Review of The University of Western Australia 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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Ozemla

DEAKIN UNIVERSITY

THE UNIVERSITY OF WESTERN AUSTRALIA

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

PHILENetwork
Public Health Indigenous Leadership in Education

Sharing knowledge – a community learning circle around the campfire

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The Public Health Indigenous Leadership in Education (PHILE) Network would like to acknowledge all those who contributed to the review of the Master of Public Health (MPH) program at The University of Western Australia.

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Foreword

The School of Population Health at the University of Western Australia (UWA) wishes to extend its sincere thanks and appreciation to the Public Health Indigenous Leadership in Education (PHILE) Network for the opportunity to participate in this exceptionally constructive review of its Master of Public Health (MPH) program.

The MPH program at UWA was established in 1987 as part of the Commonwealth Government's response to the Kerr White Review of education and research into public health and tropical medicine in Australia conducted in the mid-1980s.

The School prides itself on academic excellence and the incorporation of a wide range of course options covering core public health competencies and relevant elective topics. Indigenous health is considered an important aspect of the UWA MPH program and we are delighted with the review's commendation of our School's integration of Aboriginal health – both vertically with a dedicated Aboriginal Health unit, and horizontally through specific learning outcomes and lecture content offered in a range of units throughout the degree.

We are especially pleased with the acknowledgment of our comprehensive integration of the Indigenous health core competencies, inclusion of units developed and delivered by specialist Indigenous focused academic centres, and teaching of Aboriginal health using a pedagogical approach that promotes cultural safety and deep learning.

In addition, the School's Teaching Executive Committee views this report as highly valuable for highlighting areas currently undertaken well and, more importantly, for 'shining a light' on the various aspects of the UWA MPH that could be improved to better integrate Indigenous public health core competencies through this degree offering.

This review has proved timely as the new UWA structure for postgraduate coursework degrees are currently being implemented. This has afforded us the opportunity to implement some of the recommendations into our program during this process.

Furthermore, with particular reference to the recommendations outlined in this report by the review project team, the School's Teaching Executive has begun to explore a range of options to engender improvements in the delivery of Indigenous public health core competencies in its Population Health postgraduate degrees and will continue to consider the feedback over the coming years.

Professor Elizabeth Geelhoed

Head, School of Population Health
The University of Western Australia
March 2014

Glossary

ANAPHI	Australian Network of Academic Public Health Institutions
AQF	Australian Qualifications Framework
CAMDH	Centre for Aboriginal Medical and Dental Health
CUCRH	Combined Universities Centre for Rural Health
HREC	Human Research Ethics Committee
IKE	Institute of Koorie Education
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
SHSD	School of Health and Social Development
UWA	The University of Western Australia

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 Master of Public Health 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 the University of Western Australia in January 2013.

The review was based on a qualitative design although some quantitative data, which focused on a series of interviews with staff from UWA, 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.

A few of the teaching staff at UWA were involved in the development of the Australian Network of Academic Public Health Institutions (ANAPHI) competencies. The majority of staff interviewed at UWA, therefore, articulated a very high level of commitment to the integration of the Indigenous health competencies within the MPH. While the School of Population Health does not currently have an Indigenous academic on staff, it draws on the expertise of Indigenous staff and academic centres that specialise in Indigenous health, including the Centre for Aboriginal Medical and Dental Health (CAMDH) and the Combined Universities Centre for Rural Health (CUCRH).

This integration has occurred with components of both vertical and horizontal models of integration, although neither model is fully achieved. Vertical integration is evident through the Aboriginal Health elective, which provides students with an opportunity to take a focused unit that covers all the competencies in a single unit. Students may also substitute two additional electives for Indigenous health units offered in other degrees or at other universities should they want to specialise further in this area. In terms of horizontal integration, all but one of the core units in the MPH has at least one of the competencies formalised in learning outcomes. Four of the six Indigenous health competencies are also collectively covered in more than a third of the elective units offered within the MPH.

The Aboriginal Health elective unit taught by staff from CAMDH was seen as valuable component of the UWA MPH. It has had demonstrated success in providing students with a broad knowledge base on which they can build in their future workplaces. The Indigenous health content is taught sensitively to ensure that students achieve the required 'deep learning' and are motivated to overcome health inequity experienced by minority groups – while not being overly burdened with an individual sense of responsibility for the state of Indigenous ill health. Additional elective units that focus on rural health, but that also incorporate Indigenous health, draw on the research expertise at CUCRH.

The review also highlighted a significant amount of informal content that is not documented in learning outcomes, and identified the need for a comprehensive mapping of content to eliminate duplication. This is also timely given that UWA is changing to a graduate teaching program structure. Such a review would also resolve identified issues around how content in the Aboriginal Health elective is differentiated from that delivered in the Aboriginal health unit within the undergraduate Bachelor of Science program, which unlike the MPH program is a core unit. It may also resolve an ongoing debate as to whether or not the Aboriginal Health unit should be a core or elective unit within the MPH at UWA. Additionally, it would ensure that staff who were previously unaware of the competencies are informed of their rationale and intended outcomes.

A strategy that UWA may wish to consider is taking up the suggestion to share Indigenous academics between the School and CAMDH through a joint appointment. This arrangement would overcome the Indigenous staffing deficiency within the School, while strengthening the links between the two entities and ensuring that Indigenous staff are supported through the structures in place at CAMDH. Increasing the number of Indigenous positions within the School would, in turn, assist in attracting Indigenous students to the MPH program.

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

- Comprehensive mapping of the individual units against the competencies and the MPH program as a whole.
- Regular MPH teaching staff meetings to share information about curriculum development and teaching, including CAMDH staff.
- Consideration of joint appointment arrangements for Indigenous academics between CAMDH and the School of Population Health.
- Promoting the opportunity of undertaking further studies in Indigenous health through cross-institutional enrolments.
- Developing recruitment strategies for Indigenous academics, guest lecturers and students.
- Ensuring that Indigenous guest lecturers are appropriately remunerated for their contributions.

However, the review team also commended the MPH program staff at UWA for its:

- Commitment and willingness to integrate the Indigenous public health core competencies throughout the MPH.
- Comprehensive integration of the Indigenous health core competencies through vertical and horizontal models.
- Inclusion of units developed and delivered by specialist academic centres including CAMDH and CUCRH.
- Teaching of the Aboriginal Health unit using a pedagogical approach that promotes cultural safety and deep learning.
- Ability to provide students with an opportunity to explore specialised studies in Indigenous health through cross-institutional enrolment options.

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. 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), a curriculum framework which integrates six core competencies in Indigenous public health that are expected of every MPH graduate nationally. The core Indigenous health competencies expected of graduating students are the ability to:

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 the first 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 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 University of Western Australia MPH was conducted from 30–31 January 2013.

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. For this reason, quotes used in this report have had their 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 such as '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. 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, e.g. 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 UWA 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 under the respective discussion thread sections that directly relate to these conceptual links.

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

4. MPH Program Overview

4.1. Structure

There are three separate MPH degree options available through the UWA School of Population Health as outlined in Table 2.

Table 2: MPH degree options at UWA

Degree name	Credit points	Duration
MPH – 91550	72	18 months full-time or part-time equivalent
MPH (with extension practicum placement) – 92550	96	2 years full-time or part-time equivalent
MPH (by coursework and dissertation with practice or research methods specialisation options) – 92560	96	2 years full-time or part-time equivalent

4.2. Delivery mode

The MPH program is offered through multi-modes.

4.3. Enrolments

The number of enrolments in the MPH, over the past five years, broken down by Aboriginality and course type, is set out in Table 3 below. The one Indigenous student successfully completed their MPH in 2012.

Table 3: MPH enrolments

	2008		2009		2010		2011		2012	
Indigenous Status (Y/N)	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
MPH – 91550	–	42	1	48	1	55	1	70	1	70
MPH (Practice) – 92550	–	–	–	–	–	–	–	–	–	5
MPH (Research Methods) – 92560	–	–	–	–	–	–	–	–	–	–

4.4. Indigenous staff

UWA does not currently have any Indigenous staff within the School who teach into the MPH, although there were two Indigenous staff some years ago. However, two Indigenous staff members employed by the Centre for Aboriginal Medical and Dental Health, a unit that sits at a Faculty rather than School level, teach into the program and coordinate units through the Aboriginal Health elective.

5. Results

5.1. Mapping of integration of core competencies

This review examined the unit outlines for the five core units and 13 of the elective units. The learning outcomes were compared to the content areas indicated in the questionnaires completed by subject coordinators.

Table 4 below maps the learning outcomes provided for the MPH units against the Indigenous health core competencies.

Table 4: Integration of Indigenous competencies by MPH unit

Streams	Subject Title	Integrated Indigenous Health Core Competencies
Core	Foundations of Public Health	1
	Epidemiology I #	1, 2, 3
	Biostatistics I	–
	Health Promotion	1
	Health Systems and Economics #	1, 2, 3, 4, 5
Electives	Epidemiology II #	1, 2, 3
	Epidemiology and Control of Communicable Diseases	–
	Clinical Epidemiology #	1, 4
	Aboriginal Health	1–6
	Biostatistics II	–
	Disease Prevention in Population Health	2, 4
	Economic Evaluation of Health Care	5
	Food and Nutrition in Population Health	1, 2, 3, 4
	Health Program Evaluation	1, 4, 6
	Leadership and Management of Health Services	–
	Qualitative Research Methods in Health	6
	Introduction to Analysis of Linked Health Data	–
	Advanced Analysis of Linked Health Data	–

# Indicates coverage of Indigenous-specific content in questionnaire but limited or no documented evidence in unit outline.

Based on this information, Table 5 (see overleaf) summarises the level of coverage of the competencies throughout the curriculum at UWA.

Table 5: Indigenous health core competencies covered in units at UWA

Integrated Indigenous health core competencies		No. of Courses	
		Yes	No
1.	Analyse key comparative health indicators for Aboriginal and Torres Strait Islander people.	9	9
2.	Analyse key comparative indicators regarding the social determinants of health for Aboriginal and Torres Strait Islander people.	6	12
3.	Describe Aboriginal and Torres Strait Islander health in historical context and analyse the impact of colonial processes on health outcomes.	5	13
4.	Critically evaluate Indigenous public health policy or programs.	6	12
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.	2	16
6.	Demonstrate a reflexive public health practice for Aboriginal and Torres Strait Islander health contexts.	3	15

The Aboriginal Health elective unit has 16 learning outcomes. The list below is the identified Indigenous health learning outcomes listed in the other unit outlines:

- Identify the key nutritional issues for Indigenous Australians.
- Appreciate the importance of appropriately designed evaluation in a rural health and Aboriginal health context.
- Understand and describe traditional Aboriginal culture, traditions and health.
- Describe the impact of colonisation on Aboriginal people and their health.
- Describe the major health and cultural issues in Aboriginal society today; understand the ways of healing for Aboriginal people.
- Describe and contrast the health of Indigenous peoples in an international context.
- Describe the ways of working with Aboriginal people and improve their skills in communicating with Aboriginal people.
- Describe effective strategies for addressing the health gap between Aboriginal and non-Aboriginal Australians.

The following are the content areas covered in the curriculum as described in the Unit Coordinator questionnaires:

- Historical and cultural issues for Aboriginal people in WA.
- Primary health care and community control.
- Contemporary issues in Indigenous health – apologies and interventions.
- An international perspective on Indigenous health.
- Mental health and substance use.
- Health status and epidemiological data on health priorities.
- Distribution of health and ill-health in the Indigenous population.
- Evidence-based approaches for improving Indigenous health.
- 'Close the Gap' initiatives.
- Need to address the social determinants of health.
- Ethical guidelines for research in Indigenous communities.
- Research paradigms and participatory action research, interpretive and narrative approaches in Indigenous communities.
- Community engagement in clinical research.
- Health inequities and health burden disparities.
- Health interventions empirically investigated in Indigenous communities.
- Methodological issues for conducting epidemiological research in Indigenous communities.
- Study designs to address health issues in Aboriginal populations.
- Role of health services in Indigenous health.

- Equity–efficiency trade-off when addressing Indigenous health.
- Evaluation approaches in Aboriginal communities.
- Appropriate data collection tools in an Indigenous health context.
- Validity and trustworthiness of evaluation findings in Indigenous health contexts.
- Reporting and effective dissemination of evaluation findings in Indigenous health contexts.
- Evaluation of chronic disease programs and policies among Indigenous Australians.
- Development of innovative, efficient and feasible strategies for facilitating sustainable improvements in Indigenous chronic disease health care.

5.2. Analysis of interview content

As shown in Figure 1, the Leximancer conceptual analysis drew out 11 key themes in order of frequency, with 'health' as the most frequent and 'change' 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 change.
- Health to competencies.
- Health to work.
- Health to students.
- Health to MPH.

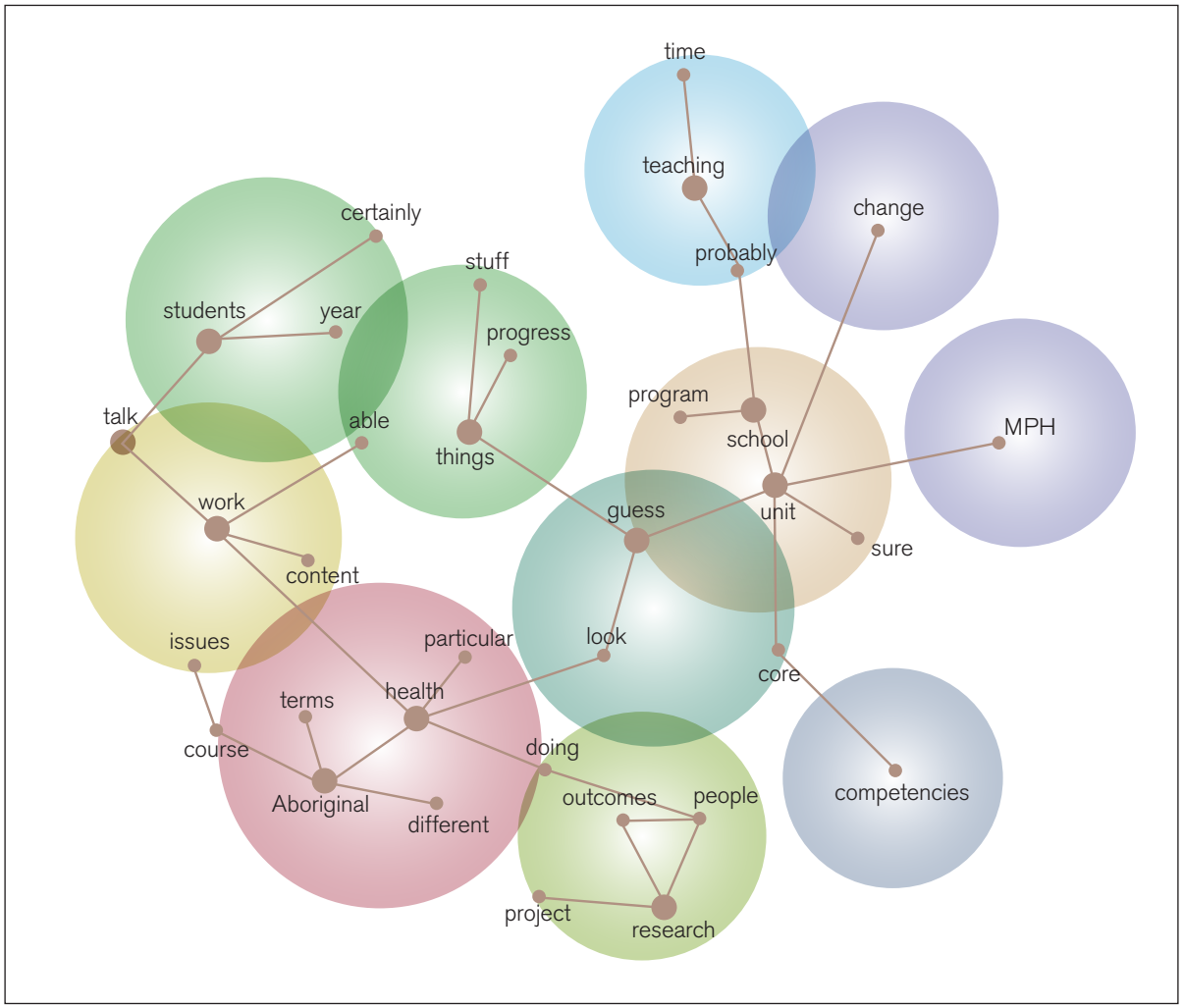

Figure 1: Concept map showing themes from interviews at UWA

5.2.1. Health to Change

This conceptual pathway linked a series of key words including 'health', 'unit', 'teaching' and 'change'. The key statements from the Leximancer discussion thread particularly relate to changes that have occurred in the MPH program in relation to integration of the competencies, and those staff teaching the Indigenous health components.

5.2.1.1. Review of content integration

The review identified that there has previously been an internal evaluation of integration of Indigenous health content, although this was not done systematically against the ANAPHI competencies. This has led to elements of vertical and horizontal integration of Indigenous health content through a dedicated elective unit as well as specific modules of content across other units in the curriculum.

> *We did have an **in-house review** of **Indigenous content** but not specifically with the focus of the public health competencies so we could go back and have another look at that… The main thing that we worked on… was that there needs to be **specific content** and there needs to be **integrated content** and that's what we try to do. So we've got the **one unit** that was the specific unit and then, for instance, within Health Systems and Economics there's one **core module**, like two lectures and a tutorial, that is specific. So that's around Indigenous [health] but then **throughout** there's **incorporation** all the way through **as well**.*

However, the lack of a systematic process has left staff uncertain about who teaches what content, and there is an identified need for a systematic mapping of content and competencies across the curriculum in a similar way to a recent review of the UWA undergraduate program.

> *I think traditionally in our MPH we've tended to **work in silos**… In terms of Indigenous health, I think it's an advantage that we have a full… unit. Maybe it **needs to be a core**… but maybe [there needs to be] a bit **more integration** – a bit more awareness of what each of us are doing in that area. [For example, we] collected the data for our undergraduate program, about what we were teaching in **Indigenous health**, and there were big gaps [and] a lot of repetition, and that was quite a useful exercise to do. Then, we met with CAMDH to see how we could improve it, but the **change is fairly slow**… So maybe… this [review] will be quite useful… so [we] can have a look and see… what are we teaching. Could we [perhaps] teach it **better?***
>
> *It works, but it could be better in terms of whether there was some sort of **systematic process** that was put in place. That's something our teaching executive group could actually take on; [we] could put together a **special working party** to actually do a **review of each of the units** to see where elements potentially could be beefed up or **improved**.*

It was noted that as part of a recent program restructure at UWA, which reflects the shift to the graduate teaching model implemented at the University of Melbourne, postgraduate courses are due to be updated, thereby providing an opportunity for these issues within the MPH to be addressed.

> *That also came about because… UWA had a massive **course restructure** for undergraduate courses. It moved to… the University of Melbourne model as of last year… As part of that, unit outlines had to be **reconstructed** and submitted for approval and course majors… They haven't done that for the **postgraduate** courses as yet, so there hasn't been that **process**.*

5.2.1.2. Influences on competency integration

A few of the teaching staff at UWA were involved in the development of the ANAPHI competencies. They discussed the debate that occurred at the time regarding which competencies should be required of all graduates given that the MPH is an internationally recognised degree. There was a suggestion that the ANAPHI competencies are less of an influence on the curriculum than the need to meet international standards.

> *Everyone was in agreement on the basic **competencies**. A lot of the earlier work was focused really around the **compulsory** units that you would have in every MPH as opposed to the electives… [For example,] environmental health… **people argued** about whether that was a **required** unit or not… I found that whole movement by and large wasn't all that informative… and ultimately it didn't really change all that much in my view. People have a pretty good idea of what should be in an MPH and obviously you want your MPH to be marketable and… commensurate with **international standards** of what an MPH [is], because it's an international degree; it's not an Australian version of the MPH. The MPH is the professional qualification right across the world, so to some extent there's that **influence** on the degree.*

However, the belief conveyed in this quote that MPH content should not be taught through an Australian context lens ignores the fact that most of the cohort will go on to practise in Australia and, therefore, need to gain the skills and knowledge to work within the Australian setting. It also dismisses the reality that the skills and knowledge that can be gained from the Indigenous public health core competencies, and their application to addressing the complex needs of the Australian Indigenous population, is transferable to other minority or disadvantaged groups or international settings in other colonised nations.

Nevertheless, there were efforts made to integrate the Indigenous core competencies across the curriculum following publication of the ANAPHI competencies.

> *That was put together a few years back by [an Indigenous academic who] was employed by our School as the Indigenous health lecturer. She was involved with actually developing and coordinating that, but also then feeding in to different units as well.*

Since then, and subsequent to the Indigenous lecturer leaving UWA, unit coordinators have been given significant autonomy to integrate content within their individual units. This has created inconsistency in the coverage of competencies, instead of a systematic approach to plan the integration of the content.

> *Although it's… been discussed at the teaching executive level and information forwarded on to unit coordinators, I think it's really been then at the **discretion** of the **unit coordinators** what they do and don't implement in their units.*
>
> *We speak to the unit coordinators regularly but it's more about the **structure**… I don't think we've ever done that with Aboriginal health components. It's really been left up to the **unit coordinators**…*
>
> *Essentially the integration occurs at the unit level. We're fairly **individualistic** here where the **academic** has control over what it is that we teach. To the best of my knowledge, I'm **unaware** of a **formal process** where we've looked at the **integration** of the Indigenous competencies across the course.*

Tailoring the program to incorporate the competencies is a challenge if staff do not have the relevant experience to teach the required content. Internal expertise, or accessibility to those with relevant expertise, therefore has a significant influence on the curriculum. It was noted that this can cause curricula content to vary over time and has, in some cases, led to a dilution of the original content when staff or stakeholders are no longer able to contribute to the teaching.

> *Our development here at UWA focused on the international stuff as well as what's coming out of national bodies; and also to some extent what we feel were the particular **strengths** or **opportunities** available in Western Australia because of the **people**… we had here… The specific Environmental Health unit was actually quite strong at **one point** in our program because of the very strong **connection** with some people in the [WA] Health Department's Communicable Diseases Branch.*

5.2.1.3. Indigenous teaching staff

One of the strategies proposed by interviewees to overcome this situation is to employ Indigenous staff within the School who can assist with integrating the Indigenous health content, as has occurred in the past. This was viewed as having a number of benefits for the School, in addition to strengthening the curriculum.

> *I would like us to have Indigenous staff [teaching health] to be quite honest, I mean having someone sit in the School and work with other people. It [would] make a huge difference to being able to deliver a **proper unit** within the program and also just to encourage more [of an] **Indigenous health perspective** and **research** within the whole School.*
>
> *I became very concerned that… we didn't have enough **Indigenous people** around. Quite frankly, the way I see it is you've got to have [these] staff. It's no use lamenting about the lack of [Indigenous] **students** if you don't have a single noticeable Indigenous person on your staff, that's where it really begins.*

However, recruitment of appropriate candidates is proving to be an ongoing challenge.

> *But all that being said, I think trying to **recruit** an Aboriginal person is **difficult**. We've certainly just tried to do that for our social work program… but we've had two rounds of trying to recruit with **no success**.*

5.2.1.4. Contribution of the Combined Universities Centre for Rural Health

One of the recent changes to the MPH program at UWA is the addition of units with a focus on rural and Indigenous health that are taught out of the CUCRH at Geraldton. However, it should be noted that these are only elective units and are therefore not taken up by all students.

*Basically what we are, we teach and do research especially pertaining to rural and **Aboriginal health**… We were asked over the **last few years** to provide some teaching programs for postgraduate students.*

*We are tasked to deliver the **four units** up here… we're trying to incorporate as much as possible **Indigenous content**.*

Although none of the current CUCRH teaching staff are Aboriginal or Torres Strait Islander, there are Indigenous staff working at CUCRH who can assist and may be involved directly in teaching in the future.

*We did have **Aboriginal staff**, we do have [Indigenous researchers] for many of the projects. None of them will be able to help us for this unit this year, but we're hoping for next year we'll be able to get [another Indigenous lecturer].*

It was also noted that CUCRH provide an online orientation course for all students who will be studying Indigenous health in their units.

*Usually all students, who are coming up for rural programs at CUCRH and elsewhere, are using this orientation package to understand Aboriginal health… So under the CUCRH **website**… the top one is **Aboriginal Cultural Orientation**.*

5.2.2. Health to Competencies

This conceptual pathway linked a series of key words including 'health', 'Aboriginal', 'people' and 'competencies'. The key statements from the Leximancer discussion thread particularly relate to the ANAPHI competencies and how they are incorporated into the program.

5.2.2.1. Value of the competencies

As highlighted in a previous quote in Section 5.2.1.2, the value attributed to the ANAPHI competencies at UWA was raised as an issue. The following quote highlights the perceived discretionary nature of the Indigenous public health competencies, without any regulatory or accreditation requirements attached to their implementation, despite the clearly stated intention that all graduates achieve these core competencies (ANAPHI 2009).

*The teaching executive group is where things such as the **competencies** will be introduced and talked about… What competencies are being addressed? What competencies aren't being addressed?… There was a lot of **criticism** about the competencies per se nationally and there was some locally as well. So the approach, really, was to discuss what we thought was the **best way**.*

Although some staff questioned their value, others found that they provided a valuable framework or guide for thinking about learning outcomes.

*I think this move to thinking about **competence** and **learning outcomes** has been good. [It] gives people direction and [creates] more consistency.*

However, consistency across the MPH and benefits in terms of student learning outcomes can only be gained if the competencies are applied systematically across the curriculum as outlined in the competency Framework (Genat 2008).

The manual thematic analysis also identified that there were some staff at UWA who were not aware of the Indigenous health competencies required for the MPH graduates, further highlighting the inconsistent application of the competencies in the UWA curriculum.

I wasn't necessarily aware that these were the core competencies for Indigenous health in the MPH Program.

5.2.2.2. Competencies and learning outcomes

The achievability of the competencies was another question raised by staff at UWA, especially in units where content provides an introductory overview of multiple concepts or health issues rather than a scaffolded, specialist knowledge.

*It's an **overview**, so they get an idea. But then hopefully they also are left with the idea that they can seek more information on any of these things, [and] that [it] **doesn't necessarily make them an expert** at the end of that unit.*

Concerns were also raised that the Indigenous health competencies can lead to a 'tick-the-box' approach to curriculum development and that content should be included based on the learning outcomes required rather than the need to include Indigenous content per se.

*They're chosen on the basis of typical public health articles and if they are relevant to a particular part of the course in terms of **illustrating things** in a course and how people use it. That's the basis they're chosen, not that they have Indigenous content.*

If content is not based on desired learning outcomes, interviewees expressed concern that the Indigenous content is devalued. Indigenous content, therefore, needs to be chosen and integrated carefully so it provides a rich learning experience.

*So in terms of I**ndigenous health**, a couple of years ago I approached CAMDH [and]*

*asked them for some examples of papers that they thought were valuable… I could have looked by myself, but I was just interested in getting some **examples** from them… because I was aware that we touch on Indigenous health, but it really is so **superficial**.*

5.2.2.3. Formal versus informal content

Section 5.1 summarises the Indigenous health content that is outlined in the UWA course documentation, including learning outcomes in the unit outlines. Formalised integration of Indigenous health content was also evident from the data collected during the interviews.

*Health Systems and Economics… we do have a very specific **Indigenous component** in that unit which is taught by an Indigenous lecturer and is always part of the assessment. There are **specific outcomes**.*

However, it was also noted that much of the Indigenous content is not formalised through documentation and occurs informally in class discussion and examples.

*Specifically in terms of **Indigenous content** there's very little. We would look at **examples** because the Indigenous applications are very [specific].*

*There's **no specific learning outcome** in Clinical Epi around Aboriginal health but it is something that is **woven through** the unit.*

Where informal content occurs and is not linked to explicit learning outcomes, there is no guarantee that the required competencies will be achieved. As the following quote also suggests, informal content is often perceived by some staff as an adequate mechanism to achieve horizontal integration, whereas this is not the case. Content needs to be linked to the competencies through formally embedded learning outcomes.

*That talks a bit about health inequality and… the social determinants of **Aboriginal health**… So **discussion** sort of comes up. It's not necessarily… an **explicit focus** but it's there, and it's **embedded**.*

5.2.3. Health to Work

This conceptual pathway linked two key words, 'health' and 'work'. The key statements from the Leximancer discussion thread relate to the work experience of staff teaching Indigenous health within the program, and also how the MPH prepares students to work in Indigenous health.

5.2.3.1. Contribution of CAMDH staff

The contribution of CAMDH staff, given their training and experience working as practitioners in Indigenous health, to curriculum development through staff support was noted by interviewees as invaluable.

*We've got the luxury of having a **Centre** which has got a bunch of people who work in it and we're able to draw on that collective expertise… of eight or nine people, many of whom are **Indigenous health practitioners** by training.*

The value of the different perspectives of the various staff at CAMDH was also seen as an asset to the teaching program, as it enriched the learning experience for students and highlighted the need for a collaborative working approach in this field.

*It's one thing for students to hear an **Aboriginal perspective** on how to work with Aboriginal people but to have the luxury of an [experienced non-Aboriginal health practitioner] who can talk about the non-Aboriginal experience of working in an Aboriginal health context becomes really important. I think the students can really identify with that because they can kind of dismiss us and go – well, you guys are going to do that anyway.*

5.2.3.2. Staff experience

It was noted that there are also staff in the School with experience working in Indigenous health who are able to incorporate examples of their work as part of the content within their units.

*He's done a lot of i**nfectious disease work** in the **African population**… [and] translated some of that work to the **Aboriginal population**. He also does… a lot of editorials and opinion pieces for journals on Aboriginal health and disadvantaged populations in terms of health. As a result of that he **weaves** those elements in to those **units that he coordinates**.*

*When we do that **research**, because Indigenous people are overrepresented in prison… we need to make sure that we have an **Indigenous researcher** on board, somebody [who] understands the cultural background and then the issues... I can't point to that **unit** [outline and claim]… this is an **Indigenous or Aboriginal health component**, but it is **weaved** through[out].*

Because cardiovascular disease is so overrepresented in Aboriginal people, he

*includes elements of that. In fact they've got a number of grants specifically looking at ischemic heart disease and heart failure in **Aboriginal people**.*

However, interviewees did not discuss whether there has been any assessment of the appropriateness of the examples in relation to the required learning outcomes.

It was noted that those without the relevant work experience in Aboriginal community contexts or knowledge on Aboriginal issues are not as confident delivering Indigenous health content and tend to draw on guest lecturers.

*So I'm really **grateful** for her to do that, particularly because it comes from a person with **experience**, rather than theoretical, because I haven't worked in **Aboriginal health** since about 1981.*

5.2.3.3. Guest lecturers

The contributions of guest lecturers who bring their work experience to the teaching program were, therefore, noted on several occasions. In some cases, the guest lecturers are non-Indigenous practitioners who work in Indigenous communities.

*We did have [a lecturer] last year. She is actually a public health physician and works out… in Kalgoorlie as a **public health physician** and she's worked in the Kimberley region and remote areas. She has dealt with and **worked in Aboriginal populations** in terms of public health and clinical medicine.*

In other cases, it was noted that Aboriginal or Torres Strait Islander staff from other areas of the Faculty, who are recognised as experts in a particular field, are invited to provide guest lectures in some of the units.

*We do try to get **Indigenous lecturers** whenever we can for those, because Indigenous lecturers **who are experts** in the content that I want to deliver [are ideal. Three such people have delivered this material in the past].*

However, perceived risks of having Indigenous guest lecturers in the program were also discussed, in terms of the potential for these sessions to be viewed as an 'add on' designed to meet requirements, and the need for these contributors and the content to be integrated in a meaningful way through comprehensive vertical and horizontal integration.

*Guest lecturers in other people's units... [is] not the same as building a rapport. I mean we did have a couple of people – **Aboriginal women** who tutored in our first year Public Health unit – and it was fabulous, because they were… just part of the team [and not] this Aboriginal person that we dragged in to give the lecture on Aboriginal health and therefore we've **ticked the box**.*

This quote also highlights a disconnect between staff within the School and the Aboriginal staff from CAMDH. It implies that the latter are not considered part of the team, despite having Faculty mandate to teach this content, unlike the guest lecturers who were engaged from the community. Recognition of the complementary contribution that Aboriginal staff and community leaders can make to teaching was also seemingly missing.

The manual thematic analysis identified that having guest lecturers teach into the program on a regular basis has also become a challenge because of a lack of resources to reimburse them for their contributions. Hence, a strategy to draw on adjunct appointments or staff from other areas of the university has been implemented.

*What we normally rely on are our **adjunct appointments**… We used to be able to **pay guest lecturers** [but] we can't do that any more. So we do rely on those who have adjunct appointments, or we've simply got arrangements with **other parts of the university**.*

5.2.3.4. Student work readiness

Preparation of students to work effectively in Indigenous health was also discussed. Concerns that the integrated Indigenous content is not sufficiently effective in producing skills versus knowledge were expressed, and there was a sense that effective learning of the required skills can only occur on the job.

*I think that, for me, was always the challenge: that we didn't develop their **skills**, we just gave them some **knowledge**. They knew about the disparities. They knew about some of the important influences on some of those disparities. I don't think we ever prepared them well to go and **work in Aboriginal health**. They would have to **learn that on the job** from people who could mentor them.*

Even the Aboriginal Health elective unit within the MPH was not considered adequate preparation for students, and that this teaching still needed to be supplemented by mentoring within the workplace.

Hopefully students with a [Bachelor of Science] major in Aboriginal Health and Wellbeing would be able to do that now. But I suspect… with our postgraduates [that] if you do one elective – it's one elective. Really you've got to be mentored in the job or ***working in it****.*

I think if I'd done a ***unit*** *in Aboriginal health, that would have given me a great understanding, and a better empathy, but I would have had to* ***learn on the job****, you know.*

As noted in Section 4.1, students are able to undertake a MPH (Practice) option that includes a six-month industry placement, following completion of their coursework, in which this kind of mentoring could occur. However, the numbers of students who have undertaken this option and completed their practicum in an Indigenous health setting have been extremely limited.

Then there's an MPH Practice, which basically has the same structure as the MPH… plus it has a ***six-month practicum*** *placement…. They basically spend a semester and a large amount of time during that semester* ***working in the industry****. There* ***might be precedents****… of people specifically wanting to work in organisations that provide support or programs… for the Aboriginal communities.*

5.2.4. Health to Students

This conceptual pathway linked the key words 'health' and 'students'. As expected, the key statements from the Leximancer discussion thread particularly relate to issues pertaining to the students undertaking the UWA MPH program.

5.2.4.1. Student choice

The importance of student choice was discussed in several ways. Firstly, Aboriginal Health is an elective unit and, therefore, its sustainability and viability is dependent on students choosing the unit. It was, however, noted that this unit is currently a popular elective, with approximately 20 students reportedly enrolling in the unit each year. This is around 50–75% of the cohort according to the enrolment numbers outlined in Section 4.3.

I guess we still have an Aboriginal Health unit but it's not a core unit for the postgraduates… In the postgraduate program there's a limited number of electives and ***Aboriginal Health*** *was a* ***popular one****, and still is a popular one.*

Well, certainly the ***Aboriginal Health*** *unit seems to be. It's normally* ***well subscribed*** *and the* ***feedback*** *is always* ***very good****.*

Secondly, it was noted that few students go on to undertake major projects in Indigenous health as part of their capstone experience. While there are likely to be several reasons for this it is an issue in that they are not having this learning reinforced.

Very few *take one that's solely related to* ***Indigenous health****. The most recent one was about alcohol and other drug programs for Indigenous males who are incarcerated, and that was by a student who is Indigenous.*

It was also highlighted during this review that students have the choice to substitute some of their electives for specialised units offered by other tertiary institutions if they have a particular area of interest that is not catered for by the UWA MPH. Students may take up to two alternative electives through cross-institutional enrolment, and this applies to all areas of study including Indigenous health.

The other thing we do have – and this has been used by a couple of students specifically related to Aboriginal health… there's a ***substitution policy*** *of up to two units. If a student wants to specifically do a unit that we don't cover… If somebody really had an interest in doing more explicit Aboriginal health units and they could identify some from either in the university or externally… they can* ***substitute two of their electives*** *to do that.*

Interest in a collaborative MPH (Indigenous Health) program (PHERP Indigenous Public Health Capacity Development Project Reference Group 2008) was expressed, particularly as UWA has existing units that could contribute to the program.

That Indigenous Public Health Masters… we were ***very keen*** *on being part of it. At that time [the Project Reference Group] had four units that they would be required to do and then they could have done* ***two units*** *here. Because we had [the Aboriginal Health] unit and then we identified a unit from Indigenous studies. Then they would do our core units in the Master of Public Health and that would have been a number of Indigenous units for that Indigenous [Public Health] Masters. That would have been part of the reason that we were really keen… that it would have allowed us to link in with* ***more Indigenous units****.*

Such a Masters would allow students a greater choice of units and enable them to complete an Indigenous health specialisation alongside students studying at other universities as part of a national

cohort, thus overcoming challenges associated with unviable elective options at single institutions.

> *We were just keen to incorporate as much as we could from here while still being able to take advantage of what was being offered in [the] core [units], especially **nationwide**… Imagine, there are huge possibilities of getting people involved from all different States and setting up **discussion boards** and it would be fantastic… We had to be really careful about [elective] units because we can't run units with **one or two people** in them.*

Interviewees also discussed student choice in terms of preferred delivery mode, with an increasing number demanding online delivery. This poses challenges for some units in terms of ensuring that content is covered in an appropriate way, especially for topics that deal with sensitive areas including Indigenous health.

> *What we've seen is that Health Promotion is a very difficult [unit] to translate to an online delivery, [but] we're **losing students** unless we can offer them [this] online. So we have to find a way of delivering online, but Health Promotion is just such an **integrative learning experience**. When I say online, what we're trying to do here is make all of our core units available online as well as face-to-face.*

5.2.4.2. Student knowledge

Interviewees discussed the challenges of teaching Indigenous health to a diverse student cohort, who bring varying levels of existing knowledge.

> *Normally the lecturers start off with the gap between Indigenous and non-Indigenous health in Australia. How much they cover on that really depends on the reaction of the class as well because of the nature of the students, especially for the Masters. A lot of them are **international students**, and so they come to our course with **no idea** at all about the gaps. Whereas for some of the **Australian students**, especially for those who have already done a Bachelor in Health Science, a lot of these facts… they **already know**… [and they would just need a refresher].*

Some students come to the MPH with experience working in the Indigenous health sector and can contribute this knowledge to the course content, adding value to the discussion.

> *[One student] actually brought lots of **real life experience** and things like that to the **discussion** and he could… reinforce that and talk about it from his experience… **working** in the **Aboriginal health sector**.*

Others have little to no experience but can usually consider concepts contained in the content in relation to their own experiences, and determine how they might apply these learnings to working in Indigenous health. But it was noted that staff often need to enable this learning experience for students.

> *We then, again, get the students to think about that in terms of their **working histories**, in terms of what they've done. Because we can't expect everybody to go out and work in Aboriginal health and Aboriginal issues and we can't expect them to be experts on it. But **we then start to talk** about the ideas of working collaboratively, ways of working, how to work, how do you get an 'in'.*

Staff teaching the Aboriginal Health unit commented on the journey that many of the students experience, especially those with limited prior knowledge of Indigenous health issues. There was an expressed need for students to understand that they are not being individually held responsible for addressing the gap in Indigenous health so they don't become overwhelmed.

> *The students kind of appreciated the fact that this isn't about them needing to do all of this work, but at the same time [they] get to the end of the week going: I'm a bit **overwhelmed**. And us needing to **reassure** them the idea is to not feel overwhelmed and to not go: well, Aboriginal health is now in the too hard basket.*

5.2.4.3. Student feedback

The university collects several forms of student feedback, which vary in their usefulness to staff.

> *At UWA [Student Perceptions of Teaching] **SPOTs** are not something that are mandatory, and they're potentially confidential. They're not something that the School collects. I'm not sure that I necessarily agree with that. I think that **would be worthwhile** for us to actually have that. But I think they're concerned that some people won't do it if – it's for the individual unit coordinator and teacher to actually get the feedback and say, okay I can see how I can improve that… But the [Student Unit Reflective Feedback] **SURF** is something that is not confidential… The individual unit ratings are provided and then that's also **benchmarked** against other units in the School, faculties and the university.*

Informal feedback from students is also considered, and has identified that the Aboriginal Health unit is a valuable and interesting component of the MPH.

> *In terms of informal [feedback]… **I meet with most students** at least once or twice a year when they're deciding what units they're going to be doing for the next semester. Invariably the Aboriginal Health unit… I get a lot of informal feedback [on]; some **emails**, some **verbally**, saying… they found it interesting or valuable or whatever it was that they thought was beneficial.*

5.2.5. Health to MPH

This conceptual pathway linked a series of key words including 'health', 'unit', 'program' and 'MPH'. The key statements from the Leximancer discussion thread particularly relate to the teaching of the specific Aboriginal Health unit in the program, which is taught by staff from CAMDH.

5.2.5.1. Aboriginal health as a core unit

The review highlighted that, with the shift to the model of graduate programs, the undergraduate program has introduced Aboriginal Health as a core unit in the Population Health major within the Bachelor of Science.

> *You can't do a **Population Health major** within the **Bachelor of Science** at UWA now, as your main major, without having an **Aboriginal Health unit**… So all public health, population health graduates from this university, will have that **compulsory [Aboriginal Health] unit**.*

Staff teaching into the undergraduate program commented that this model of vertical integration has been very successful, more so than a horizontal model of integration where duplication of content is a major risk.

> *So students who were doing our **Population Health major** [at] the **undergraduate** level have to do **Aboriginal Health**. It's much **better** for us, because before [students] used to get dribs and drabs [on Indigenous health in different units] and it often used to be the **same material** even though we asked people not to do that. Trying to integrate it… didn't really work.*

Hence the question of Indigenous health as a core unit in the MPH has been discussed at UWA for some time.

> *I think it's been discussed quite a bit over the years, but I guess the **core content** of the MPH is not very big. There's only like **five units**.*
>
> *I think it's something we'll **revisit**… But we haven't had success with it so far… So whether the success and the evaluation that come from having done this course, and whether building a relationship [with the School] enables it to become **core** rather than an option, we'll have to see.*

However, it was noted that there are limited opportunities for inclusion of units as core requirements.

> *You can't have too much **core content**. So it would be an interesting debate as to whether it should automatically be one.*

Including Indigenous health as a core unit in the structure of the MPH is also a major challenge, as the intensive teaching mode used for most of the elective units is more appropriate for content delivery in this unit, which provides an immersion experience for students. Furthermore, teaching a core unit throughout the semester would place an additional workload on the CAMDH staff currently teaching the unit.

> *A lot of the work they do that is coursework is on campus, [students] come every week for a semester… and a lot of [the electives are done in] **intensive** summer school or winter school… So it's really about where do you place it; what **value** does it get in the scheme of things. If it was core, maybe they might want to spin it out over a **semester**, but would we want to be **teaching our undergraduate** unit on Mondays and Thursdays and **a postgraduate** unit… in between.*

5.2.5.2. Ownership of Indigenous health content

If Indigenous health was to become a core unit in the MPH, staff from the School expressed a desire to have more involvement in the teaching and how the content is linked with other units in the MPH.

> *I think if there was going to be a **core unit in Indigenous health** in the MPH we would want to have some degree of control over what was in it so that it did meet the public health requirements, and that it did integrate with the other courses we were teaching. [This would mean that] there was really a proper **integrated syllabus** and not something which was just taught by someone else who didn't care what degree it was fitting into.*

The review identified that this lack of involvement by School staff in teaching the Aboriginal Health unit has created a sense of competition between the staff at the School and those who sit externally at CAMDH.

*At this university there's always been a bit of a **tension** as well between who teaches the unit. For a long time we actually taught it. We actually had **Indigenous lecturers** on staff… We don't teach it any more, [CAMDH] teach the unit. But I must admit we do have difficulty …having them teach a unit that we think is purpose-designed for the MPH. They tend to have **generic material** which they spread everywhere rather than **purpose-designed** stuff.*

Data from the interviews seemingly indicates that this competition stems from both disciplinary rivalries as well as the sense that staff teaching Indigenous health, or any unit in the MPH, should have public health qualifications in addition to their primary area of specialisation. However, this is not an expectation of other specialisation areas such as nutrition, for example, nor does this recognise the social determinants approach required for Indigenous health practice.

Conversely, there is recognition of the need for specific experience within Aboriginal community settings to teach Indigenous health.

*Fortunately, we did have [an Indigenous lecturer] who ran our Indigenous unit for us… Then we essentially had to give that unit… to CAMDH… so that there would be **Indigenous teaching** of the unit. We've still got that unit in the program, but it's [no longer] being run by a staff member within this School. Whether or not the people who run the unit have **public health qualifications**, we've **lost** a little bit of **control** over I guess, which is a bit sad.*

*It's a standalone unit for a range of reasons – it's easier to do it that way, **we've got control** of **the content** and control over the **way it's delivered**. We don't have to then deal with other issues as far as **erosion of content**…*

As these quotes also indicate, this tension has generated questions over where Indigenous health should sit, both within the MPH but also more broadly across the School – and, ultimately, even the university. At present there is a strong sense that Indigenous health teaching is segregated and seen as the responsibility of CAMDH. This view was also explained by CAMDH staff as recognition that specialist teaching is needed.

*Even though the students are part of the MPH we actually don't have a lot of knowledge about the **other content** – what isn't in the rest of the units… If we're going to do it, we're not going to assume knowledge and we're going to have clarity about what **students** should be able to **come out with** once they have finished the course. So it's not integrated with anything else that goes on.*

Yet some staff within the School of Population Health believe this should not be the case and that responsibility for teaching Indigenous content should be integrated throughout the various Schools within the university.

*I'm certainly in favour of integrating things in a way that doesn't have some sort of separate, whole-of-university Indigenous empire… where every lecturer in Indigenous whatever is part of some school. But… if you want to have **cultural change** within an organisation you've got to bring in the Trojan horse and they… [need] to be **part of the organisation**.*

*They're a fairly successful unit at least politically within the university, so they get their way quite a lot…. I guess it's a way of ensuring that they have control over all of this and that they have the staff sitting there to do it, but in my view having **people out in the disciplines**… would be a **better way** of doing it.*

As the following quote highlights, there is an acknowledged need for greater collaborative effort to address the gap between Indigenous and non-Indigenous health status. It was noted that the current segregation of Indigenous health teaching has not always been in place and that other models have been proven as successful. Integration of content throughout the MPH program has occurred previously and staff within the School have shared responsibility for teaching Indigenous health content.

*I agree that for people to support Aboriginal people to take **ownership** of their **health issues**, that [it] needs to be a very broad **range of people**… not just one group of people who think they have ownership of it. We need everybody to have an input into their health to **make changes**… Well, the people that have sat **in our School** that have played that role, they've all been very successful public health Indigenous people, so it can't be a bad model.*

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 majority of staff interviewed at UWA articulated a very high level of commitment to the integration of the Indigenous health competencies within the MPH. This review has demonstrated that all the Indigenous health competencies have been incorporated across the program at UWA, as shown in Section 5.1, although some units have covered more of the competencies than others. The few units that do not have the competencies integrated in the learning outcomes are those that focus on statistical methods and data analysis, with the exception of the Leadership and Management of Health Services unit.

This integration has occurred both vertically and horizontally. UWA offers an Aboriginal Health elective unit, which provides students with an opportunity to take a focused unit that covers all the competencies in a single elective. Should students wish to further their studies in this area, UWA allows them to substitute two of their electives for Indigenous health units offered in other degrees or at other universities, thereby providing a potentially strong vertical model of integration through access to a series of specialised units. Given the current competitive climate that permeates the Australian higher education sector (Quiddington 2010), this dispensation is admirable. However, this option has apparently not been taken up by students to date and the promotion of Indigenous health studies units needs strengthening.

The horizontal integration of Indigenous health core competencies is also evident. All but one of the core units in the MPH have at least one of the competencies formalised in learning outcomes. Four of the six competencies are also covered in more than a third of the units within the MPH, thereby demonstrating a relatively high level of integration. However, given the review also highlighted that a significant amount of informal content is not documented in learning outcomes, there is a need to review exactly what is being taught and by whom. Thus, a comprehensive mapping of content is essential to ensure there is no duplication of content.

This level of integration is seemingly due to the presence of Indigenous staff and academic centres that specialise in Indigenous health, including CAMDH and CUCRH. While the School of Population Health does not currently have any Indigenous academics on staff, previous Indigenous staff have had an influence on the curriculum at UWA. It is important that the program continues to draw on the expertise of the Indigenous academics and appropriately experienced and qualified non-Indigenous staff working in Indigenous health at CUCRH and CAMDH in particular.

6.2. Innovations to integrate the Indigenous competencies

The Aboriginal Health unit taught by staff at CAMDH was seen as valuable component of the UWA MPH, and it has demonstrated success in providing students with a broad knowledge base on which they can build in their future workplaces. Indigenous health content needs to be taught sensitively to ensure that students are motivated to overcome health inequity experienced by minority groups, while not being overly burdened with an individual sense of responsibility for the parlous state of Indigenous health. Staff at UWA acknowledged that staff at CAMDH are better placed to teach the Aboriginal Health unit, as they can appropriately guide students through the required 'deep learning', rather than superficial or 'surface learning' (Ramsden 1992).

This also recognises that, even as adult learners, MPH students come to the course largely ignorant of Indigenous culture and health issues. Therefore, their 'personal frames of reference need to shift… and opportunities for students to deal with their emotional responses need to be included with the pedagogical approach' (Onemda, IKE & SHSD 2006). The pedagogical approach of CAMDH staff reflects best practice in teaching Indigenous health to a mainstream cohort in that it is interdisciplinary, introduces a range of perspectives including Aboriginal ones, and engages students in an immersion style of teaching (Rasmussen 2001).

Drawing on the research expertise at CUCRH to develop and deliver specialist units that focus on rural health, but that incorporate Indigenous health, is another unique component of the UWA program. The online orientation program for all students undertaking studies through CUCRH is particularly innovative. This approach provides another level of learning that allows students to immerse themselves in the foundational content prior to taking up studies. The unit delivery can subsequently focus on the theoretical and conceptual components of the content, facilitating engagement with the more complex subject matter (Onemda, IKE & SHSD 2006).

6.3. Improving integration of the Indigenous competencies

The review highlighted the need for a comprehensive mapping of the MPH content against the ANAPHI public health competencies (ANAPHI 2009), and specifically the Indigenous health competencies, but also of how each unit within the MPH complements or builds on content contained in the core units. The latter point equally applies to the Aboriginal Health unit, which currently is a stand-alone unit and is not integrated with content from the rest of the MPH. The aforementioned commitment of staff to the integration of the Indigenous health competencies in the curriculum was reflected in their expressed willingness to undertake such an internal review exercise. This is also timely given the imminent changes to a graduate teaching program structure within the university, and the requirement for education programs to align with the new Australian Qualifications Framework (AQF) (AQF Council 2011) by December 2013.

Such a review would also ensure that staff who were previously unaware of the competencies are informed of their rationale and intended outcomes in accordance with the ANAPHI competencies and supporting framework (Genat 2008). The need for on-going, regular meetings to discuss and exchange ideas about teaching and curriculum development was also raised, to ensure that staff not involved in the Teaching Executive Committee are informed of any changes within the program or innovations in teaching.

Throughout the review there appeared to be a tension between the School and CAMDH in terms of ownership of the Indigenous content, as outlined in Section 5.2.5.2. As the Aboriginal Health unit is perceived to be the domain of CAMDH staff, there was concern expressed that the Indigenous health content was being taught from a generic knowledge base rather than with a public health focus. As such, some staff were unclear how the content in this unit was differentiated from that delivered in the core unit within the undergraduate Bachelor of Science program. Mapping of content and learning outcomes against the AQF requirements (AQF Council 2011), however, should resolve this concern, as the AQF requires demonstration of learning outcomes that differentiate between these levels of learning.

A systematic mapping exercise will not only ensure that the required competencies are covered and formally documented, but will also act as a mechanism for strengthening the integration of Indigenous health content, and hopefully alleviate the sense of segregation between the School and CAMDH. It would assist staff within the School to gain both an understanding of what CAMDH staff teach, and a better appreciation of the specialist knowledge and Aboriginal perspective they can provide that is critical to teaching Indigenous public health. This may also resolve the debate on whether or not the Aboriginal Health unit should be a core or elective unit within the MPH.

Another strategy that UWA may wish to consider is the suggestion made by some of the participants to share Indigenous academics between the School and CAMDH through a joint appointment arrangement. This would overcome both the Indigenous staffing deficiency within the School and the challenges of recruiting to identified positions, while simultaneously strengthening the links between the two entities and ensuring that Indigenous staff are supported through the structures in place at CAMDH. It would also contribute to staff development in the School, as has occurred previously when Indigenous academics assisted with curriculum development and teaching. If this is not possible, at the very least CAMDH staff should be involved in all curriculum development committees and School meetings and processes to strengthen the relationship.

Even though it is acknowledged that Indigenous academic staff are in short supply nationally (Behrendt, et al. 2012), this does not preclude the

School from continuing to pursue a recruitment strategy to increase Indigenous staff into the program, whether they be permanent employees or regular guest lecturers. It was noted that UWA has limited community-based guest lecturers contributing to the program due to reduced levels of resourcing, which has necessitated an increased dependency on adjunct staff and those employed in other sections of the university. Although drawing on adjunct staff is a laudable strategy, it is nevertheless unsustainable and does not adequately remunerate individuals for their time and valued contributions. As noted by participants, increasing the number of Indigenous positions within the School would, in turn, assist in attracting Indigenous students to the MPH program.

6.4 Commendations

Based on the above findings and analysis, the review team commends the MPH program staff at UWA for it's:

- Commitment and willingness to integrate the Indigenous public health core competencies throughout the MPH.
- Comprehensive integration of the Indigenous health core competencies through vertical and horizontal models.
- Inclusion of units developed and delivered by specialist academic centres including CAMDH and CUCRH.
- Teaching of the Aboriginal Health unit using a pedagogical approach that promotes cultural safety and deep learning.
- Ability to provide students with an opportunity to explore specialised studies in Indigenous health through cross-institutional enrolment options.

6.5 Recommendations

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

- Comprehensive mapping of the individual units against the competencies and the MPH program as a whole.
- Regular MPH teaching staff meetings to share information about curriculum development and teaching, including CAMDH staff.
- Consideration of joint appointment arrangements for Indigenous academics between the CAMDH and the School of Population Health.
- Promoting the opportunity of undertaking further studies in Indigenous health through cross-institutional enrolments.
- Developing recruitment strategies for Indigenous academics, guest lecturers and students.
- Ensuring that Indigenous guest lecturers are appropriately remunerated for their contributions.

7. References

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8. Attachments

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 Curricula[5]

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 2010[6]. 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***[7]

Name of participant:

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

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 interview ☐

   and 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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