewing about **Indigenous content**. You can't not do it. So it's reviewed then.*

*As I said the good thing about this university is that the **Indigenous term of reference** is **non-negotiable**. You can't say: We're not there yet or we're thinking about it so please can we do it in another five years.*

However, it is unclear whether having this term of reference promotes a superficial 'tick the box' approach to Indigenous health content, or whether it promotes comprehensive content and dedicated teaching that will enable 'deep learning'.

5.2.3.2. Other forms of evaluation

In addition to the university reviews, the MPH is also reviewed regularly by the Faculty. Student Experience of Teaching (SET) surveys are also conducted to evaluate every course each semester. In this way, evaluation forms a three-tiered process with each level feeding into the others.

*We've got to see how it goes and we do have that three-layer process that the university will drive. If we get **SETs** coming back and those SETs are passed on to the head of department and are terrible saying: Well, we've got this thing to talk about, Indigenous health, which doesn't sound like the topic coordinator knows anything about. Or in their learning outcomes it says something about Indigenous health and I can't see we've actually taught that, then alarm bells will start ringing. Again the five-year **topic reviews** and again the **faculty review** will come up.*

It was noted that this evaluation does not include graduate follow-up to assess measures such as application to the workforce, for example, except when linked into one of the formal review processes, which may elect to seek previous students' feedback.

*In comparison say to medical courses [that] keep a lot of **data on graduates** and track them, **we don't**. It's not part of the culture really of public health to do that.*

5.2.3.3. Inadequacy of SETs

In relation to evaluation, the manual thematic analysis also identified a discussion around the SETs and the challenges of student participation when these processes are undertaken online. A suggested means of overcoming this challenge was discussed.

She just rented a room, you know, a computer bank. Towards the end of the semester she marched all her students to this room and said: Right, now we're doing SETs. So they all had to sit on a computer and do their SETs during the tutorial time. I mean it means you lose a tute or half a tute, but you get that evaluation.

5.2.4. Health to competencies

This conceptual pathway linked a series of key words including 'health', 'Aboriginal', 'topic', 'teaching' and 'competencies'. These discussions focused on where the Indigenous competencies fit within the overall competencies expected of MPH graduates, and the role that competencies play versus content coverage.



5.2.4.1. Awareness of competencies

The first of these areas was the discussion regarding staff awareness of the Indigenous health competencies. Although all staff were aware of the competencies developed through the Public Health Education and Research Program (PHERP), and eventually published as the Foundational Competencies for MPH Graduates in Australia (ANAPHI 2009), not all of them were aware of the Indigenous-specific competencies contained within the overall document. They expressed their views that they should have been and that more emphasis should be given to these competencies.

*No, I knew about the **PHERP competencies**, but I **didn't know** about the Indigenous competencies specifically. I do now.*

*I **didn't even know** they were there. It's possible that I've forgotten. I don't know... So it's a matter of **giving these the same space** as the other ones.*

5.2.4.2. Content versus competencies

Another view that was expressed related to the importance of the competencies versus content areas covered. While it was acknowledged that the competencies are an important mechanism for informing and reviewing curriculum content, it was also highlighted that they can be quite specific and limiting if used without consideration of broader and complex contexts and workforce needs.

*It's a different task to what we do because, for us, it's about – are we meeting the **needs of industry**? Are we meeting the **needs of students**? Are we **covering everything** that we need to cover in the curriculum? I suppose making it a **competency** lifts it to a different level, which is why it's good that they're there. But it produces a different challenge, in terms of reviewing **topics**.*

*If that's where **competencies** take us, that you have to be able to tick box with some level of confidence, I don't think I could that... We carefully construct these statements and they're easy to understand, but do we really have the knowledge? Do we really have the capacity to act on it in a really **genuine way**, without just – I mean, we could all... tokenistically **tick box** all of it. But that's not what you're after. You want the real stuff happening.*

5.2.4.3. Coverage of competencies

The manual thematic analysis identified several comments that relate to the coverage of Indigenous

core competencies within the curriculum. While most of the competencies were covered, the one pertaining to economic evaluation was noted as being a gap in the curriculum. This finding correlates with the data from the questionnaires presented earlier in the report.

*We'll talk about people's assumptions about what they think is spent on Aboriginal health. We can show the stats of what's spent per non-Aboriginal person and what's spent per Aboriginal person. Other than to highlight some of those disparities or myths or whatever, I **don't think we've really done a comprehensive job** of looking at the principles of **economic evaluation**.*

The reason provided was a lack of staff with the expertise to teach such specialised content.

*Then there are things like apply the **principles of economic evaluation**. Do we really have the knowhow? That assumes that we've got **people** on board, in the **Discipline**, who teach something around resource distribution, and specifically this is around an economic evaluation... Like I said, we would generally talk about resource distribution and what issues are around [these] resources, but I don't know that I would confidently put a tick against that...*

5.2.5. Health to students

The last conceptual pathway linked a series of key words including 'health', 'Aboriginal', 'people', 'work' and 'students'. The focus of these discussion threads is on the students and how they engage with or use the Indigenous health content.

5.2.5.1. Diversity of student cohort

Recognition of the role that students play in the teaching was discussed, partly given the diversity within the student cohort and the varied life and work experiences they are able to contribute and apply to the content being taught.

*Many of them are practitioners from a **variety of disciplines** from Australia and internationally; it's a really broad-based student body. They have a **wealth of experience** that they actually already bring to the topic.*

*So the majority of our students were externals. They were from all over the country, many of whom were **working already** on Aboriginal communities or working in public health.*

We're... going to have a conversation about the role of colonialism in terms of

health, and there's going to be some **really interesting conversations** in that tutorial because there are many people that come from that **experience**.

While this adds to the teaching and learning experience, it was noted that it can also create challenges associated with students' expectations of topic focus on their specific areas of interest.

*They tend to come in with: I'm into diabetes, or it might be... I'm into working class something or other, or I'm into working in Indigenous communities, or I want to go and work in Mongolia. They do tend to come in with, in some cases, past history [of] working in those places and they're going back, whether it's in Australia or elsewhere. I think there's some, not **limitations**, but those are some of the **factors** that we're dealing with in terms of the student body that we have.*

Student diversity can also pose challenges relating to learning needs that impact upon the delivery modes used in the course, especially with the increasing international student cohort for whom English is a second language.

*I try to use – because the **student base is varied**, because **literacy is varied**, too – what I try to do is use case studies.*

5.2.5.2. Applicability to students

Applicability of the Indigenous health content to local students was unquestioned by the staff interviewed, as articulated in the following quote.

*It's a program particularly for local students, because at one stage they [may] need to work [with Indigenous communities] and they leave more familiar [with the issues relating to] all public health areas for all populations, [especially] disadvantaged populations. Therefore, if **they're working here**, they should know [about] issues of Indigenous health in order for them to **be prepared to work** in... Indigenous communities or with Indigenous people. Or they may have **colleagues at a workplace** who are Indigenous so they **have to really know**.*

However, given the growing numbers of international students, the applicability of Indigenous health content – in particular the Indigenous health-focused core subject – to these students has increasingly been questioned. Pressure to internationalise content was an issue experienced by several of the interviewees.

*There's a bit of **pressure** here also to **internationalise** the topics which, as I said, can have its benefits... I tend to try and do that again through the comparative mode, so that they're able to reflect on their own practices on what's in the readings, but also more in an Indigenous component.*

Nevertheless, some of the interviewees expressed their views that international students should learn about Indigenous health in the Australian context because of the place that Aboriginal and Torres Strait Islanders have as our First Nation peoples.

*Because we have so many different students, if we said it wasn't a core then some students, for example **international students**, won't need it. But I think it would be good, because Indigenous [people] are our **first people** here... there's a lot of **politics** as well. Who are our students? Who brings the cash? But if I had a choice there I would make it a core program.*

It was also noted that many international students can apply the Indigenous health competencies in their own country.

*When I think about our intake, you get a number of **international students**, who live in countries where the Indigenous population... is not necessarily in the public eye in any way. You've got to make them aware of the fact that there is something called an **Indigenous population**. Yet you're starting at square one.*

*Because if you look at our student body, a huge... [number] come from **Indonesia, Vietnam, India** – all sorts of places. The question for them is why should I study Social Determinants of Indigenous Health? I think what they do is they get a contrast between social determinants of Indigenous health [and] general social determinants. It allows them to see that social determinants is not a one size [fits all, that] you see **tools** and you **apply it to different** contexts. I think they may learn something about indigenous health, which is good, but I think they **learn other things as well**.*

Other interviewees commented that the international students often took a greater interest in the Indigenous health content than local students, possibly for this very reason.

*The other ones were **international students**, but they were **interested**. One did [an assignment on] Indigenous health to look at issues of workforce in Indigenous health. The other person looked at the*



issues of colonisation in the Indigenous health and they looked at global issues, including Indigenous people in Canada, Australia and elsewhere.

Interestingly, there are such a range of people that many of them are working [in] situations where they're actually dealing with similar health issues to what you might generally expect to encounter... That's where the **comparative thing** is quite interesting. I find that the **international students engage and relate** much more. That's a bit of a stereotype on my part... But based on my very limited experience, I've found there's a willingness to engage with that and to understand, and then appreciate the complexity, too.

5.2.5.3. Engagement with content

The complexity referred to in the previous quote is a key challenge of delivering Indigenous health content faced by many of the staff teaching the core course. Facilitating a safe and appropriate environment in which the students can engage with the challenging issues is an important part of teaching in this domain.

All our research, all our scholarship is showing that you need a vehicle to deliver Indigenous health, [which] because of its **challenges**, its many challenges, is comprehensive. If you call it an Indigenous health topic or not, it's not so important as actually having that **mechanism** that does what I said – gives you at least six, eight or 10 weeks with the students, week after week after week, and **they must engage**, even with the challenging material. They go on a **journey** and they come out okay at the end. We must walk them through that journey. That's the only way we get any progress.

5.2.5.4. Returning to the workforce

However, even with a supportive environment for the students to undertake this learning journey in the Indigenous health topic, staff indicated concern that their learning and work practices on return to the field can be undermined. Hence, there is a great need for further workforce development.

You know, this is the **real world** now. So students are **undermined** when they get out there. The way that we can do it better I think is to not just have our training looking at undergraduates or even postgraduates, but looking at **work place training** as well.

5.2.6. Teaching approaches

The manual thematic analysis also identified teaching approaches as a theme emerging from the interviews. The philosophy of cultural safety is modelled throughout the teaching approach of Indigenous health content at Flinders by Poche Centre staff. This modelling is a reflection of the teachings from Aboriginal Elders to Indigenous and non-Indigenous academic staff.

So we very much have the philosophy of cultural safety as our, I suppose, driving theme throughout the program. We think it's very important to model **cultural safety** in the delivery of the topic... We **co-delivered the tutorials**. There was always the two of us in the room delivering the tutorials. [In] a lot of the teaching that I have done, I have been taught by the Ngarrindjeri Elders, as a race relations and cultural education philosophy, that it's got to come from non-Aboriginal as well as Aboriginal [people]. It can't possibly always be Aboriginal people's responsibility to teach non-Aboriginal people. So Uncle Tom Trevor taught me a great deal about how to do that in a way that keeps non-Aboriginal people in the conversation, because often the material is very confronting. So we really tried to practise that with the way we delivered the tutorials. I think it was really effective. ... At times students would say: Look, I just wanted to ask you this question... So modelling cultural safety in the way we deliver the stuff is really crucial.

That's why I think that's one of [the] best aspects of our teaching is that if we can get them to **understand those historical contexts** and not feel like their ancestors are being bashed or their country's being demonised. ... Students will say they feel like they're being attacked when they read Binan Goonj; because they're hearing harsh stories that they're just overwhelmed by. So I think that's one of the **best aspects of our teaching** that works really well.

I'm not really a PowerPoint guy, so most of my PowerPoint was just **pictures** and **photographs** of ngaitjjs and spiritual totems on Coorong and the waters, and talking about really what I'd been taught and given permission to teach by Uncle Tom when I worked there as a cultural educator. So in one sense that was almost a guest lecture because most of what I was saying was what Uncle Tom taught me.

A range of teaching tools are used in the embedding of the Indigenous health content that enhance student engagement and understanding of the content.

*We use an **activity** called **Colonise Me**, for example, developed originally for Nursing. We did this in our workshop the day. We sit people around and we get them to write out all their family on one Post-it note, or all their extended family or community, and their hopes and dreams on another one and something else on another one. They stick them on their arm. In the middle of the process of this activity... someone comes around, Officer so and so, and rips away their family or rips away their hopes and dreams. Then they unpack that in a small group and the large group. [And] actually people get emotionally engaged. Half of our work is to try and keep that balance between the cognitive and an affective mode of teaching. We're trying to engage the head and the heart at the same time. If you only engage the head, then it's dry and some people don't go on any kind of journey and you don't go anywhere. If it's only the heart, it's not hard to make people cry. I've got a colleague in another institution that used to say to me: I want to make them cry. I thought that's just absolutely counterproductive – counterproductive and insulting. It's not about that. It's about allowing people to have a genuine emotional connection and engagement with the material we're talking about in a **cognitive framework** that makes sense – [that] they can make sense of it. So the two things happen.*

*Actually sitting [and] watching, say for example, ... we have lots of really good **YouTube** clips. So instead of just talking about children being stolen we show them a clip from **Rabbit Proof Fence** where the copper pulls up and first takes the three girls. It's only a very short clip but it says more than I can ever say or anyone could ever say because you're visualising that pain. So it's an interesting one because it's fairly emotive. We have to be careful... of what we do with that. It brings it home a lot clearer and stronger than anything they're going to read. That's just one **activity** that we do.*

*The **Carson and Dunbar text**, we draw on that. We draw on *Beyond Band Aids*, which has a similar approach in a **CD-Rom***

*form, and each has their strengths and they complement each other nicely. We can refer to specific chapters. One's got a good chapter on socioeconomic status and one's got a good chapter on mental health, social and emotional wellbeing, for example. So we can draw on that. But there is no one text book... For example, our first week we take the *Productivity Commission*. I think it was a 2009 or '10 version ... called **Overcoming Indigenous Disadvantage**. There's about a 70-page overview of which we mandate that they critique as one of their readings.*

*Again, trying to broaden what we do all the time and contextualise what we do. We use lots of examples from what's going on in terms of **ABC online**, **columnists** or a **report** here and there and then bring them into the mix of our more structured learnings. I might use – for example, talking about Northern Territory, not just the *Intervention* – not just what's been published, as useful as that is. For example, *AIDA* [Australian Indigenous Doctors' Association] have done a kind of a health impact statement, but there are also similar **books** around about what community people say themselves and they're quite enlightening, ... so that kind of stuff we introduce... You get this **Indigenous grey literature**, which is the kind of stuff that hasn't found its way into the peer review of literature, and that's often where the real interesting stuff is or all the real telling stuff is happening. We ask students to actually balance these two things, a desire and a need to be a good scholar with really **citable sources**, at the same time as considering the worth of this so-called grey piece of literature. [So] bring[ing] that in the mix as well and using their judgment about how far you can go with different kinds of evidence.*

5.2.7. Need for curriculum development support and resources

Building examples of best practice was discussed during the interviews as an intended outcome of this overall review process. However, the way in which this process occurs was also discussed, with clear recommendations provided concerning the need for a detailed resource that can effectively support curriculum development.

*Examples of **best practice** don't always speak for themselves and they're not an **instruction manual**. Knowing what people*



have done and putting it into place yourself are two different things. Sometimes you just need to add a bit of an instruction manual, kind of thing. We do this with poor practice. We get lots of detail around what not to do but we don't actually get the same level of information around how to put something into place. I think, at the risk of sounding like we're all incompetent because it's not what I'm saying, if the outcome is trying to improve things, then the **more information** that you can [get, the better]. I don't mean in terms of quantity, but the more assistance, the more support you can get – it's just not self-evident. When you pick up a best practice [example] and you [think:] Oh wow, this is amazing, [but] it doesn't tell you how do they do this. Who are the stakeholders? How do they make relationships work?... What were the barriers for? How did they overcome those barriers? Where did they get their funding from? Those sorts of things that you just don't get information around... But you've got to step people through. You've just got to step them through and then you're trying to tick [off] this sort of stuff. And you go: Oh how do we, in this space of time, go from zip, nothing, completely blank, to [best practice]... That's what we need support with doing... from people who understand the stuff, understand the best practice.

5.2.8. Funding of public health education programs

In addition to the aforementioned comments about the need for resources to enable mapping activities to ensure the competencies have been adequately and appropriately integrated throughout the curriculum, the resourcing of Indigenous public health education programs more broadly was identified during the manual thematic analysis. Without sufficient resources to develop and deliver the curriculum, and conduct research, these programs struggle to exist without imposing higher fees on students. This in turn jeopardises the sustainability of these programs and is a barrier to development of the workforce required to close the gap in Indigenous health status.

*It's a logistic issue, which we talked about in this meeting yesterday, how do we make sure the **resources** are there? ... Someone suggested yesterday in this meeting [to] organise a strategy to go to Canberra and say: You got behind rural health 10 or 15 years ago and you found the money on a national basis to fund university departments of rural health and realised the costs were higher. You need to do the same if you're serious about closing the gap, **without billing the workforce**. You have to put the money in to have the people on the ground to deliver the programs, to do the training and develop the curriculum, do the research because we're running on the **smell of an oily rag**. So that has to be a concerted [effort] and I think it will be part philanthropic, part government – but we have to make those calls. We couldn't do what we do without the Poche money.*

6. Findings, Commendations and Recommendations

This next section will discuss the integration of Indigenous content according to the research questions that have guided this review.

6.1. Integration of the Indigenous competencies

The five-yearly internal review processes and the compulsory terms of reference that routinely assesses Flinders' programs for inclusion of Indigenous content, outlined in Section 5.2.3.1, demonstrate the commitment that this university takes towards the integration of Indigenous content. The internal reviews of content are not necessarily directly related to the core competencies that are the focus of this review. Nor is it clear whether the evaluation prompts a superficial 'tick the box' approach to the assessment of inclusion of content, or whether it promotes comprehensive coverage and teaching that enables deep learning.

The Flinders University Discipline of Public Health is recognised for its expertise around social determinants of health; and the public health principle of equity that drives the philosophy of teaching within the MPH program lends itself to inclusion of Indigenous health content as exemplified in this statement by one of the interviewees:

*Closing the Gap was all about equity. Equity is the **public health principle**, it's the major public health issue; the public health issue. Again if you're going to be teaching public health, by its definition what better example [is there] in this country? So it's not just about **Indigenous health**, it's also about **equity**.*

Flinders University has, therefore, adopted a model that uses both horizontal and vertical integration of Indigenous health content. Vertical integration has occurred through the teaching of Social Determinants of Indigenous Health, which is a core course in most

of the MPH specialist streams. However, full vertical integration has not been achieved. There are currently three streams that do not have this course as a core component due to limited space in the curriculum. This also raises concerns regarding the true level of support within the Discipline for the integration of Indigenous health content.

The intention is that these streams adopt the horizontal model of integration, and teaching staff are reportedly working towards integrating Indigenous health content throughout the other courses contained in these specialisations. Of concern was the uncertainty expressed by staff in strategic coordination roles, around the extent to which this integration has occurred. The review team was also unable to clarify this with the staff teaching these courses. This poses concerns that some students may not be exposed to the requisite content that will enable them to achieve the required competencies expected of all graduates.

It was noted that Indigenous health content is not limited to the Social Determinants of Indigenous Health course, but is horizontally integrated throughout many of the other courses within the MPH program at Flinders. This appeared, however, to be dependent on the level of confidence of individual teaching staff to deliver such content, their knowledge of constructive examples and applicable content, and/or their access to community advisors and external guest speakers to inform or provide relevant content. This raised concerns about the level of systematic integration of content throughout the program.

It was also unclear whether there had been a methodical process for integrating the ANAPHI competencies into the curriculum to ensure that all of them were covered. The need for a formal mapping exercise was highlighted by several interviewees, as discussed in Section 5.2.2.3, with the time and resources to undertake such an exercise also raised as a barrier to this occurring.



6.2. Innovations to integrate the Indigenous competencies

The support within the Faculty for the establishment of the Poche Centre at Flinders University, and the positioning of the Centre in terms of providing teaching as well as undertaking research, demonstrates a true commitment to the inclusion of Indigenous health in the curriculum at an institutional level.

Staff at the Poche Centre are dedicated to producing culturally safe graduates. Their focus is on highlighting racism as a social determinant, enabling students to unpack what the implications are for Indigenous health in Australia. In this way, Indigenous health is used as an exemplar of the impact of social determinants and the importance of understanding health within a social context. This is in line with best practice for Indigenous health curriculum (Ewen, Paul & Bloom 2012).

Flinders achieves this learning through an innovative approach of transformative unlearning (McDermott 2012; Ryder, Yarnold & Prideaux 2011). The 'pedagogical strategy of taking students on a journey of discovery', is undertaken 'through sensitive classroom facilitation in a mutually respectful environment', (McDermott 2012), which allows students to examine and challenge their own racially based beliefs and encourages critical self-reflection. In this way, the course achieves a balance between safety and discomfort that facilitates transformative learning, an approach that is also in line with best practice (Ryder, Yarnold & Prideaux 2011).

All MPH graduates should be culturally safe, irrespective of whether they intend to work in either the Indigenous health sector or communities, as it complements and may even be a prerequisite to, competent practice (McDermott 2012). The course dedicated to Indigenous health provided by Poche Centre staff is, therefore, pivotal to the MPH program, as it provides graduates with the opportunity to develop skills that will enable them to work effectively not only in Indigenous programs and communities, but also in other minority communities. It trains them to become judgment safe practitioners, which is the ultimate goal of the Indigenous health core competencies.

6.3. Improving integration of the Indigenous competencies

Irrespective of the innovation of the course provided by the Poche Centre, it is nevertheless only a core course in some streams of the MPH. As such, it is constantly under threat of becoming

merely an elective in other streams, as pressure to internationalise the curriculum and add content from other specialised areas continues. If the commitment to a model of vertical integration is to progress, with Social Determinants of Indigenous Health remaining as a core course, the length of the MPH needs to be reconsidered. Extending the course to a 2-year, full-time degree may, therefore, be necessary.

If, as discussed, the horizontal model is chosen, or indeed even if the mixed approach is to continue, a comprehensive mapping process must occur to ensure that all Indigenous health competencies are adequately covered across the entire curriculum. In this way, even those students who do not complete the Social Determinants of Indigenous Health course still achieve the required competencies. This mapping will also highlight any duplication of content across the curriculum, and is a useful mechanism for mapping appropriate Indigenous health content to other learning objectives where appropriate. It may be helpful to engage an education or curriculum development expert to assist with this process.

Given that the new Australian Qualifications Framework (AQF Council 2011) must be implemented by December 2013, it is timely that these considerations are accounted for in any process undertaken to align the curriculum with the AQF.

Additionally, if the horizontal or mixed approach is continued, there is a need to further up-skill and support staff who will be teaching Indigenous health content so they are adequately prepared and confident to do so. As this review has confirmed, as discussed in Section 5.2.1.1, there are varying levels of staff capacity across the Discipline of Public Health to teach Indigenous health content. While it is acknowledged that this process is occurring, and the Poche Centre is also running staff development workshops to address this issue, there is nevertheless a need for more focused work with some individual staff as well. The Poche Centre needs ongoing support and resourcing for these activities, especially if its staff are performing these duties across the entire faculty, and not just to strengthen the MPH program.

In terms of the MPH core competencies, which are the focus of this review, it was noted that five of the six Indigenous-specific competencies were effectively promoted by the curriculum at Flinders. However, the competency that requires students to 'apply the principles of economic evaluation to Aboriginal and Torres Strait Islander programs, with a particular focus on the allocation of resources relative to need' was acknowledged as a deficiency. Although the allocation of resources to Aboriginal and Torres Strait Islander programs is covered within the curriculum, staff were unable

to agree with any confidence that the principles of economic evaluation are applied to this content. The achievability of this competency by all MPH providers was indeed called into question by interviewees, given the specialist expertise teaching staff need to deliver such content, as highlighted in Section 5.2.4.3.

The applicability of the ANAPHI competencies overall was also questioned, as discussed in Section 5.2.4.2. While it was acknowledged that they assist in highlighting content areas of importance, and provide a checklist of essential content to be covered in curricula, their relevance to student and workforce need was questioned. It should also be ascertained whether graduates are gaining skills and competencies that are relevant to the workforce need. While this could partially be determined through university graduate surveys, as discussed in Section 5.2.3.2, a broader national public health workforce survey to determine whether or not graduates are meeting workforce need, and valued for the skills and competencies they gain through the MPH, is also required. Although such activities are beyond the scope of recommendations linked to the Flinders program, it was nevertheless a noteworthy outcome of the results that should be considered for strategic action by stakeholders of the IPHCB Project.

Additionally, as outlined in Section 5.2.5.4, there were concerns expressed that the skills and competencies gained by graduates in the MPH are often undermined on return to the workforce and there is a need for ongoing workforce development. As discussed in Section 5.2.8, expanding the MPH program to reach more of the workforce, and developing and delivering professional development courses in the field, requires additional resources and targeted initiatives by government.

6.4. Commendations

Based on the above findings and analysis, the review team commends Flinders University for:

- Supporting the establishment and operations of the Poche Centre that provides Indigenous teaching and research expertise and support to staff throughout the Faculty.
- Demonstrating commitment to the inclusion of Indigenous content in the university's curricula through ongoing internal reviews that include Indigenous content as a Terms of Reference.

In relation to the integration of Indigenous health content in the MPH, the review team commends:

- The delivery of the Social Determinants of Indigenous Health as a core course as an exemplar of the way that the social determinants of health in the Australian context should be taught.
- The innovative transformational (un)learning approach utilised by the Poche Centre staff in teaching the Social Determinants of Indigenous Health course, which provides students with the opportunity to develop culturally safe judgment skills and practices.
- The intention of teaching staff within the Discipline of Public Health to integrate Indigenous content and core competencies horizontally throughout the rest of the MPH curriculum.

6.5. Recommendations

The team also proposes the following recommendations to strengthen integration of the Indigenous public health core competencies at Flinders University:

- Consideration be given to extending the length of the MPH to facilitate inclusion of the Social Determinants of Indigenous Health as a core course across all streams of the MPH.
- Horizontal integration of content is treated as a priority and implemented in a systematic manner so that content clearly links to and builds on core content.
- Ongoing staff development and support for the teaching of Indigenous health content is adequately resourced and provided.
- That a survey of MPH graduates is conducted to assess the relevance and applicability of the program to their workforce needs.

For broader consideration by stakeholders of the IPHCB Project, the team recommends:

- A national workforce survey of MPH graduates to assess application of the competencies and graduate outcomes and their relevance to workforce need.
- Provision of additional resourcing for public health education and professional development courses in much the same way that rural health has been supported previously.
- Review of the ANAPHI competencies to ensure they are still applicable and achievable.

7. References

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8. Attachments

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8.1. Expressions of Interest letter



Indigenous Public Health Capacity Development Project

Funded by the Department of Health and Ageing, National Public Health Program and jointly managed by Onemda, VicHealth Koori Health Unit at the University of Melbourne and the Institute for Koorie Education at Deakin University.

Call for Expressions of Interest

The strengthening of Indigenous curriculum components within Master of Public Health (MPH) programs nationally is a key element of the Commonwealth's Indigenous Public Health Capacity Development Project, Stage Three. This builds on previous work in the sector that included:

- identifying core Indigenous public health competencies for the MPH program;
- disseminating a curriculum guide for their inclusion in MPH programs, the *National Indigenous Public Health Curriculum Framework*¹; and,
- integrating these competencies within the key national 2010 MPH curriculum guide, *Foundation Competencies for Master of Public Health Graduates in Australia*².

It is expected that all national MPH programs will ensure graduates meet these competencies.

In parallel with this work, the National Indigenous Public Health Curriculum Network was formed. Subsequent to Network participants' engagement and leadership in the competencies project over the past three years, Network participants have led the Indigenous stream of the annual Australian Network of Academic Public Health Institutions' (ANAPHI) Teaching and Learning Forum. The Network leadership group comprises leading national Indigenous public health academics and professionals.

The Network, in collaboration with Onemda VicHealth Koori Health and the Institute for Koorie Education, is seeking *Expressions of Interest* from MPH teaching programs nationally to partner in order to further consolidate national Indigenous public health curriculum reform.

We propose to engage MPH Programs in a collaboration to review existing Indigenous curriculum components with reference to the core MPH Indigenous health competencies, document existing program innovations in Indigenous public health, what is working well, and where appropriate, share innovations from other programs and develop further strategies for strengthening Indigenous components. Primarily, this exercise would involve both capacity development for staff and strategic curriculum reform. We hope to work alongside existing Indigenous public health academics within departments, and existing community teaching partners to consolidate Indigenous curriculum within MPH programs. We propose to record, document and co-author case studies with academics from each program about this work in order to disseminate innovative teaching and learning practices to further the reform agenda.

Indigenous health workforce reform is a foundation plank of current policy initiatives to 'Close the Gap' in Indigenous health. We invite you to partner with us and further support the effective integration of Indigenous health components within the national MPH program.

1 <http://www.onemda.unimelb.edu.au/docs/PHERPFramework.pdf>

2 http://www.anaphi.org.au/PDFs/Competencies/ANAPHI_MPH%20competencies.pdf

8.2. Letter of Introduction



Commencement of MPH Reviews

Indigenous health workforce reform is a foundation plank of current policy initiatives to 'Close the Gap' in Indigenous health. The Public Health Indigenous Leadership in Education Network, which is a coalition of leading national Indigenous public health academics and professionals, was formed from a clearly identifiable need to provide a forum to exchange resources, ideas and develop policies and programs of relevance to teaching and learning activities in Indigenous public health.

The strengthening of Indigenous curriculum components within Master of Public Health (MPH) programs nationally is a key element of this project. This builds on previous work from the Indigenous Public Health Capacity Building Project (IPHCBP), which is funded by the Department of Health and Ageing and jointly managed by *Onemda* VicHealth Koori Health Unit at the University of Melbourne and the Institute for Koorie Education at Deakin University.

Key outcomes of the previous work included:

- identifying core Indigenous public health competencies for the MPH program;
- disseminating a curriculum guide for their inclusion in MPH programs, the *National Indigenous Public Health Curriculum Framework*³; and
- integrating these competencies within the key national 2010 MPH curriculum guide, *Foundation Competencies for Master of Public Health Graduates in Australia*⁴. It is expected that all national MPH programs will ensure graduates meet these competencies.

In 2010, an Expression of Interest was distributed to all Australian academic institutions that provide an MPH program. The intension was to seek partners for Stage Three of the IPHCBP to be involved in the MPH program reviews during 2011–12. Your institution responded, indicating interest in participating in this project.

The Network, in collaboration with *Onemda* VicHealth Koori Health and the Institute for Koorie Education, is therefore seeking to partner with your institution to further consolidate national Indigenous public health curriculum reform.

The aim of the review is to investigate the integration of the core Indigenous public health competencies into the curriculum of MPH programs in order to document and disseminate examples of best practice and to find ways to strengthen the delivery of this content.

We propose to review existing Indigenous curriculum components with reference to the core MPH Indigenous health competencies, document existing program innovations in Indigenous public health, what is working well, and where appropriate, share innovations and develop further strategies for strengthening Indigenous components. Primarily, this exercise would involve both capacity development for staff and strategic curriculum reform.

We hope to work alongside existing Indigenous public health academics within departments, and existing community teaching partners to consolidate Indigenous curriculum within MPH programs. We propose to record, document and co-author case studies with academics from each program about this work in order to disseminate innovative teaching and learning practices to further the reform agenda.

We invite you to partner with us and further support the effective integration of Indigenous health components within the national MPH program. To this effect, you will shortly be contacted by members of the Network to discuss how such a partnership can be implemented.

Should you require additional information at any time, please do not hesitate to ask Network members, or contact the IPHCBP Coordinator: Ms Leanne Coombe at the *Onemda* VicHealth Koori Health Unit, The University of Melbourne by phone on 03 8344 9375 or email at lcoombe@unimelb.edu.au.

3 <http://www.onemda.unimelb.edu.au/docs/PHERPFramework.pdf>

4 http://www.anaphi.org.au/PDFs/Competencies/ANAPHI_MPH%20competencies.pdf

8.3. Plain Language Statement



Review of the Integration of Indigenous Public Health Competencies within MPH Curricula⁵

The aim of this review is to investigate the integration of the core Indigenous public health competencies into the curriculum of MPH programs in order to document and disseminate examples of best practice and to find ways to strengthen the delivery of this content. It is administered by Ms Leanne Coombe from the University of Melbourne in partnership with academics in Indigenous health from the Public Health Indigenous Leadership in Education Network and has been approved by the University of Melbourne Human Research Ethics Committee.

The Indigenous public health competencies are a core component of the 'Foundational Competencies for MPH Graduates in Australia' published by the Australian Network of Academic Public Health Institutions in early 2010⁶. We have invited you to participate as you co-ordinate or teach in a subject that delivers Indigenous content within your MPH program and we are interested in your professional experience and perspectives on the delivery of this material.

Participation in this review will involve completing either a forty-five minute interview and/or an optional one and a half hour focused group interview. The maximum time commitment will be approximately three hours. We will take notes of these interviews and also audiotape them.

We will protect your anonymity and the confidentiality of your response to the fullest possible extent. The data will be stored in a password-protected computer accessible only to the researchers. In the final report, if you wish, you will be referred to by pseudonym. We will remove any references to personal information that might allow someone else to guess your identity, however, you should note that as the number of people from each institutions involved in the research is small, it is unlikely, but possible that someone may still be able to identify you.

Once this research has been completed, the findings from your own program will be made available to you. The research results will also be presented in journal articles and at academic conferences. The original data will be kept securely in the School of Population Health for five years from the date of publication, before being destroyed.

Please be advised that your participation in this study is completely voluntary. Should you wish to withdraw at any stage, or to withdraw any data you have supplied, you are free to do so without prejudice.

If you would like to participate, please indicate that you have read and understood this information by signing the accompanying consent form.

Should you require any further information, or have any concerns, please do not hesitate to contact Ms. Leanne Coombe on +61 3 8344 9375 at the Centre for Health and Society. Should you have any concerns about the conduct of the project, you are welcome to contact the Executive Officer, Human Research Ethics, The University of Melbourne, on ph: +61 3 8344 2073, or fax: +61 3 9347 6739.

5 HREC #: 1034186.2, Version: 15 April, 2011.

6 http://www.anaphi.org.au/PDFs/Competencies/ANAPHI_MPH%20competencies.pdf

8.4. Consent Form



School Of Population Health

Consent Form

PROJECT TITLE: *Review of the Integration of Indigenous Public Health Competencies within MPH Curricula⁷*

Name of participant:

Name of investigator(s): Prof. Wendy Brabham, Dr Shaun Ewen, Ms Leanne Coombe, Ms Vanessa Lee and Prof. Jenny Baker

1. I consent to participate in this project being undertaken for research purposes, the details of which have been explained to me, and for which I have been provided with a written plain language statement.
2. I understand that my participation will involve (please check required box/s):
 - (i) participation in an semi-structured interview
 - (ii) participation in a focus group interviewand I agree that the researchers may use the results as described in the plain language statement.
3. I acknowledge that:
 - (a) I have been informed that I am free to withdraw from the project at any time without explanation or prejudice and to withdraw any unprocessed data I have provided.
 - (b) I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements.
 - (c) I have been informed that the small sample size may have implications for protecting the identity of participants.
 - (d) I have been informed that the interviews will be audio-taped and I understand that audio-tapes will be stored at the University of Melbourne and will be destroyed five years after final completion of the project.
 - (e) unless I request otherwise, my name will be referred to by a pseudonym in any publications arising from the research.
 - (f) the organisation with whom I'm affiliated will be identified in the findings.
 - (g) I have been informed that a copy of the research findings will be forwarded to me.
 - (h) Once signed and returned, this consent form will be retained by the researchers.

Signature

Date

(participant)

⁷ HREC #: 1034186.3

8.5. MPH Coordinator questionnaire



Questionnaire for MPH Program Coordinators

Review of the Integration of Indigenous Public Health Competencies within MPH Curricula

Name of participant: _____

Email contact: _____

Department: _____

Institution: _____

1. Please identify Coursework Awards offered in Public Health by your Department:

2. Please describe any formal statement included within the MPH program's vision, aims or underlying principles directed towards capacity development in Indigenous Australian public health:

3. Please estimate number of prescribed formal contact hours devoted to Indigenous Australian health within your MPH program:

4. Please number identified Indigenous Australian MPH program enrolments (previous 5 years):

5. Please number identified Indigenous Australian MPH program completions (previous 5 years):

6. Please number identified Indigenous Australian MPH program student withdrawals or non-re-enrolment (previous 5 years):

7. Please number Full-Time Equivalent Indigenous academics employed in your department:

8. Please describe any incentives/disincentives to student participation in Indigenous Australian health components:

Key incentives for non-Indigenous students

Key dis-incentives for non-Indigenous students

Key incentives for Indigenous Australian students

Key dis-incentives for Indigenous Australian students





9. Please describe the input and status of Indigenous advisors to the Indigenous Australian health content within your MPH program:

10. Please describe current staff development strategies aimed at improving capacity in Indigenous Australian health or Indigenous learning styles:

11. Please describe key outcomes of any recent evaluation regarding Indigenous Australian health content within the MPH Program:

12. Please describe factors enhancing or detracting from the viability of substantial Indigenous Australian health content within your program:

Other comments:

Thank you for your participation

8.6. Unit Coordinator questionnaire



Questionnaire for Unit/Subject Coordinators

Review of the Integration of Indigenous Public Health Competencies within MPH Curricula

Name of participant: _____

Email contact: _____

Department: _____

Institution: _____

Subject/Unit Title: _____

1. Total formal contact hours for unit: _____

2. Formal contact hours allocated specifically to Indigenous Australian health: _____

3. Is it possible for the researcher to review the relevant course outline in order to ascertain content (please tick relevant answer):

Yes

No

4. Please list subject learning objectives specifically related to Indigenous Australian health:

5. Please list areas of Indigenous Australian health covered by the subject/unit:



6. Core Indigenous public health competencies covered by the subject/unit:

Content Area	Yes	No
1. Analyse key comparative health indicators for Aboriginal and Torres Strait Islander people.		
2. Analyse key comparative indicators regarding the social determinants of health for Aboriginal and Torres Strait Islander people.		
3. Describe Aboriginal and Torres Strait Islander health in historical context and analyse the impact of colonial processes on health outcomes.		
4. Critically evaluate Indigenous public health policy or programs.		
5. Apply the principles of economic evaluation to Aboriginal and Torres Strait Islander programs, with a particular focus on the allocation of resources relative to need.		
6. Demonstrate a reflexive public health practice for Aboriginal and Torres Strait Islander health contexts		

7. Human Resources Utilised:

a) Identify direct teaching input (% of total hours) of Indigenous academics (staff, outside professionals or community members) involved in the subject/unit?

b) Identify direct teaching input (% of total hours) of non-Indigenous people (staff, outside professionals or community members) involved in the subject/unit?

8. Delivery Mode (please mark all relevant categories):

Format	Yes	No	N/A
Lecture (face-to-face on campus)			
Tutorial (face-to-face on campus)			
Seminar (face-to-face on campus)			
Intensive Block (face-to-face)			
Placement/Field Visits			
Online Interactive Forum (synchronous)			
Online Interactive Forum (asynchronous)			
Online Podcast/Vodcast			
Self-directed/self-paced distance module			
Teleconference (incl. Skype or similar)			
Other (please list)			

Other comments:

Thank you for your participation



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