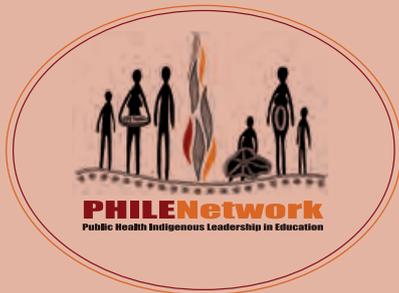




Review of the Menzies School of Health Research at Charles Darwin University Master of Public Health Program

**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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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



This review documents the outstanding success of the Menzies School of Health Research (Menzies) in integrating the Indigenous Public Health competencies into our Master of Public Health curriculum. This is both a source of pride and motivation for Menzies. The Charles Darwin University's Master of Public Health, which is taught by staff from Menzies, is unique in that it is developed and delivered by a research organisation. The advantages of this arrangement are visible in the deliberate curriculum focus on meaningful action to improve health outcomes for Indigenous people. By linking Indigenous health research knowledge to learning activities we hope that students will be better equipped to implement learnings in their work.

The Menzies lecturing team has benefitted from the guidance provided by a national curriculum approach. However, the review attests to the local innovative approach and passionate commitment to teaching in a context where the students are mostly exposed to content through e-learning, supported by face-to-face intensives.

Although this review focused on one particular aspect of the public health curriculum, there are many things to learn from this external evaluation. Menzies will be addressing its recommendations to improve marketing in order to grow the student cohort, including attracting a greater number of Indigenous students. We will also consider this evaluation alongside self-evaluation and student feedback in the current round of course accreditation. Our ongoing approach to teaching evidence-based public health will be informed by asking, 'which students need what skills developed, and how do we best achieve this?'

Lastly, I would like to thank the Public Health Indigenous Leadership in Education team for a high-quality review, the opportunity to learn through sharing and, in particular, Melody Muscat and Leanne Coombe for the time they spent in Darwin conducting this review.

Professor Alan Cass

Director, Menzies School of Health Research



Glossary

ANAPHI	Australian Network of Academic Public Health Institutions
CAPHIA	Council of Academic Public Health Institutions Australia
CDU	Charles Darwin University
HREC	Human Research Ethics Committee
IPHCB	Indigenous Public Health Capacity Building
MPH	Master of Public Health
Menzies	Menzies School of Health Research
NT	Northern Territory
PERP	Public Health Education and Research Program
PHILE Network	Public Health Indigenous Leadership in Education Network

1. Executive Summary

The Indigenous public health competencies are a core component of the *Foundational Competencies for Master of Public Health Graduates in Australia* (ANAPHI 2009), a curriculum framework that integrates the six core competencies in Indigenous public health expected of every MPH graduate nationally. 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. This report, one in a series, relates to the curriculum review conducted at the Menzies School of Health Research (Menzies) at Charles Darwin University (CDU) in May 2012.

The review was based on a qualitative design, although some quantitative data was also collected, which focused on a series of interviews with staff from the Menzies School of Health Research at CDU. 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.

The review found that Menzies is well placed to integrate the Indigenous core competencies into the MPH due to the geographical and demographic context of its location. The high proportion of Aboriginal and Torres Strait Islander people living in this region, coupled with the political context associated with the Northern Territory Emergency Response has created a natural demand for the program offered at Menzies. However, it was noted that student numbers remain low, threatening the long-term sustainability of the program, and there is a need for a coordinated effort to improve both enrolments and the fiscal health of the institution.

Menzies' position as a research institution with a focus on Indigenous health further strengthens its position to integrate Indigenous evidence-

based content into its MPH units. However, it was noted that this emphasis on research can also be counterproductive in terms of the value, and the consequent allocation of funding and human resources, attributed to teaching in the MPH. Human resource issues, therefore, need to be carefully considered within a strategic plan for Menzies, including the creation of pathways for Indigenous academics.

The integration of Indigenous content into Menzies MPH subjects is both vertical and horizontal, with a specialised elective stream in Indigenous health and a core unit that introduces Indigenous health in terms of sociological theories and understandings, and innovatively embeds Aboriginal and Torres Strait Islander perspectives to engage students in a different way of thinking. Examination of the course content also confirmed that there is a significant amount of informal Indigenous content implicitly incorporated into every unit within the MPH at Menzies.

It was easy to identify this content due to a detailed mapping of the curriculum led by an education and curriculum development specialist. This mapping has also enabled content-specialist staff to effectively structure their units against learning outcomes, and ensure content within units complements and builds on, rather than duplicates that of other units. The role of the specialist also includes leading an ongoing quality improvement review of curriculum and inclusion of topical content in the program so that it remains responsive to sector directions.

This review also highlighted the incongruence that can occur between the development of industry standards and graduate competencies, and supporting framework documents, as well as evolving sector development and workforce need. These standards and their supporting documentation, therefore, need to be reviewed regularly to ensure they do not become overly dated and irrelevant.



The online delivery mode used at Menzies enables access for students who are living and working in remote communities, which means that students can apply their learning in real-life settings. Additionally, this environment promotes real-time and peer learning through opportunistic interaction between students and with staff.

Based on the above findings and analysis, the review team commends the MPH program staff at Menzies for:

- Comprehensive vertical and horizontal integration.
- Utilisation of research to enhance the teaching program in a meaningful and comprehensive manner.
- Utilisation of formal and informal networks and partnerships with industry and community in a mutually beneficial manner.
- Methodical mapping and structuring of the program against the Australian Network of Academic Public Health Institutions (ANAPHI) competencies.
- Engagement of a curriculum development specialist to assist with quality control and improvement on an ongoing basis.
- Creation of learning pathways into the MPH program.
- Online delivery to enable access to students working in regional and remote areas.
- Embracing and embedding the Indigenous content within Aboriginal and Torres Strait Islander perspectives and ways of doing, instead of using the Western paradigm for its guiding principles.

The team also proposes the following

recommendations to strengthen the MPH program at Menzies:

- Improve the marketing of the program to increase enrolments.
- Provide institutional recognition of the value of teaching roles that is reflected in organisational systems and processes.
- Create employment pathways for Indigenous academics.

For broader consideration by stakeholders of the Indigenous Public Health Capacity Building (IPHCB) Project, the team recommends:

- The core competencies and framework documents be updated.

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 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 PHILE members 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 Program Coordinator (Attachment 8.5) and Course Coordinators (Attachment 8.6).

3.3.2. Qualitative data collection

Participation in the review involved a two-hour focus group with all Menzies-based staff (including lecturers and coordinators) and a joint one-hour semi-structured interview with the Program Leader and Education Coordinator.

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 Menzies School of Health Research MPH was conducted on 22 May 2012.

3.4. Data analysis

Both the focus group and interview 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). The 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 Menzies 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 Menzies has the following structure:

- 1.5 years full-time or part-time equivalent.
- Five core courses (10 credit units each) and EITHER 7 specialist electives (including 2 from the Public Health Practice stream) OR 3 specialist electives and a 40-credit point research project.

There are three specialist programs offered within the MPH program:

- Public Health Practice.
- Indigenous Health.
- Global Health.

4.2. Delivery mode

The MPH program is primarily offered externally, but some units have on-campus intensives.

4.3. Enrolments

4.3.1. MPH enrolments

The number of enrolments in the MPH, since 2008, is set out in Table 2 below.

Table 2: MPH enrolments

Year	MPH enrolments		
	New	Existing	Total
2008	19	18	37
2009	11	16	27
2010	19	12	31
2011	32	41	73
2012	25	43	68

4.3.2. Indigenous student enrolments

In the past five years there have been four Indigenous student enrolments and two withdrawals and completions.

4.4. Indigenous staff

Menzies has one full-time equivalent Indigenous staff member who teaches into the MPH program.

5. Results

5.1. Mapping of integration of core competencies

The ethos at the Menzies is clearly driven by its vision:

To improve health outcomes and reduce health inequality for populations in Australia and the Asia–Pacific regions, particularly Aboriginal and Torres Strait Islander communities through excellence and leadership in research, education and capacity development (Menzies School of Health Research Strategic Plan 2012–2016).

Indigenous health is embedded in its 'ways of working' statement and is evident in the learning outcomes of the various units. Table 3 below maps the learning outcomes provided for nine of the MPH units against the six Indigenous health core competencies.

Based on this information, Table 4 (see next page) summarises the level of coverage of the competencies throughout the curriculum at Menzies.

Table 3: Integration of Indigenous competencies by MPH subject in learning outcomes

Streams	Subject Title	Integrated Indigenous Health Core Competencies
Core	Foundations of Public Health #	2, 3, 4
	Introduction to Epidemiology	1
	Qualitative Research Methods	
	Indigenous Health & Social Change #	1, 2, 3, 4, 6
	Health Policy	4
Public Health Practice	Health Systems Planning & Management	
	Public Health Decision Making	5
	Research Design	
	Health Research Skills	
	Introduction to Biostatistics	
Indigenous Health	Health Promotion #	1, 2, 4
	Indigenous Health Research #	3, 6
	Public Health Anthropology #	3, 4, 6
Global Health	Tropical Child Health	
	Epidemiology and Control of Communicable Disease	
	Chronic Conditions Control #	1, 2, 4
	Global Health	



Table 4: Indigenous health core competencies covered in subjects at Menzies

Integrated Indigenous health core competencies	No. of courses	
	Yes	No
1. Analyse key comparative health indicators for Aboriginal and Torres Strait Islander people.	3	14
2. Analyse key comparative indicators regarding the social determinants of health for Aboriginal and Torres Strait Islander people.	4	13
3. Describe Aboriginal and Torres Strait Islander health in historical context and analyse the impact of colonial processes on health outcomes.	4	13
4. Critically evaluate Indigenous public health policy or programs.	6	11
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.	1	16
6. Demonstrate a reflexive public health practice for Aboriginal and Torres Strait Islander health contexts.	3	14

Questionnaires provided for six of these subjects (indicated in Table 3 by #) outlined the content areas covered in the units. The list below is a summary of these broad areas of Indigenous health, including:

- Aboriginal perspectives, definitions of health, and inequities in health.
- Miscommunication in health practice.
- Social and cultural determinants of health, including chronic conditions in Indigenous populations.
- Closing the Gap and subsequent policies.
- Sociology of Indigenous health and illness.
- Persistence of history and its impact on Indigenous health.
- Globalisation and health issues (including identity) for Indigenous communities.
- Burden of chronic disease including Indigenous populations.
- Aetiology of chronic conditions including specific early childhood risks for Indigenous people.
- Client and cultural perspectives on chronic disease.
- Chronic illness systems.
- Screening as an ethical issue.
- Interventions and sustainable programs, particularly in relation to Indigenous primary health care.
- History and context in Indigenous health research.
- Indigenous research paradigms, ways of being and knowing, and methodological issues.

- Ethical and cross-cultural issues in Indigenous health research.
- Health needs assessments specific to Indigenous populations.
- Planning and evaluating Indigenous health promotion programs.
- Anthropology and public health interventions.

5.2. Analysis of interview content

As shown in Figure 1, the Leximancer conceptual analysis drew out nine key themes in order of frequency, with 'health' as the most frequent and 'context' as the least. Within the 'health' theme, 'Indigenous' 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 context.
- Health to doing.
- Health to year.
- Health to learning.
- Health to students.

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

- Staffing.

5.2.1. Health to context

This conceptual pathway linked a series of key words including 'health', 'Indigenous', 'course', 'content', 'people', 'use', 'different' and 'context'. The key statements from the Leximancer discussion thread refer to the attributes of the program that are influenced by the geographical location of the institution.

5.2.1.1. Location context

Menzies is located in the Northern Territory (NT), which holds the largest proportion of Aboriginal and Torres Strait Islander people in Australia, by State and Territory (ABS 2011). This geographical location and context has established Menzies as one of the leading institutions in Indigenous health in Australia, and has subsequently influenced the development and positioning of their MPH program in a niche market.

*It was really about positioning ourselves as a **niche public health degree**... Really, our focus today, which is on **Indigenous health** and global health, came out of the quite **strategic decision making** about who comes to our courses; what sort of skills do they need.*

*But all of this is probably reflective of us working at the **Northern Territory** because the whole **Indigenous health** thing is **mainstream here**. So it's really quite ordinary to have all our units having some content in it.*

The manual thematic analysis highlighted that while some of the demand for the course is from Aboriginal and Torres Strait Islander students, it is primarily non-Indigenous practitioners working in Indigenous health for whom the program has been tailored.

*So we're not necessarily focusing on **Indigenous students**. We do have some Indigenous students but really the **main demand** for our work has been from people who want to **work in Indigenous settings**. So we've tailored our courses to fit to that need specifically.*

Although the development of the program to meet a niche market is a clear strength, this context does not come without challenges. As the following quote highlights, there is a perception among staff that awareness of the program is limited, which in turn affects enrolments.

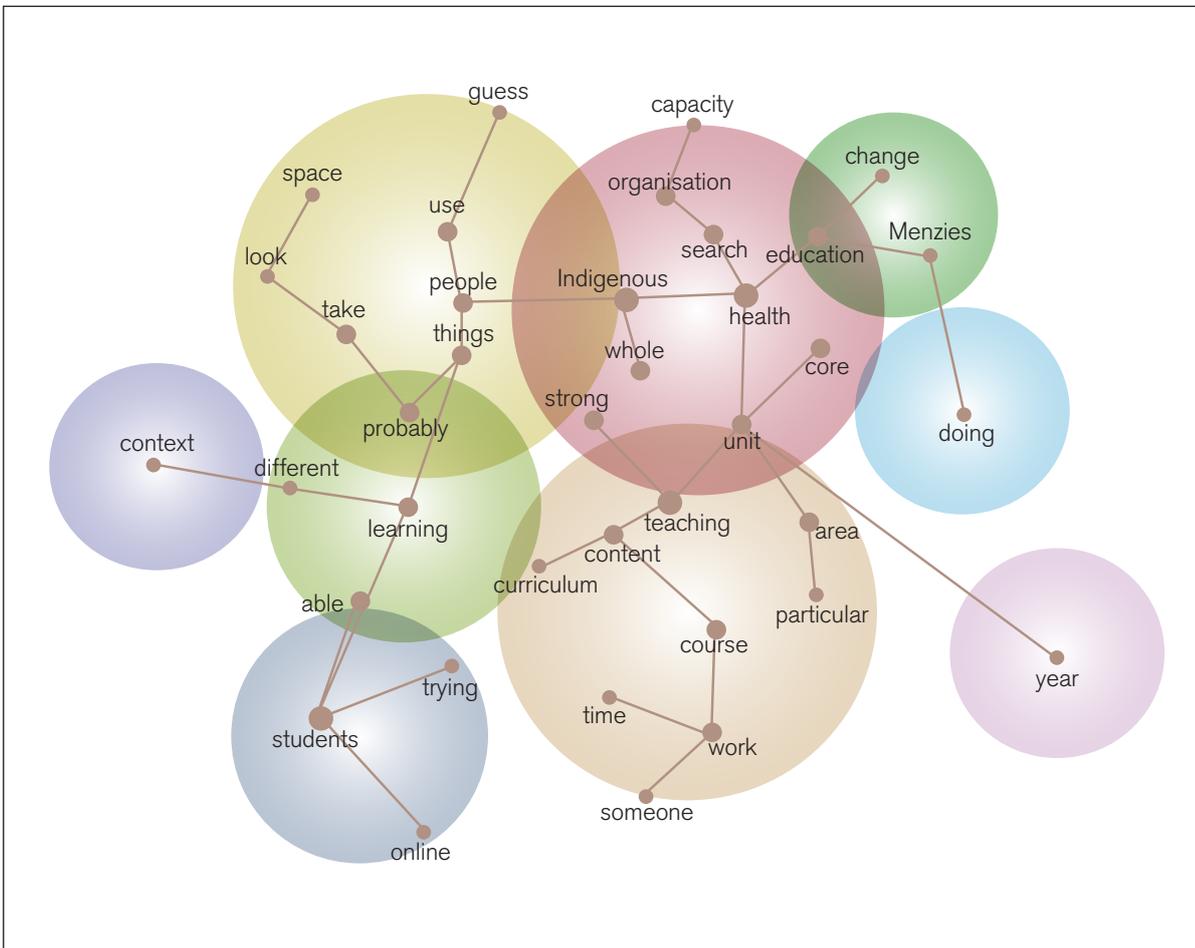


Figure 1: Concept map showing themes from interviews at Menzies



*I think... because **we're hidden** in the NT and Charles Darwin University hasn't got a large profile... people often **don't know** there is a Master of Public Health offered through Charles Darwin University. There are many people in Darwin itself who use the JCU [James Cook University] course, because that's well known.*

5.2.1.2. Integration of content

Indigenous content is clearly embedded in the MPH in a number of ways. Firstly, students can choose to specialise in Indigenous health through an explicit optional Indigenous health stream.

*So we have **three streams**: Public Health Practice, Indigenous Health, and Global Health. So our course has an **explicit Indigenous health stream**.*

In addition to embedding content in the Indigenous health specialist stream subjects, content is also embedded in the core subjects, as highlighted in the following quote and in reference to the content of Table 3 above.

*We've got **Indigenous health promotion**, we've got **Indigenous research methods in-built**, and we've got **Indigenous health policy**. [That is] not what they are called, but they're really strong in the course.*

5.2.1.3. Contextual content

The geographical location and context also enables easy access to guest lecturers who are able to contextualise Indigenous health content from both community and practitioner perspectives, which adds richness to the program.

*Its one thing we haven't done... I've noticed going to the Teaching and Learning Forums that other people... use videos of Indigenous speakers... We are in such a **rich content area**, when we've got the students in [for intensives] we can have **Indigenous people teaching**.*

*In the intensives, as well as for the public health MPH coursework, like with the health promotion intensive... [we] asked a number of people **from the community** to talk... specifically on their practice... In Foundations [of Public Health], we had people coming in as well, **practitioners with Indigenous content**.*

5.2.2. Health to doing

This conceptual pathway linked a series of key words including 'health', 'Indigenous', 'research', 'organisation',

'education', 'Menzies' and 'doing'. The key statements from the Leximancer discussion thread discuss how research influences the MPH program.

5.2.2.1. Research culture

It is evident that the Indigenous content within the MPH at Menzies draws upon its strong research culture.

*The way we use evidence, because we are a **research organisation** primary research is put forward in our units a lot. Like the papers that we choose to put in for students to read; we do **draw on local research** or Indigenous health research.*

*Because it's **taught by researchers**, it's in a **research organisation**, a lot of the evidence that we put forward stems from primary research. So we will tend not to use a lot of secondary sources of evidence. We will use book chapters because obviously books are written for students so they help them with the theory side of it. But we'll draw on that **primary evidence** from research consistently, which is probably another **unique** thing that we tend to do.*

*Because some of us are already **doing Indigenous research**... we offer opportunities for students to participate in our research. It's kind of a **mentoring** opportunity for **students**.*

The manual thematic analysis found that this culture of basing content on research equally applies to staff who are public health practitioners working in their respective fields of specialisation.

*It allows us to have that **inter-practice** link. So people who teach in our units... they are **practising** in the field that they teach in a lot. It's something we try to do.*

5.2.2.2. Research partnerships

Menzies' partners have a significant influence on the program, even if not teaching into the program directly, due to the research base on which it is founded. Many of the research projects undertaken at Menzies, or with research partners, are incorporated into the curriculum.

*So we have drawn on our **colleagues' and peers' work**, but of course... when you're in Indigenous health research organisation[s], that's where you're going to be drawing from.*

Several stakeholders, including industry partners, are also involved in curriculum development through advisory committees that the institution has in place.

Because it's a small community we have quite **close partnerships** because we're already doing research with a number of these **organisations...** like the Heart Foundation, Fred Hollows [Foundation]... they're on our **curriculum advisory groups** for new units or course curriculum advisory groups already.

Feedback from our **stakeholders** [was] around health promotion, particularly on our **course advisory committee**, and the [NT] Health Department had been a strong advocate.

5.2.2.3. Research priority

Although this research base is a key strength of the program, from the staff perspective it often overshadows the teaching program, in terms of promoting of the MPH, and also recognising the teaching role undertaken by staff.

*Although we might be hard to find on the market and... we're hard to find on the web... newcomers may not [recognise we **teach public health program**]. But most of the organisation does and so even in the lead up to building this strategic plan, education was very strongly **supported by researchers** across the organisation and in the public health space... It's the only thing that Menzies teaches so it's privileged in that respect; disadvantaged in others, in that perhaps... what we need to do for teaching **isn't often recognised** at [the] **organisational level**. For an example, our **performance framework... it doesn't really reflect our roles** because we're in the 'grab all' bucket. We're not a researcher and we're not a business manager...and it doesn't necessarily talk about our teaching or our responsiveness to students.*

5.2.3. Health to year

This conceptual pathway linked a series of key words including 'health', 'Indigenous', 'unit', 'core', 'change' and 'year'. The key statements from the Leximancer discussion thread refer to the changes made recently to the curriculum, and how this was achieved.

5.2.3.1. Integration process

The recent need to reaccredit the program appears to have driven a significant review and consolidation of the curriculum at Menzies, the timing of which aligned with release of the Indigenous public health core competencies, thus informing the process.

*When we **reaccredited** for this year... we made our course [structure] more explicit...*

*Previously there'd been core units and a whole swag of specialist electives; so we made it... basically have **core units**... We were lucky in our timing for the reaccreditation. The **ANAPHI document** had just come out – been worked on in draft form. It was finally consolidated at the end of 2010... We already had the **Indigenous** curriculum document so we'd already done a bit of a look-see. So our timing of reaccreditation was very useful for **incorporating** [the competencies]...*

*[We carried out] a classic **curriculum development** activity, with stakeholder feedback where we [were] looking cold and hard at the units, what was strong, what was out of date and how they met the **ANAPHI competencies**, and, within what we had, what would be a really structured way for us to address those.*

The manual thematic analysis identified that, while the ANAPHI competencies informed the redevelopment of the curriculum, the Framework document (Genat 2008) published to assist the integration of Indigenous content was unhelpful in the context of the NT. As such, it needs to be updated to reflect current political and industry imperatives.

I have to say the document that was least helpful was actually the Indigenous curriculum document. That was actually the least helpful in our overall curriculum design, partly because it was already dated... Because we're in the field a number of new reports had come out. The [Northern] Territory had had the Intervention [Northern Territory Emergency Response] and the curriculum document didn't acknowledge any of that stuff... We can't ignore the Intervention and how we're looking at social determinants.

Nevertheless, this process has resulted in integration of Indigenous health content in every unit within the MPH at Menzies, either explicitly through learning outcomes or implicitly through informal content.

*But there's other units that we haven't provided [explicit learning outcomes for,] but it's in there because it's in the assessment options or the way they do things. There's **no unit** that hasn't got an **Indigenous reading** in it.*

5.2.3.2. Competency integration

As the previous quote highlights, incorporation of the competencies is evident in the Menzies MPH,



although the level of integration varies between units. The Leximancer analysis identified quotes explaining that the reasons for this variance include the type of content within the unit, but also on whether it is a method-based or content-based unit.

*So in terms of the **Indigenous MPH competencies** that are embedded in [Indigenous Health Research] because it's specific to health research, there was mainly **just the two**. Whereas [the subject] Indigenous Health and Social Change covers **nearly all** of the competencies because... it does talk about various content-like issues.*

*We have another unit that sits in the public health practice area, the Public Health Decision Making unit, which is [about] the decisions [made] around **health economics**. But that has quite a bit of content as well. It actually addresses one of the explicit Indigenous public health [competencies applying principles of economic evaluation].*

Despite the expected decrease in content in methods-based units versus content-based units, the program at Menzies nevertheless incorporates such content in its methods-based units.

*Qualitative Research Methods has Indigenous health content but it's really... a **methodological course** so what we've tried to do... is teach the methodology and Indigenous health. There's **readings**, and the **examples**, and there's **assignments**, but it's less... explicit [than] in the ones [that are content driven].*

5.2.3.3. Curriculum consolidation

Despite Indigenous health content being integrated through most of the course, there was a decision made to prioritise an Indigenous health unit as a core over the Biostatistics unit, which became an elective.

*We had had a curriculum where you could either do epi or bio stats and that created some difficulties over time. So [there was] great debate amongst the whole team about pulling **bio stats** off as a core unit and letting it sit as an **elective**. Of course why we did that is we wanted the **Indigenous health [unit]** to come in as a **core unit**. We really felt that for our MPH... even though it was throughout [the] courses, we really wanted to have that strongly in there, and particularly as a theoretical unit.*

This core Indigenous health unit was redeveloped by merging two existing units to provide a solid foundation for the remaining units in the program.

*Indigenous Health and Social Change is an interesting one because it's actually **evolved** over a period of time... it's a **merge** between a unit I teach called Sociology in Health and the one that was called Indigenous Health and Social Change. So in this merger I felt I had a very strong responsibility to keep an **Indigenous content** area that was very responsive and up to date and engaged with emergent issues. But to also give students the key critical and theoretical tools from a sociological background to be able to effectively engage, dissect, pull apart and tease out all these issues.*

Similarly, other units were created from content that had previously been scattered across several units in the program.

*So we could focus on the **enhancement** and make things explicit that we actually had sitting there before: ...we actually realised we had all this content around Indigenous health research **scattered amongst units**. So we went right – let's teach that as a **stand-alone unit**.*

In some cases, this created teaching space in units to which additional content needed to be added, to ensure that all ANAPHI competencies were included in the curriculum.

*One of the things we **don't** have is the health protection... we don't have a core **environmental health unit**... Except we just don't have the lecturers or the space or the students to offer a lot more courses. So we made some judgments around... the health promotion... content out of the introductory unit where [the students are] not... really ready for it. We left some ideas in there but pulled it out and **structured it into its own unit**, combined with a lot of content we had from a short course... Then you have a health promotion unit which **left us some space** in the fundamental sort of introductory unit. And so... we decided to teach the old public health... and actually teach the environmental health and nutrition [content and the] impact of climate change.*

The manual thematic analysis also highlighted how the curriculum is reviewed by relevant industry stakeholders to ensure workforce relevance.

*I guess we're able to call on people to join **curriculum development** who are in practice, both Indigenous and non-Indigenous people, to make sure that we've got the right **content** covered or ...so they can give some **information** around texts*

that they see [as] better or worse, or they can provide that **input**...

While some of this input is provided through curriculum advisory committees, as referred to in earlier sections of this report, it can also happen informally.

*We can formalise if we want but we do get **informal input**... It's not as if you have to set up a meeting with the peak affiliate body... Menzies herself, because it's a founding member of the Lowitja [Institute], obviously benefits from Lowitja partnerships and collaborations, so we have **frank and fearless advice** at times from those affiliates.*

5.2.3.4. Curriculum specialist

To assist this process of curriculum review and redevelopment, Menzies employed an education and curriculum development expert to coordinate the process and provide an ongoing advisory role to content-specialist teaching staff.

*For me it's more of a management position... actually having someone with an eye on the **curriculum content** and particularly being able to be a **resource** for content specialists to be able to go: ...I don't know how to write learning outcomes. This is the content I want to cover and this is what I want to teach.*

The manual thematic analysis highlighted the quality improvement aspect of this role, and identified how detailed mapping of the curriculum content has enabled Menzies to focus on a structured approach to its program delivery rather than being driven primarily by content.

*It has a... **quality improvement** role in it is as well as curriculum development and **competency mapping** and making sure that there's **consistency** across all the units and not too much of an **overlap** within units.*

*[The curriculum specialist] does a lot of **quality control**... In the online mode we've got a high hand in quality control... every semester they get **checked** and re-checked and if anything's missing or needs fixing or **updating** [it's done]...*

*I notice other MPHs sort of run off **content specialists** and who you've got [available] to teach the courses; we tend to run from a **curriculum** [focus].*

The manual thematic analysis also identified details of the actual process that was followed, to map and refine the curriculum.

*I started off **mapping** out all the **competencies** and then fitted each **unit** under each general area of competency. And then within that – we had decided already based on other factors like **student numbers** and **demand** and **teacher availability** and that kind of thing – which units were going to go and [we] already had ideas about which ones were needed. Then it was a matter of... identifying where the **strengths** and **weaknesses** were.*

5.2.4. Health to learning

This conceptual pathway linked a series of key words including 'health', 'Indigenous', 'units', 'teaching' and 'learning'. The key statements from the Leximancer discussion thread outline how the MPH sits within the broader public health education program at Charles Darwin University (CDU), but also identifies various aspects of teaching and learning within the MPH program.

5.2.4.1. Learning pathways

Menzies has created clear learning pathways for both entry and exit into the MPH. A Graduate Diploma is used as the entry point into the MPH.

*The **Graduate Diploma** is embedded in the Master of Public Health. So if someone does the Graduate Diploma at CDU they get all the **credit** rolled in and then they finish off with the final four units with the Masters.*

Should students choose to exit the MPH early, they can do so with a Certificate in Public Health.

*We do offer a **Certificate in Public Health** as an **exit award**. It's not an entry award. It's only as an exit and they have to do three core units and another. So for people who get into and don't want to continue this, they get some award.*

5.2.4.2. Delivery mode

The delivery mode for this program is primarily external through online teaching. However, there are several units that also run intensive teaching blocks to supplement the online material.

*Pedagogically the big thing is it's an external course so it's **online teaching**... we've picked out six of those units to have... one day, two days, and the health promotion is the only unit that has three days **face-to-face**.*

The manual thematic analysis identified that this approach has certain advantages, in that it is accessible to students in remote areas and those who are juggling working hours around their study.



*The reality of the online teaching mode is something that the university ...does a lot. It's because not everyone lives in Darwin. So the university has chosen to invest in **online teaching** in that mode and encouraged us to go down that path. The other reality for online teaching is that nearly all our students **work full-time**.*

However, it also poses challenges in relation to ensuring a culturally safe environment for all students.

*From a **cultural safety** perspective... because we have a group of people who are fairly new to this context, they will occasionally put things in **online** that get **misinterpreted**... Online it's **asynchronous**. Someone might have come on at eight o'clock last night and put something on and four people have interacted by the time you discover it a day later or two days later because you only check once or twice a week... We've put up notices about being **respectful** when you're online and what respectful might mean... However, all we've got at the end of the day if someone is fairly **culturally insensitive** is to pull off their text... Sometimes it requires an interjection with a comment but other times we just refer to policies... Or if it's something specific that we need to tailor a comment to, we'll do that.*

5.2.4.3. Teaching resources and approaches

The online teaching environment creates several opportunities for innovative teaching approaches and student learning activities.

*But at the same time [we] also give people a range of different **assessment options** — so like a **group Wiki, presentations, blogs, field notes** — a whole range of different things. [Another example is] the **research circle** in Indigenous health research, where they have a whole range of different ways of meeting the requirements of the course.*

However, more traditional resources were also noted, with the following texts referred to as distinct examples that support the Indigenous content. They are also creatively used to reflect the methodologies highlighted throughout the program, and to challenge students' thinking.

*Indigenous Health Research... uses the Research as Ceremony text which is all about **Aboriginal methodologies** and perspectives... it's got a very **story-telling approach** to the whole unit. [It's] about each person bringing their story, telling their*

story, and [having] a narrative.

*But instead of students taking those texts for granted or as the final word, they are learning how to really pull apart those texts, how to really tease out what is actually meant by those things. Possibly the most important text for this one is [the one] we use — **Social Determinants of Indigenous Health**.*

Other examples of student learning activities were also provided, which highlight the creative use of different activities to enhance the learning outcomes.

*One of the things I give them to do is look at the **Millennium Development Goals [MDGs]** and draw up their own **table** comparing three countries and choosing whichever indicators they want. Often our students will say: 'I want to pick Australia' and focus on Australia's MDGs. What they notice is it actually masks the inequality, so that's really insightful.*

*In Qualitative Research, it was actually an **assessment** set... which I thought was fantastic, which was... go and talk to your friends and **interview** them about Indigenous health. I've always kept it.*

5.2.5. Health to students

This conceptual pathway linked a series of key words including 'health', 'Indigenous' and 'students'. The key statements from the Leximancer discussion thread were focused on features of the student cohort within the Menzies program.

5.2.5.1. Student researchers

Staff observed that as a health research institute, Menzies attracts students already working in this field and wanting to advance their research skills.

*Another feature is that a **high proportion** of our students are already **doing research** in Menzies or in other organisations.*

5.2.5.2. Indigenous health practitioners

Similarly, students already working in Indigenous health form a significant proportion of the cohort undertaking the Menzies MPH. But as the following quotes indicate, the focus on Indigenous health at Menzies also generates graduates who are interested in this area of research or practice as a result of the program.

*I think that gets sorted out very early on, that if **they're interested** in [Indigenous health] they'll stay and if they're not they go elsewhere. And I suppose that sometimes can be tricky when people choose to*

work in the [Northern] Territory and do an MPH that doesn't have a lot of strength in **Indigenous health**.

*I think one of the **niches** for us that works is that although there's not a lot of Indigenous students doing the MPH, the people who do the MPH come out with a solid foundation in public health and Aboriginal health... because it's already in the core units and people's selection of electives tends to be their **own interests**. So we have a **natural cohort** of students who are interested in **Indigenous health research anyway**.*

5.2.5.3. Indigenous students

As the previous quote infers, although there are only a small number of Indigenous students enrolled in the Menzies program, they can be appropriately supported due to the experience of staff working in their communities.

*I guess the other thing... is that all of us have just about got a substantial experience in Indigenous settings, [and there's] the sense that a number of us have got substantial experience in **teaching Indigenous students**. Now that said... we haven't got a lot of Indigenous students coming through because... we've been explicitly either steering them to Deakin [University's Institute of Koorie Education] if that's what is best for them. But if they've wanted to stay we've supported them.*

The manual thematic analysis identified that those Indigenous students who have chosen Menzies over the community-based pedagogical model program offered by Deakin University have done so because it is a mainstream program. It was noted that there has also been very successful students who haven't needed significant additional support.

*I know where we've done well. The **Indigenous students** we have had through the door have been well catered for. We've been able to hook them up with tutors if they've needed. In fact they haven't needed to because they've **stellars** – they've been **great students**.*

5.2.6. Staffing

Although, as previously identified in earlier sections of this report, there are several Indigenous researchers and practitioners who teach into the program at Menzies, it was noted during the manual thematic analysis that none of these people are engaged as core staff in the organisation.

Indigenous researchers may often teach in our programs and offer to do stuff, but they're **not core** staff... So although we haven't got a lot there's actually not much room for expansion within the current situation... Perhaps as a very small unit on one hand you can be supportive, on the other hand we really require people to come in with ready-made skills. We don't have a lot of **companion positions** to grow people.

While the organisation has a focus on capacity building, there is no structure or funding currently identified to support developing Indigenous academic positions within the teaching program.

*We really don't have a lot of academic positions, as such, identified in our organisation. So the idea of developing a pathway for Indigenous academics is a little bit fraught with **ideology** rather than **practicality**... Without the **IPHERP funding**... we're getting our money [because] people are bringing in research grants or we're contributing a small amount towards things.*





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

Menzies is well placed to integrate the Indigenous core competencies into the MPH due to the geographical and demographic context of its location. The high proportion of Aboriginal and Torres Strait Islander people living in this region, coupled with the political focus of the Australian Government on these communities and their health issues through the Northern Territory Emergency Response, creates a natural demand for the Menzies' program. This is clearly reflected in the organisation's intention to capitalise on this niche market opportunity, as stated in its Strategic Plan.

Menzies' position as a research institution with a focus on Indigenous health further strengthens its ability to integrate Indigenous evidence-based content into the MPH units. The teaching staff, whose primary role is research, are able to draw on their own work to ensure that content is both timely and relevant. The teaching is further enhanced through Menzies' research partnerships, with colleagues and community members who can provide readily accessible, complementary content into the program. This not only increases the relevance of the content to the students participating in the program, but also demonstrates the relevance of the teaching to community and industry stakeholders through this two-way partnership.

The integration of Indigenous content at Menzies is both vertical and horizontal. The MPH not only has a specialised elective stream in Indigenous health but also a core unit that introduces Indigenous health in terms of sociological theories and understandings. The choice to include the Indigenous Health core unit

rather than the Introduction to Biostatistics, a subject traditionally seen as a key foundation of public health competence (Durham & Plant 2005), demonstrates just how fundamental Indigenous health content is to the Menzies program. It also reflects the commitment at Menzies to addressing Indigenous health inequalities through the curriculum.

The horizontal integration is less obvious but nevertheless evident and comprehensive. Mapping of the competencies against the documented learning outcomes suggests there are a significant number of units that do not address the Indigenous competencies. However, closer examination of the course content and statements from interviewees confirm that there is a significant amount of informal Indigenous content implicitly incorporated in every unit within the MPH at Menzies as outlined in Section 5.2.3.1.

It was possible to easily identify this content due to the detailed mapping of the curriculum that has occurred at Menzies led by the education and curriculum development specialist. This mapping has also enabled content specialist staff at Menzies to structure their units effectively against learning outcomes that are appropriate to the Indigenous core competencies, and to ensure that content within units complements and builds on other units rather than duplicating content. This synchronisation across the units is possible not only because of the coordination role played by the curriculum specialist, but also because of the small cohort of teaching staff at Menzies – thereby producing a cohesive program.

Although staff commented during the interviews on how 'tedious' the mapping process against the MPH competencies was, it has nevertheless produced a well-structured program that clearly reflects the 'ANAPHI structure' and demonstrates responsiveness to sector directions. This responsiveness is also evident in the program's ongoing quality improvement process of curriculum review and inclusion of topical content.

This review also highlighted the incongruence that can occur between the development of industry standards and graduate competencies, and the contemporaneousness of supporting framework documents, as well as evolving sector development and workforce needs. These standards and supporting documents, therefore, need to be reviewed regularly to ensure they do not become overly dated and irrelevant.

6.2. Innovations to integrate the Indigenous competencies

Menzies has demonstrated academic leadership in Indigenous health curricula by embedding Aboriginal and Torres Strait Islander perspectives within at least two of its units – Indigenous Health Research and Indigenous Health and Social Change. However, this approach should not be considered innovative, but rather as fundamental to the teaching of Indigenous health. Furthermore, acknowledging the success of Menzies in founding appropriate units on such principles is pivotal in providing a benchmark for other institutions. Clearly this approach has an impact on students' learning as it engages them in a different way of thinking about situations that confront them in their work practice. This is reflected by comments made throughout the interviews with teaching staff from Menzies, such as:

The most common feedback I get from people who are actually out working in remote settings... is 'Suddenly I know how to think about this particular problem. You know I've been confronted with this problem, it's part of my working life, and as result of being engaged in this course, I've got tools to think about this problem now.' Which is quite a significant thing when you think about someone who's in a remote setting isolated from the rest of the workforce and is slowly learning through this and saying: '...I don't understand it, but I know how to think about it now', which is important.

The MPH at Menzies also contributes to meeting the Indigenous public health workforce need through its online delivery mode, which provides access for students who are living and working in remote communities. While online delivery is not necessarily innovative in the modern context, teaching online in the Indigenous content space has not been widely implemented for cultural safety reasons (PHERP 2008). However, Menzies has been able to successfully embrace this delivery mode to enhance student learning by providing rich and interesting

content online. It has also highlighted the benefit of providing an environment that enables students to apply their learning in real-life settings, as outlined in Section 5.2.4.2.

Additionally, this environment promotes real-time and peer learning through opportunistic interactions between students, and with staff. It was noted by an interviewee that:

*Our students are also bringing their situations to the course because through those mechanisms, through **discussion boards** and everything else, you get someone saying: 'I'm in Lajamanu and this happened **today**'. Another person says: 'that happened to me when I was...'. So there's a subtext going on in all these units too, of all these students in quite **remote settings** sharing those sorts of examples as well.*

As previously highlighted, managing cultural sensitivity issues poses an ongoing challenge for online delivery, which is one of the key reasons teaching Indigenous health online is often limited. However, due to the strong culture of quality control in the MPH program at Menzies, staff appear to handle negative input appropriately and turn it into a positive learning outcome.

This is, in part, attributable to the student cohort that seeks out the MPH program at Menzies. It was acknowledged that a large number of the cohort are either interested or working in Indigenous health already, or come from culturally diverse backgrounds, and are therefore 'sensitive' to 'inequality' and the need for appropriate and culturally safe behaviours.

Access to the program is also addressed at Menzies through the provision of various learning pathways, as outlined in Section 5.2.4.1. It was highlighted by interviewees that 'some people don't meet the entry requirements to Masters, so [they] have a soft entry to the Graduate Diploma', as a bridge to the MPH. This is particularly the case, given the program at Menzies attracts 'more people who are already working perhaps, in public health, but don't have a qualification', and want to return to study or to up-skill.

6.3. Improving integration of the Indigenous competencies

The data analysis elucidates that strategic enrolment planning to improve the current level of students undertaking the MPH at Menzies is required. Although it is evident that the majority of students who currently study through Menzies are attracted by the focus of the MPH on Indigenous health issues, academic staff forecast that the current small number of student enrolments in the program raises



the issue of its long-term sustainability. Subsequently, therefore, Menzies may benefit from an integrated and systemically coordinated effort that connects its mission, current state and changing environment within the NT to improving long-term enrolments and fiscal health for the institution. However, this will largely depend on a strategic analysis of the time, staff and technology required to implement an enrolment strategy, the expected impact of such a strategy and Menzies' commitment to accomplishing enrolment projections.

Although it is clear that Menzies places significant emphasis both on providing high-quality academic teaching staff and producing qualified public health professionals – not only for the geographical context in which they are located but also within the international public health arena – the data in this report suggests its research priorities may inherently limit growth in the student enrolment space. During the interviews, staff indicated that the dominance of the research agenda at Menzies, while it plays a significant role in contributing to supporting the core competencies within the MPH, can also be counter-productive in terms of the allocation of funding and human resources required for its teaching. It is apparent that current staff, who divide their time between research and teaching, are operating at close to their maximum physical activity within existing roles. Therefore, ensuring the availability of staff resourcing to support increased student enrolments must be considered prior to marketing the MPH program.

Taking human resources issues into consideration within a strategic enrolment framework for Menzies may also provide an opportunity to consider pathways for developing and supporting Indigenous academic roles within the institution. Although it is clearly evident that Menzies already has an agenda to expand, recruit and retain Indigenous faculty staff, it has been a challenge to attract Indigenous staff with appropriate credentials to the institution. To address this gap, Menzies currently has established learning pathways in place to support students into the MPH program through enrolling them in the Graduate Diploma program, which could potentially be tailored to support Indigenous students.

Menzies would benefit from considering a small Indigenous cohort program to increase participation, and providing peer social support among these students. Not only would this address the need to increase the number of Indigenous enrolments at Menzies, but also provide a pathway for these students to potentially go on to complete their MPH. With this in mind, incorporating succession planning within the institution's enrolment strategy may lead to the retention of these students as academic staff at Menzies.

6.4. Commendations

Based on the above findings and analysis, the review team commends the MPH program staff at Menzies for:

- Comprehensive vertical and horizontal integration.
- Utilisation of research to enhance the teaching program in a meaningful and comprehensive manner.
- Utilisation of formal and informal networks and partnerships with industry and community in a mutually beneficial manner.
- Methodical mapping and structuring of the program against the ANAPHI competencies.
- Engagement of a curriculum development specialist to assist with quality control and improvement on an ongoing basis.
- Creation of learning pathways into the MPH program.
- Online delivery to enable access to students working in regional and remote areas.
- Embracing and embedding the Indigenous content within Aboriginal and Torres Strait Islander perspectives and ways of doing, instead of using the Western paradigm for its guiding principles.

6.5. Recommendations

The team also proposes the following recommendations to strengthen the MPH program at Menzies:

- Improve the marketing of the program to increase enrolments.
- Provide institutional recognition of the value of teaching roles that is reflected in organisational systems and processes.
- Create employment pathways for Indigenous academics.

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

- The core competencies and framework documents be updated.

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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 Curricula¹

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 2010². 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 Curricula*³

Name of participant:

Name of investigator(s): Prof. Wendy Brabham, Dr Shaun Ewen, Ms Leanne Coombe and Ms Melody Muscat

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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