National Indigenous Public Health Curriculum Audit & Workshop Project Report October 2004

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This is a national project that includes all Aboriginal and Torres Strait Islander cultures within Australia. In this report, the term 'Aboriginal' will be used to refer to Aboriginal and Torres Strait Islanders in general.

This document presents the findings and conclusions of the authors and may not represent the views of PHERP, the Department of Health and Ageing or the Australian Government.

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FOREWORD

This report on the background, findings and recommendations emerging from the National Indigenous Public Health Curriculum Audit and Workshop is situated in a national policy context in which Aboriginal health is a national priority. Both the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NATSIHC 2003) and the Aboriginal and Health Islander Workforce Strategic Framework (SCATSIH 2002) target the capacity building of the Aboriginal health workforce as an urgent priority. Particular priority has also been placed on the development of public health capacity in Aboriginal health. This involves developing the capacity of non-Aboriginal people working in this sector, and, most importantly, developing pathways for Aboriginal people into health professional training at all levels.

The gap in Aboriginal and Torres Strait Islander public health capacity is broad, and capacity is required in a number of distinct workforce contexts. For example, we need to develop the capacity of policy makers to make decisions that take into account public health knowledge and evidence. We also need to develop the capacity of primary care professionals to link clinical care with public health activities (through, for example, screening programs, or linking clinical care to health promotion). And, we need to develop the capacity in the sector generally to undertake public health research and evaluation.

This report documents one component of the PHERP Innovations Project, 'Innovations in the Design and Delivery of Curricula on Indigenous Australian Public Health', which is designed to respond to the above public health workforce capacity issues. The project has a two-fold focus of:

(i) developing the pedagogy and educational processes (and modifying curricula) to enable a cohort of Koorie people to undertake a Masters of Public Health; and

(ii) developing curricula that will enhance the skill, knowledge and attitudes of non-Aboriginal people undertaking the Master of Public Health (MPH) with respect to Aboriginal health.

The implementation of the mainstream Victorian Consortium of Public Health (VCPH) Master of Public Health program, using teaching and learning methods appropriate for a Koorie cohort of students, is a critical component of capacity building in Aboriginal public health. There are two strategic reasons for this:

1. A significant proportion of Aboriginal health trainees will work within their own community.

2. All projects to reorient the health system to work more effectively for Aboriginal people require the presence, in a systematic way, of Aboriginal health professionals as a reforming influence with their peers (as opposed to one of cross-cultural awareness sessions). Therefore, it is important that Aboriginal health professional training provides empowerment and the capacity to engage with health system reform.

The current health system reform agendas in Aboriginal and Torres Strait Islander health places significant priority on the development of a population health focus within clinically oriented health care services, particularly at a primary care level. Thus, the contents of this report can be seen as a crucial first step towards strategic reform in Aboriginal public health capacity building.

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Key Organisational Partners

PHERP	The Public Health Education and Research Program of the Commonwealth Department of Health and Ageing—Project Funder
OATSIH	Office of Aboriginal and Torres Strait Islander Health of the Commonwealth Department of Health and Ageing—Travel Support for Workshop Participants
PHAA	The Public Health Association of Australia—Inclusion of the National Workshop in the Annual PHAA Conference Program

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We would also like to acknowledge:

- Program managers and academic staff who participated in the audit or workshop from the universities listed in Appendix 1.
- Staff from both Aboriginal primary health care organisations (or their peak bodies) and government departments who attended the national workshop listed in Appendix 4.

VICHEALTH KOORI HEALTH RESEARCH & COMMUNITY DEVELOPMENT UNIT

Discussion Paper Series

The VicHealth Koori Health Research and Community Development Unit (VKHR&CDU) was launched in June 1999 and has been developed in partnership with the Victorian Aboriginal Community Controlled Health Organisation, the Victorian Health Promotion Foundation (which funds the Unit) and the University of Melbourne through the Centre for the Study of Health and Society where the Unit is located.

At the core of the Unit's work is a commitment to undertaking, collaborating in and supporting research that directly benefits the Koori community. The work of the Unit spans academic and applied research, community development, and medical education. The combination of these activities is a central and innovative aspect of the Unit's function, as is the identification and use of mechanisms to link research with the improvement of health care practices and policy reform. Overall, these tasks are guided by both an Advisory Committee and a Research Advisory Group.

In relation to the research program, five key areas govern the inquiry undertaken within the Unit. These comprise: historical research into Koori health policy and practice; historical and contemporary research into health research practice, ethics and capacity building; applied research on the social and cultural experience of Koori health, well-being and health care delivery; health economics research on the factors and processes that impact on the provision and use of Koori health care; and the evaluation of Koori primary health care and related health promotion programs.

The Discussion Paper Series (DPS) is directly linked to this diverse program of research and provides a forum for the Unit's work. The DPS also includes papers by researchers working outside the Unit or in collaboration with VKHR&CDU staff. Individual papers aim to summarise current work and debate on key issues in Indigenous health, discuss aspects of Indigenous health research practice and process, or review interim findings of larger research projects. It is assumed that the readership for the series is a broad one, and each paper is closely edited for clarity and accessibility. Additionally, draft papers are 'refereed' so as to ensure a high standard of content.

More information on the series, on the preparation of draft papers, and on the work of the Unit can be obtained by directly contacting the VKHR&CDU.

Discussion Paper Series

Discussion Paper No. 1: *Ian Anderson, Harriet Young, Milica Markovic & Lenore Manderson*, 'Aboriginal Primary Health Care in Victoria: Issues for Policy and Regional Planning' (December 2000)

Discussion Paper No. 2: *Kim Humphery*, 'Indigenous Health and "Western Research"' (December 2000)

Discussion Paper No. 3: *David Thomas*, 'The Beginnings of Aboriginal Health Research in Australia' (September 2001)

Discussion Paper No. 4: *Michael Otim*, 'Indigenous Health Economics and Policy Research' (November 2001)

Discussion Paper No. 5: *Daniel McAullay, Robert Griew & Ian Anderson*, 'The Ethics of Aboriginal Health Research: An Annotated Bibliography' (January 2002)

Discussion Paper No. 6: *Ian Anderson*, 'National Strategy in Aboriginal and Torres Strait Islander Health: A Framework for Health Gain?' (March 2002)

Discussion Paper No. 7: *Anke van der Sterren & Ian Anderson*, 'Building Responses to Blood-Borne Virus Infection among Kooris Using Injecting Drugs—Improving the Link between Policy and Service Delivery' (December 2002)

Discussion Paper No. 8: *Kim Humphery*, 'The Development of the National Health and Medical Research Council Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health Research: A Brief Documentary and Oral History' (December 2002)

Discussion Paper No. 9: *Michael Otim, Ian Anderson and Russell Renhard*, 'Aboriginal and Torres Strait Islander Hospital Accreditation Project: A Literature Review' (November 2002)

Discussion Paper No. 10: *Nili Kaplan-Myrth*, 'Political Visions: Blindness Prevention Policy as a Case Study of Community–Government Relations in Aboriginal Health' (June 2004)

Discussion Paper No. 11: *Gregory Phillips and the Project Steering Committee, Committee of Deans of Australian Medical Schools*, 'CDAMS Indigenous Health Curriculum Development Project: National Audit and Consultations Report' (August 2004)

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EXECUTIVE SUMMARY

This report presents the findings of a national audit of Indigenous content within Public Health Education and Research Program (PHERP) funded Master of Public Health (MPH) programs, and the recommendations of a national curriculum workshop of key stakeholders in Aboriginal health that considered the audit. It also represents some interim outcomes from the PHERP Innovations Project: 'Innovations in the Design and Delivery of Curricula on Indigenous Australian Public Health'.

Key findings of the national audit of Indigenous public health curricula conducted between April and September 2003 include:

- Only seventeen Aboriginal MPH students graduated nationally in the previous five years within PHERP-funded MPH programs.
- A concentration in Queensland and Northern Territory of MPH programs with Aboriginal health content as a key focus, which bears little correlation to the existing distribution of Aboriginal populations.
- Aboriginal health subjects within existing MPH programs tend to have either broad generic content or a focus on specific diseases or risks, with minimal emphasis on social science and cultural analysis within Aboriginal health.
- Only one national MPH program, delivered through the Institute of Koorie Education (IKE) at Deakin University, is specifically tailored to Aboriginal students.

Key outcomes of the National Indigenous Public Health Curriculum Workshop convened to discuss the audit findings include:

- A unanimous recommendation for the inclusion of Aboriginal content within all compulsory core units of MPH programs nationally.
- A unanimous recommendation that the MPH programs tailored specifically for Aboriginal cohorts be adequately resourced and replicated.
- A unanimous recommendation for the establishment of a network of public health professionals focused on Aboriginal health content within public health education through affiliation with the Public Health Association of Australia.

The following pages of this report outline the background to the audit, the results of the audit and items for discussion, and recommendations emerging from the National Curriculum Workshop.

Relevance to the PHERP Review

The Commonwealth Department of Health and Ageing's Public Health Education and Research Program is a Commonwealth government program that funds tertiary programs across Australia to maintain the capacity of the public health workforce through the provision of postgraduate education and training. PHERP funds are allocated to five State-based university consortia and centre for public health that provide Master of Public Health programs and articulated postgraduate courses, short courses and doctoral programs.

The project described within this report comes from the PHERP Innovations funding program. This program encourages creativity and collaboration in public health capacity building, and provides small grants that stimulate innovations in education and training for the public health workforce.

Building population health workforce capacity in Aboriginal health is a key priority both of the PHERP program in general and its Innovations funding. In presenting this report it should be noted that PHERP is currently under review.

This PHERP-funded project, 'Innovations in the Design and Delivery of Curricula on Indigenous Australian Public Health', is jointly managed by the VicHealth Koori Health Research & Community Development Unit (VKHRCDU) at the University of Melbourne and the Institute of Koorie Education at Deakin University. The audit and curriculum workshop report, which is at the centre of this project, received funding by addressing several of the key principles guiding PHERP Innovations funding:

- Aboriginal health is a national priority.
- Project partners are national leaders in Aboriginal health education, training and research, with the infrastructure and resources necessary to develop innovative ways of building Aboriginal public health capacity to address a recognised gap in national public health workforce education.
- Partners are located within multi-disciplinary academic precincts that maximise opportunities for inter-disciplinary collaboration.
- Partners represent two tertiary institutions with further extended linkages to the Aboriginal community health sector and other PHERP consortia partners.
- Partners have contributed significant funds of their own to the project and have been supported by further grants from each of their institutions and other sources.
- Outcomes of the project inform the development of national Aboriginal public health curricula through their dissemination at conferences, in journals and through development of a national network of Aboriginal public health educators.
- The project methodology received endorsement from a review by a panel of peers and relevant stakeholders.

The outcomes of this project have already begun to inform policy and practice in the delivery of public health education, with the Victorian Consortium of Public Health adopting a key recommendation from the National Indigenous Public Health Curriculum Workshop. It is recommended that all Part 1 subjects within the Master of Public Health program should have appropriate Aboriginal health content. The PHERP Innovations Project funding has ensured that Aboriginal input is available from the VKHRCDU to guide this process. Potentially, this initiative will pre-empt a greater focus on Aboriginal health within public health education nationally.

Nevertheless, although progress is evident by the increasing provision of places for public health professionals in mainstream courses, the MPH for Aboriginal cohorts at the Institute of Koorie Education at Deakin University continues to be under-funded and reliant upon goodwill within the VCPH to resource community-based delivery of the Consortium MPH subjects. This cannot continue, particularly as the National Indigenous Public Health Curriculum Audit found that only seventeen Aboriginal MPH students had graduated within the past five years. Adequate funding of the MPH for Aboriginal cohorts at Deakin University has the potential to increase significantly the number of Aboriginal MPH graduations. At a time when the PHERP program is under review, it seems timely to highlight this urgent need.

INTRODUCTION

This report outlines the background, context and outcomes of two key components of the PHERP Innovations Project 'Innovations in the Design and Delivery of Curricula on Indigenous Australian Public Health'. The two components of the project described within this report are:

1. a national audit of Aboriginal content within PHERP-funded MPH programs; and

2. a national workshop that examined the outcomes of the audit and made recommendations concerning Aboriginal health content within MPH programs nationally.

A Master of Public Health is recognised by the health industry generally as the standard training award for licensing health professionals within the community and public health fields. It is widely agreed that this award should provide a generic range of skills in key areas of public health practice including, principles of public health, epidemiology, biostatistics, health management, health promotion and education, health policy, health economics, health research methods, and studies in a particular area of public health practice. There is strong argument that public health should articulate a clear commitment to equity.

With the continuing and widening disparity in the health status of Aboriginal Australians, compared to the rest of the population (AMA 2003), a range of reports have questioned whether existing public health workforce training provides all the necessary skills to ensure better health outcomes for this community. Questions about the training of the public health workforce in Aboriginal health led to the funding of this PHERP Innovations Project to investigate the Indigenous health content of MPH programs.

National Aboriginal Health Policy Context

The National Aboriginal Health Strategy (NAHSWP 1989) emphasised the urgent need to upgrade the Aboriginal health skills of the public health workforce, a priority given even greater emphasis by the recent release of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NATSIHC 2003), and the corresponding Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework (SCATSIH 2002). The latter suggests:

> A competent health workforce is integral to ensuring that the health system has the capacity to address the health needs of Aboriginal and Torres Strait Islander peoples… action is now required on specific strategies to improve the training, supply, recruitment and retention of appropriately skilled health professionals, health service managers and health policy officers in both mainstream services and the Aboriginal and Torres Strait Islander specific services (SCATSIH 2002: 1).

Traditionally, university-based MPH programs have given scant attention to the social and cultural determinants of health, to their historical basis or to community development as an intervention method. To address this failing and to better provide for the health needs of Aboriginal communities—as well as the education of public health professionals, health service managers and health policy officers, and, by implication, the content of MPH programs—national Aboriginal health strategies have an emphasis on appropriate community development and cultural skills and recognition of historical impacts on Aboriginal social and emotional wellbeing.

A recent report on national public health strategies in relation to Aboriginal Australians by the National Public Health Partnership (NPHP) also examined workforce issues (NPHP 2002). In the background to discussion of Aboriginal public health, the report observes:

> Consistent evidence in the past decade has shown that health disparities among people are not declining, and in some cases increasing, particularly in Western countries such as the UK, USA and Australia (NPHP 2002: 27)

Similar observations are echoed in the recent report card on Aboriginal health released by the Australian Medical Association (AMA) that also notes the widening disparity in the health status between Aboriginal Australians and the broader community (AMA 2003).

The NPHP (2002) also suggests that the values and culture of public health professionals is a key factor in their provision of services. Within the report, a National Health and Medical Research Council (NHMRC) study is quoted that suggests:

> Health strategies, policies and programs often reflect the values and culture of decision-makers and other senior managers. In Australia, service models have been dominated by concepts originating in Europe and, more recently, North America. Public policy development and tasks tend to reflect the values and priorities of those who undertake them, primarily those in politics and bureaucracies (NPHP 2002: 26).

Subsequently, the NPHP report observes that:

> Some of the values underpinning (public health practice) can be at odds with the wider general community, and with specific ethnic and cultural minority communities, including Aboriginal and Torres Strait Islander peoples (NPHP 2002: 26).

The NPHP paper quotes similar findings from a range of researchers. For example, 'Communities that hold holistic models of health are at odds with health services focused on discrete illnesses or body parts' (Morgan, *et al.* 1997 in NPHP 2002: 27), and 'there is considerable cynicism about the performance and relevance of public servants and their knowledge of the issues affecting 'ordinary people' (Berman 1997; Manderson, Keleher, Williams & Shannon 1998 in NPHP 2002: 27). Of particular concern are the implicit values and perspectives that public health professionals bring to their practice. Studies of Aboriginal and Torres Strait Islander Health Workers in both remote and urban settings have revealed the gap between the values, perspectives and priorities of those Aboriginal Health Workers practising at the community level, and those of health managers, planners and policy makers further up the management hierarchy (Tregenza & Abbott 1995; Genat 2001).

The continuing disparity in health gains between Aboriginal Australians and the broader population, reports of differing perceptions and priorities of Aboriginal health workers and clients from those of health managers and policy-makers, and results of wider workforce studies within the field of Aboriginal health, prompted this national investigation of MPH education and training.

PHERP INNOVATIONS PROJECT OUTLINE

'Innovations in the Design and Delivery of Curricula on Indigenous Australian Public Health' is a project funded by the Public Health Education and Research Program, a special program within the federal Department of Health and Ageing that funds, researches and monitors public health education nationally.

The project is jointly managed by the VicHealth Koori Health Research & Community Development Unit (VKHRCDU) at the University of Melbourne and the Institute of Koorie Education (IKE) and the School of Health and Social Development at Deakin University, in collaboration with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), the Victorian Aboriginal Education Association (Incorporated), the Combined Research Centre on Aboriginal and Tropical Health, Menzies School of Health Research, and the Burnet Institute.

The project has two key aims:

One, being undertaken by the IKE at Deakin University, is to increase the number of Aboriginal public health graduates by:

- innovating and articulating a community-based pedagogical model appropriate to the training of Aboriginal MPH students; and
- adapting the delivery of core MPH units to this pedagogical format.

The other key aim of the project, being undertaken by the VKHRCDU, is to improve the capacity of MPH graduates to respond to Aboriginal health issues by

- conducting a national audit of Aboriginal health content within MPH programs funded by the PHERP program;
- convening a national workshop to identify critical gaps and broad level principles of teaching and Aboriginal health content by comparing the audit findings with workforce and stakeholder priorities; and
- developing, implementing and evaluating new curricula in Aboriginal public health.

The overall project aims to address Aboriginal public health workforce education and training gaps by:

1) Providing the *educative infrastructure* to improve the capacity of the public health workforce to respond to identified needs in Aboriginal Australian health. The development of a national Aboriginal public health education network, curriculum models and complementary policy structures that will provide valuable foundations for evidence-based policy development in Aboriginal Australian public health.

2) Increasing the number of *Aboriginal Australian public health professionals.* While there are many Aboriginal Australians with strong community credentials in Aboriginal health leadership and management roles within the health workforce, many have not had the opportunities to pursue tertiary studies to attain qualifications that reflect their high skill levels. Many work within organisations that cannot provide study release or back-fill positions if staff are fortunate enough to secure a scholarship. In addition, provision for recognition of prior learning within the tertiary sector is poor, while full recognition of crucial cultural skills and provision of appropriate courses that build on cultural knowledge and expertise is minimal. Mainstream course frameworks, philosophies and contents are cultural barriers to many Aboriginal Australian students gaining access to high-quality public health education.

3) Strengthening the range of *skills of non-Aboriginal workers in Aboriginal Australian public health* contexts. Aboriginal health service delivery, within the public health sector, is fragmented by a system of vertical programming. In the main, those working in Aboriginal public health contexts have either a clinical or quantitative research background. Public health practice in Aboriginal health requires an understanding of the particular historic and socio-cultural, political and economic contexts in which Aboriginal health disadvantage develops. This contextual knowledge is also critical for the development of strategies for Aboriginal health gain. In Aboriginal public health contexts—such as public sector administration, community-based practice or research—there is a relative dearth of practitioners with a comprehensively developed social sciences skills base integrated with other spheres of public health knowledge. This project will broaden the public health workforce's understanding of Aboriginal issues and strengthen its capacity to address Aboriginal health needs through the development of innovative curricula that draws on social science theory and methods.

4) Fostering an overarching *policy and pedagogical framework* through which *collaborative partnerships* can be networked using a common approach to Aboriginal health workforce training in cross-cultural contexts. The collaborative partnership between the University of Melbourne and Deakin University, through which this project will be delivered, arose from the express mandate of all key Aboriginal community health stakeholders. The integrity of the collaborative process underpinning this project will lay the groundwork for the development of national competencies and benchmarks in the field of Indigenous Australian public health workforce practices. This will address the current *ad hoc* approach to Indigenous Australian public health initiatives.

Methodology & Participation

The National Indigenous Public Health Curriculum Audit involved the design of an audit tool and its distribution to all the national tertiary Master of Public Health programs funded by the PHERP program. Project liaison staff within each of the institutions recruited MPH program managers to gain their perspectives on the overall status of Aboriginal health content within their program, the strategies in place to ensure its prominence, and the data on Aboriginal enrolments and completions. The program managers of all seventeen PHERP institutions offering MPH programs responded. In addition, MPH staff whose subjects offered Aboriginal health content also completed the audit schedule. The results are documented later in this paper.

The National Indigenous Public Health Curriculum Workshop was convened at the conclusion of the audit process and held to coincide with the national conference of the Public Health Association (PHA). The specific aims of the workshop were to:

- examine current curriculum within Aboriginal public health including
  - (i) guiding strategy and principles;
  - (ii) pedagogical approaches; and
  - (iii) course content;
- identify existing curriculum gaps; and
- develop specific recommendations about Aboriginal public health education.

Participants at the National Indigenous Public Health Curriculum Workshop included Aboriginal MPH students and academics, health workforce representatives, nominees from the National Aboriginal Community Controlled Health Organisation (NACCHO) and its State affiliates, PHERP and the Office of Aboriginal and Torres Strait Islander Health (OATSIH). Together this group reviewed the audit outcomes and made recommendations to strengthen MPH Aboriginal health curricula.

ABORIGINAL HEALTH CONTENT: KEY CURRICULUM CONSIDERATIONS

Prior to the National Indigenous Public Health Curriculum Workshop, participants were provided with a briefing paper that gave a technical and theoretical background for the examination of the audit outcomes. The background paper suggested that three areas of knowledge were relevant. These were:

1. foundational understandings of Aboriginal health;

2. pedagogical approaches within Aboriginal education; and

3. an understanding of sub-disciplinary areas of specialist knowledge within the domain of public health to assist considerations about which of these require a specific Aboriginal teaching component.

Foundational Knowledge of Aboriginal Health

Central to a public health professional's practice within Aboriginal health is foundational knowledge, including:

- Aboriginal conceptions of health;
- comprehensive primary health care approach;
- Aboriginal community control;
- social justice and Australia's human rights obligations; and
- recognition of Aboriginal knowledge.

While many readers of this paper will be familiar with most of these, a brief comment on each follows.

Aboriginal Conception of Health

Two crucial aspects of Aboriginal health are both its holistic perspective and its recognition of local diversity. Australian public health, however, generally falls between a more reductionist biomedical model of health that focuses on discrete biological organs and disease processes, and, at the other end of the spectrum, a universalist system that generalises public health approaches to whole populations.

According to the report from the National Public Health Partnership, which examined public health strategies in relation to Aboriginal people (NPHP 2002), the diverse specialist areas of expertise that constitute the arena of public health may create silos of vertical programming that fragment an Aboriginal holistic approach:

> Public health policy tends to be thematic: it deals with specific health or disease problems (such as cancer, mental health, or HIV/AIDS), specific populations (such as young people or women), specific interventions (such as screening for cervical cancer or immunisation), and specific aspects of health system organisation (such as funding mechanisms, and the roles and responsibilities of health-service agencies). Health policy themes reflect problems and opportunities confronting the health system and they lead to a concentration on specific issues that become the focus of resource allocation and, the planning and implementation of programs and interventions. This concentration on specific issues is pragmatic, but it inevitably leads to fragmentation and, despite efforts to coordinate and integrate programs and services, public health policy remains the sum of the parts. Thus, policy is often inconsistent with Aboriginal and Torres Strait Islander views of health, which tend to be comprehensive and holistic, emphasise social, emotional and cultural well-being, and make little distinction between the well-being of the individual and the well-being of the community (NPHP 2002: 7).

Furthermore, in reference to the diversity of Aboriginal peoples, the report suggests that:

> Intellectual resources, such as 'best practice guidelines', are frequently developed under the auspices of the national public health strategies… such efforts need to take into account the very different cultural, clinical, and service delivery issues in Aboriginal and Torres Strait Islander health. Due to these differences, generic resources are often of little value in the Indigenous health context (NPHP 2002: 117).

A key consideration within the education of public health professionals working with Aboriginal Australians are the curriculum implications, in particular programming and also teaching and learning strategies that are congruent with a holistic approach and a recognition of local diversity. Both are components of culturally appropriate health services, a central plank of comprehensive primary health care.

Comprehensive Primary Health Care

Comprehensive primary health care is a cornerstone of the National Aboriginal Health Strategy (NAHSWP 1989) and of policy within the Office of Aboriginal and Torres Strait Islander Health Services, although interpretation may differ somewhat, Comprehensive primary health care officially emerged from the International Conference on Primary Health Care at Alma Ata (UNICEF & WHO 1978), which defined primary health care as:

> … essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to all individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (UNICEF & WHO 1978: 5).

According to the conference report, a comprehensive primary health care approach is affordable, accessible, acceptable, equitable and culturally appropriate, engages the participation of clients, enables both their empowerment and self-determination and fosters partnerships between agencies. It is founded on principles of social justice. 'It is these principles which distinguish "comprehensive primary health care" from "primary care"' (Keleher 2001). Aboriginal Medical Services, which were first established in 1971, already structured their service delivery this way, with community control as a key plank of self-determination (Fagan 1991). The National Aboriginal Health Strategy (NAHSWP 1989) articulated an Aboriginal Australian comprehensive primary health care approach founded on a holistic perspective of health.

Emerging from calls for comprehensive primary health care within national programs, the Ottawa Charter on Health Promotion (WHO 1986) advocated five key public health imperatives:

1. build healthy public policy;
2. create supportive environments;
3. strengthen community action;
4. develop personal skills; and
5. reorient health services.

The Jakarta Declaration on Health Promotion into the 21st Century (WHO 1997) advocated a further five action areas for health promotion: promote social responsibility for health, increase investments for health development, consolidate and expand partnerships for health, increase community capacity and empower the individual, and secure an infrastructure for health promotion.

These foundational documents—the Alma Ata Declaration, the Ottawa Charter, the Jakarta Declaration and the National Aboriginal Health Strategy—together advocate an integrated approach to Aboriginal health founded upon specific values, assumptions, principles, practices and objectives. Consequently, the performance of the public health practitioner at the heart of Aboriginal public health rests upon these foundations. This, in turn, sets a particular agenda for public health educators.

Aboriginal Community Control

According to Anderson, a holistic approach that accommodates the diversity of Aboriginal peoples within Australia requires local community-based services:

> Given the social and environmental factors which undermine the health of Aboriginal people, the appropriate solutions lie just not in effective disease diagnosis and therapy, but in overall community development… Experience has shown that the production of large scale, research-based blueprints for rural development

> programs in third world countries has been largely unsuccessful. Similarly, the Aboriginal community requires services that reflect changing needs. Program design must be open-ended, adaptable and responsive to community direction… Given that health is determined by a whole range of factors such as housing, employment and educational opportunities, it is necessary that these should be taken into account when developing services for the Aboriginal community. Such an integrated approach is possible with the development of community-based services (Anderson 1988: 109).

Aboriginal Community Controlled Health Services, both at the regional and local level, can negotiate these services for local people and ensure that they are delivered in an integrated and holistic way. Anderson adds:

> The development of Aboriginal Community Controlled Health Services guaranteed Aboriginal people access to care, a situation often previously not the case, overcame the indifference, even frank hostility, of some health care providers and… created primary health centres where Koories can comfortably go, see a Koori health worker, and be treated with respect by people who know something of their lives and culture (Anderson 1993: 34–7).

Aboriginal community control is one of the nine principles (see Appendix 2) upon which the National Strategic Framework for Aboriginal and Torres Strait Islander Health is founded:

> Community control of primary health care services: supporting the Aboriginal community controlled health sector in recognition of its demonstrated effectiveness in providing appropriate and accessible health services to a range of Aboriginal communities and its role as a major provider within the comprehensive primary health care context. Supporting community decision-making, participation and control as a fundamental component of the health system that ensures health services for Aboriginal and Torres Strait Islander peoples are provided in a holistic and culturally sensitive way (NATSIHC 2003: 2).

In terms of public health education, what does Aboriginal community control mean for the training of a public health practitioner? Within university-based MPH programs, graduates will emerge with a Master of Public Health, a recognised award for knowledge and competence in the field. Nevertheless, in the field of Aboriginal public health, the MPH graduate needs to recognise that they are not the sole 'expert' able to manage health programs only as *they* see fit. The need to work in partnership with Aboriginal organisations is fundamental. Key foundations of such a partnership are respect, trust and a commitment to human rights and social justice.

Social Justice and Human Rights

Public health practitioners working alongside Aboriginal people require an acute awareness of Australia's human rights obligations. Australia is a signatory both to the Universal Declaration of Human Rights and the Covenant on Economic, Social and Cultural Rights. The human right to health is recognised in both. Article 25.1 of the Universal Declaration of Human Rights affirms:

> Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services (UN 1948).

Furthermore, General Comment No. 14 on Article 12 of the Covenant on Economic, Social and Cultural Rights clarifies more about the right to health:

> The right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment… The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State: availability… accessibility (non-discrimination, physical accessibility, economic accessibility, affordability, information accessibility); acceptability (culturally appropriate—respectful of culture); and, quality… as well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality (UN 2000).

According to the former UN High Commissioner on Human Rights, Mary Robinson, taking human rights seriously means, first and foremost, holding governments accountable for the legal commitments they have made:

> There is increasing recognition that if human rights are to be implemented effectively it is also essential to ensure that obligations fall where power is exercised, whether in the local village or in the international meeting rooms of the WTO, the World Bank or the IMF (quoted in Smith 2002).

Nevertheless, as indicated above, the NPHP report observes that, 'Consistent evidence in the past decade has shown that health disparities among people are not declining, and in some cases increasing, particularly in Western countries such as the UK, USA and Australia' (NPHP 2002: 27).

Although human rights protocols provide public health practitioners with a foundational standpoint from which to challenge the inequities surrounding Aboriginal Australians' access to supportive environments and appropriate health services, does their training provide them with the capacity to articulate these, or challenge those who ignore or refute them, and negotiate just health policies, programs and outcomes for Aboriginal Australians? And are public health practitioners able to undertake such action in a political context where these rights may be disputed?

Recognition of Aboriginal Knowledge

Within Aboriginal public health, Aboriginal standpoints and perspectives are fundamental both to research and the development, implementation and evaluation of programs. Much of public health is based upon research and the imperative of evidence, however both 'research' and 'evidence' have a tainted history with Aboriginal populations. What is a research agenda that acknowledges Aboriginal standpoints? According to Maori academic Linda Tuihiwa Smith:

> The (Aboriginal) research agenda is conceptualised here as constituting a programme and a set of approaches that are situated within the de-colonisation politics of the Indigenous peoples' movement. The agenda is focused strategically on the goal of self-determination of Indigenous peoples. Self-determination in a research agenda becomes something more than a political goal. It becomes a goal of social justice which is expressed through and across a wide range of psychological, social, cultural and economic terrains. It necessarily involves the processes of transformation, decolonisation, of healing and of mobilisation as peoples… decolonisation, healing, transformation and mobilisation—represent processes. They are not goals or ends in themselves. They are processes which connect, inform and clarify the tensions between the local, the regional and the global. They are processes which can be incorporated into practices and methodologies (Smith 1999: 115).

Smith emphasises how decolonisation, healing, transformation and mobilisation need to be embedded within the methodology of public health research, processes that require partnerships with Aboriginal people. She also highlights the need for Aboriginal control of aspects of the design, implementation, interpretation, write-up and dissemination of Aboriginal health research (see NHMRC 2003a, b, c). Historically, many public health researchers considered population health data to be their sole and exclusive domain. However, recognition and respect for Aboriginal knowledges and standpoints requires alternative methods of undertaking research, new research partners and new interpretative standpoints. Such changes point to a re-conceptualisation of the idea of a public health researcher with direct curriculum implications.

Pedagogical Approaches within Aboriginal Education

Investigating teaching and learning approaches that enable effective transfer of key understandings, knowledge and skills about practice within Aboriginal settings are central to graduating a competent public health practitioner from a non-Aboriginal background. This objective is one key component of the overall PHERP project. Another is an investigation by Deakin's Institute of Koorie Education that examines the enabling of Aboriginal participation in a public health curriculum. The delivery of a MPH to a cohort of Aboriginal students sets challenges for the teaching and learning approaches within MPH programs to grant equal respect to Aboriginal knowledges and standpoints and mainstream theoretical models of public health practice—a key to graduating competent Aboriginal public health professionals.

Ensuing reports from the IKE and VKHRCDU collaboration within this PHERP project will shed further light on these issues over the life of the project. Meanwhile, some frameworks for examining current MPH curricula are provided by what is already known about Aboriginal pedagogical issues.

Barriers and Enhancers to Learning about Aboriginal Health

Responses of mainstream medical students to learning about Aboriginal health found three groups of barriers and enhancers to student learning (Rasmussen 2001). These included:

1. those that were structured within the curriculum;
2. those that were driven by the awareness level of students; and
3. those to do with teaching.

Despite the focus of Rasmussen's research being undergraduate medical students, some of her findings appear relevant to mainstream postgraduate public health curricula.

Rasmussen indicates that **structural curriculum factors** have a negative impact when cultural, social, historical and political determinants of health are not studied fully and 'centrally incorporated' into the curriculum. If these broader health determinants are not integrated, students perceive them as side issues rather than *real* health issues. In the crowded medical curriculum, students believe 'soft' sciences distract their focus from the 'hard' sciences. In order to change student perceptions of these distinctions, she makes four recommendations:

- a carefully planned, integrated, inter-disciplinary approach within the curriculum;
- broader student selection and staff recruitment processes to encourage diversity;
- bringing Aboriginal perspectives into the program; and
- gaining program advice on the basis of local partnerships with Aboriginal organisations.

Rasmussen states that social determinants should be seen to apply broadly within health rather than towards one particular group. This is a stance supported in a *MJA* Editorial on the 'national shame' of Aboriginal health (Eades 2000), which cites a growing body of evidence showing a clear worldwide relationship between social exclusion and illness. Alongside such understandings, Rasmussen advocates staff encouraging a notion of responsibility toward minorities.

Key **student factors** identified by Rasmussen as barriers to learning include a lack of previous personal contact with Aboriginal people and reliance on second-hand (media) or fleeting impressions. Many students fell back on cultural stereotypes, failing to identify with contemporary Aboriginal and Torres Strait Islander cultures, and had difficulty understanding concepts of Aboriginal identities. Several held preconceived inaccurate notions about where Aboriginal people lived and the levels of spending on Aboriginal health. Few understood the impact of institutional barriers. Linked to these impressions were the students' own unacknowledged personal emotional responses of anger, fear, hatred, guilt, anxiety and grief that disabled their ability to engage in the learning.

To overcome the barriers put up by the students themselves, Rasmussen suggests that the administration, staff and curriculum should all clearly convey the importance of Aboriginal health, stress the notion of the social responsibility of an ethical health professional, and expose students to the existing gaps in their knowledge. They should also facilitate significant opportunities for students to form relationships with Aboriginal people through exposure to a wide range of Aboriginal voices. She stresses that it is crucially important to assist students to understand their pre-existing emotional responses.

Within the category of **teaching factors**, Rasmussen suggests that poorly co-ordinated curricula and unhelpful teaching methodologies, such as a reliance on academic lecturing-based teaching, constituted barriers to learning about Aboriginal health. Previous negative teaching experiences, particularly concerning Aboriginal health, also constitute barriers. Solutions identified by Rasmussen include: a combination of compulsory and non-compulsory curricula; immersion style field-trips; different teaching venues; informal and flexible teaching methodologies; and small group teaching and self-directed learning. Student interaction with Aboriginal people, however, requires good support.

Effective Learning

The effectiveness of different teaching methodologies, and their impact on student learning, is also central to examining public health curricula. Ramsden (1992) draws a helpful distinction between 'deep learning' and 'surface learning'. Deep learning aims to have the student go beyond mere memorisation and skill acquisition, past being passive spectators (surface learning) to becoming active participants in learning. Students are encouraged to experience the world differently by enabling them to 'apprehend and discern phenomena related to the subject, rather than what they know about them, or how they can manipulate them' (Ramsden 1992: 4).

In order to go beyond merely 'knowing about', it is necessary for learning to connect with the student's existing experience of the world and how they integrate new understandings. The student must articulate this so that both they and others understand what it means. The imperative is to go beyond merely knowing about the subject matter to making links to related issues, and further to engaging learners to articulate about the subject matter through their experience of the world. In this way, the student's capacity for self-reflection is encouraged.

Aboriginal Learning and Support

The PHERP project is also concerned with increasing Aboriginal enrolments by articulating effective and appropriate pedagogical approaches for Aboriginal students within public health programs.

Recent research has examined successful pedagogical approaches with Aboriginal tertiary students and factors governing their success at university. A study undertaken with Aboriginal health students at the University of Sydney suggests that programs which are overly content based do not readily serve the needs of Aboriginal students. The authors of the report suggest a need for 'two-way learning' that has some connection to the life experience of the students in the tradition of Freire (1972). They describe the characteristics of community-based learning as including:

- the use of learning resources from within the student's own community;
- group learning activities;
- participation by both enrolled students and other community members;
- teaching that is shared with members of local Indigenous communities;
- learning that is shared with members of local Indigenous communities;
- student's work on problems emerging from within the local community;
- study and analysis as a community activity;
- learning as integrated and holistic;
- teaching and learning as multi-professional and cross-disciplinary; and
- texts including country, community, people, books, video and the World Wide Web (Koorie Centre: Yooroang Garang 1996: 4).

While the capacity of some public health programs to incorporate all these components may be limited, they do provide some useful ideas and models for teaching and learning approaches, not only for Indigenous public health students but also, subsequently, for the non-Indigenous health professional's practice with Indigenous communities. Subsequent to this study, Curtin University researchers Walker and Humphries (1999) suggested that in order to enhance the participation of Indigenous students, course curriculum should:

- include Indigenous perspectives and topics in existing mainstream courses;
- actively encourage the involvement and input of Indigenous people in the development and review of curricula for mainstream courses;
- adopt appropriate teaching styles and encourage the development of conducive learning environments in mainstream courses;
- develop more flexibility within study and assessment requirements to accommodate the specific needs and learning styles of Aboriginal students;
- acknowledge the demands of personal issues on the social and emotional wellbeing and physical health of both the student and their family members, and of any financial difficulties that may affect the ability of Aboriginal students to perform well and complete assignments;
- be more flexible and sensitive in negotiating assessment deadlines; and
- explore options and opportunities for developing block-release and alternative mixed mode delivery models in mainstream courses to accommodate students' socio-economic and geographic realities (Walker & Humphries 1999: 35).

Other pedagogical approaches reported by Walker and Humphries that enhanced Indigenous student success included:

- more flexible and extended use of tutors;
- the appointment of Indigenous liaison officers within schools;
- the establishment of monitoring or buddy systems;
- enrolling clusters of Indigenous students; and,
- instituting procedures to deal with any racist language, attitudes and behaviour displayed by staff.

The study found that the majority of Aboriginal students withdrew from courses due to the need to relocate because of unsatisfactory accommodation, homesickness and loneliness, and pressure from family, health or financial demands. (Walker & Humphries 1999: 18, 19). Central to this PHERP project is the development and articulation of curriculum frameworks for Aboriginal public health education, for both Aboriginal and non-Aboriginal cohorts.

Aboriginal Health Components within the Domain of Public Health

An overview of the constituent themes within the discipline of public health is necessary to identify where Aboriginal health content already does, and potentially could exist within the national public health curricula. Table 1 provides an overview of the constituent themes with public health:

Table (1) Themes within the Domain of Public Health

Disciplinary Foundations
- definition
- history
- ethics, principles and values
- key theoretical concepts
- professional education

Public Health Research
- epidemiology
- biostatistics
- social sciences
- genetics

Specific Health or Disease Problems: Aetiology, Treatment & Prevention
- mental health
- sexual health
- drugs and alcohol
- communicable diseases
- chronic diseases
- reproductive health
- accident and injury

Specific Population Sectors
- women's health
- men's health
- adolescent and youth health
- refugee health
- Aboriginal health
- international health
- aged

Public Health Equity
- Medicare
- pharmaceutical benefits
- community health clinics
- allied public health services

Public Child Health
- child health clinics
- ante-natal care
- immunisation
- school health

Public Health Regulation
- drug supply
- waste disposal
- vehicles and traffic
- policing
- professional accreditation
- pollution—air, water, noise
- social impact
- building and development
- food safety
- advertising
- workplace health & safety
- patient records
- access to services

Public Health Surveillance & Control
- disease notification
- screening
- population surveys
- census
- water quality
- health inspectors
- food quality

Public Health Education & Promotion
- hygiene
- smoking
- alcohol and drugs
- heart disease
- breast cancer
- sexually transmissible infections
- diet and nutrition
- exercise
- risk-taking behaviours
- self efficacy

Health Policy & Planning
- health management
- health economics
- health policy development
- demographic analysis
- inter-governmental agreements

NATIONAL INDIGENOUS PUBLIC HEALTH CURRICULUM AUDIT OUTCOMES

National Master of Public Health programs funded by PHERP were audited during the period April to September 2003. Seventeen tertiary MPH programs participated in the audit. Program managers and subject co-ordinators who included Aboriginal content within their subject participated. While every attempt was made to develop a full picture of Aboriginal components within each program, the audit does have limitations, namely:

- institutions' commitment to the audit varied widely;
- responses were dependent on the co-operation of busy academic staff; and
- the design of the audit tool captured only formal elements of curricula.

Nevertheless, the audit does provide a broad overview of Aboriginal content with PHERP MPH programs nationally.

The results of the audit describe:

- geographic distribution of programs with Aboriginal health as a key strategic objective;
- Aboriginal content within the national PHERP MPH curriculum (see Appendix 2—Existing National MPH Coverage of Aboriginal Health); and
- responses from program managers.

The program managers described:

- factors affecting participation in learning about Aboriginal health;
- pedagogical approaches;
- the viability of Aboriginal content;
- how Aboriginal advice to programs is structured; and
- staff development in the area of Aboriginal health.

On the basis of these responses, emergent questions concerning Aboriginal health within MPH programs are proposed. A summary of the Aboriginal health content in each tertiary program is found in Appendix 1: Program Responses—All Institutions.

MPH Programs with an Aboriginal Health Focus: National Coverage

The audit identified that four tertiary MPH programs position Aboriginal health as a key goal within their strategic plans[1]:

- Institute of Koorie Education, Deakin University;
- Menzies School of Health Research;
- James Cook University (JCU); and
- The University of Queensland.

[1] *While the NCEPH–ANU program also has this commitment, rather than offering a generic MPH, it has a narrower epidemiological focus offering a Master of Applied Epidemiology program.*

The University of Queensland MPH (Indigenous Health) prescribes two designated Aboriginal health subjects as core (compulsory for all students). However, no other MPH program prescribed a designated 'Aboriginal health' subject as core.

Deakin's Institute of Koorie Education program is of particular note. In partnership with the School of Health and Social Development, it offers a nationally accessible MPH tailored for Aboriginal cohorts within the overall framework of the MPH offered by the Victorian Consortium for Public Health. The course comprises ten coursework units and a minor project. Teaching delivery is through a community-based pedagogical framework developed over the IKE's seventeen-year history. The participatory adult learning process draws upon the students' substantial Aboriginal health experience enabling their expertise to be shared, theorised and applied to public health problem solving. The articulation of a community-based pedagogical framework is a key component of this overall PHERP project. IKE graduated three Aboriginal MPH students in 2004 immediately prior to publication of this report and another five graduates are expected in 2005.

Deakin University, Menzies School of Health Research, James Cook University and the University of Queensland MPH programs have Aboriginal health as a key strategic goal. All four offer a wide range of Aboriginal health content and devote a higher percentage of teaching hours to Aboriginal content within both specific Aboriginal health subjects and mainstream MPH subjects (see Table 2). During 2003, two Aboriginal-specific subjects and a range of specific Aboriginal health sessions were offered across the MPH programs within the Victorian Consortium of Public Health (four more specific Aboriginal health subjects are accredited at the University of Melbourne for 2004). However, apart from the four first-mentioned programs above, Aboriginal health is not identified as a key goal by any other of the audited MPH programs.

The location of institutions offering significant coverage can be matched with recent Aboriginal population figures. Significant gaps in accessibility to mainstream Aboriginal public health education appear to exist in NSW, South Australia and in Western Australia. According to the most recent Australian Bureau of Statistics (ABS) data (ABS & AIHW 2003) the distribution of Aboriginal populations are as follows:

- Queensland 27%
- New South Wales & ACT 29%
- Western Australia 15%
- Northern Territory 13%
- South Australia 6%
- Tasmania 4%
- Victoria 6%

And distributed within each State as either:

- Remote areas 25%

or

- Major cities 30%

Emergent Questions:

- *How is it possible to ensure Aboriginal health coverage in public health programs where there are significant Aboriginal populations?*
- *Should all MPH programs have Aboriginal health content or should some key institutions specialise in Aboriginal health? If some institutions should specialise, is the current geographic spread adequate?*

Table (2) Distribution of Aboriginal Content & Aboriginal Enrolments within MPH Courses*

Geographic Area	Key Institution & Other Consortium Providers	N= subjects >30% Aboriginal Health Content	Aboriginal Enrolment (previous 5 years)	Aboriginal Completion (previous 5 years)
Northern Territory	**Menzies School of Health Research**	~ 9	4	2
Northern QLD	**James Cook University**	~ 7	12	5
Southern QLD	**University of Qld** Griffith University Qld University of Technology	3 1	5 2 1	5 0 1
NSW	University of Sydney University of NSW University of Newcastle (MClinEpi)	1	n/a n/a 4	n/a n/a 2
Victoria	Melbourne University Monash University/Burnet La Trobe University **Deakin University(IKE)**	1(4:2004) 1 >9	0 n/a 1 11	0 n/a 0 0(3:2004)
South Australia	Flinders University Adelaide University	1 1	3 2	1 2
Western Australia	University of WA Curtin University		1 n/a	1 n/a
ACT	NCEPH–ANU (MAppEpi)	1/3 of all overall instruction	28	13

Total: Aboriginal—Master of Public Health	42	17
Total: Aboriginal—Master of Applied Epidemiology	28	13
Total: Aboriginal—Master of Clinical Epidemiology	4	2

**as of September 2003*

Aboriginal Health Components of MPH Programs

Initially, this section examines designated 'Indigenous health' subjects offered within MPH courses nationally, followed by an examination of specific Aboriginal health sessions offered within other public health subjects.

Complete Aboriginal Health Subjects

The audit reviewed all subjects offered nationally within MPH programs under the banner 'Indigenous Health', and ten of the seventeen MPH programs offer at least one designated subject on Aboriginal health. These subjects came under the banner (or close equivalent) of:

- 'Indigenous Health—General' (8)
- 'Indigenous Health Policy' (3)
- 'Indigenous People and Alcohol and Drug Problems' (2)
- 'Aboriginal Mental Health'
- 'Nutrition of Aboriginal Peoples'.

This includes the Indigenous health stream within the Master of Applied Epidemiology at the Australian National University (ANU) that has a far narrower epidemiological focus than the MPH subjects. Of the subjects reported upon in detail, all covered the historical and socio-economic context and related Aboriginal policy issues and factors.

The following is of particular note:

- Some of these specific Aboriginal health subjects failed to include some key policies, reports and inquiries, including the National Aboriginal Health Strategy (NAHS 1989), the Royal Commission into Aboriginal Deaths in Custody (Johnstone 1991) or the Bringing Them Home Report (HREOC 1997).
- Some subjects indicated a lack of reference to an Aboriginal health paradigm and specific Aboriginal health initiatives, which are key components of Aboriginal self-determination in health.
- Other subjects disregarded discussion of Aboriginal access to services, a fundamental rationale for the establishment of Aboriginal Community Controlled Health Services.
- Other significant content omissions within particular subjects included reference to:
  - the diversity of Aboriginal Australians;
  - comparative health spending inequities;
  - Aboriginal healing practices;
  - health partnerships; and
  - related policy structures and findings by Aboriginal researchers.

Emergent Question:

- *What are the foundational understandings necessary for a public health professional working in Aboriginal health?*

Aboriginal Content within Generic Public Health Subjects[2]

The audit revealed that most PHERP-funded MPH programs offer at least one or two specific Aboriginal health sessions within their generic public health subjects. The four key MPH programs with Aboriginal health as a strategic goal, outlined above, offered a wide range of specific Aboriginal sessions within their generic public health subjects:

- Menzies School of Health Research, Darwin (8 subjects reported);
- James Cook University, Townsville (7 subjects reported); and
- Institute of Koorie Education, Geelong (7 subjects specific to the Aboriginal student cohort).

Thirty per cent or more of the reported formal face-to-face teaching hours were focused on Aboriginal content in most of the subjects offered by Menzies, JCU and IKE. All of these MPH programs have a strategic focus on Aboriginal health and can be seen as key institutions in Aboriginal public health curricula.

Of the forty-one MPH subjects within the national PHERP MPH program offering specific sessions devoted to Aboriginal health content, Menzies, JCU and IKE offered twenty-two of them. The University of Melbourne offered seven of the remaining nineteen subjects with specific Aboriginal health sessions. The remaining twelve subjects are spread across the remaining ten institutions. Apart from three subjects with between 10 and 20 per cent Aboriginal health content, the remainder contained under 10 per cent.

Embedded Aboriginal Topics, Case Studies, References and Examples

A number of programs reported coverage of Aboriginal health as topics, case studies, examples and references within other public health subjects without the allocation of specific sessions (or whole subjects) to Aboriginal health. Within the constraints of the audit, this content could not be reported in a systematic way. Likewise, in terms of distance education programs, the extent of Aboriginal health coverage was difficult to ascertain within the limitations of the audit tool.

Emergent Question

- *How are foundational understandings of Aboriginal health best transmitted? Is it through an Aboriginal specific subject, an elective, a core unit or as components of other core public health subjects?*

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[2] *Excluding the specifically designated Indigenous subjects*

Aboriginal Coverage across the Public Health Domain: National Program

Across the national Master of Public Health curriculum, specific Aboriginal health sessions are embedded within generic public health subjects as set out in Table 3 (allocated within areas and under sub-heading as per Table 1 for the purposes of comparison).

Table (3): Aboriginal Coverage across the Public Health Domain: National Program

***Disciplinary Foundations** • Foundations of Public Health • Health Ethics • Human Rights ***Public Health Research** • Health Research Methods • Epidemiology & Disease Control • Medical Anthropology & Sociology • Biostatistics ***Specific Health & Disease Problems Aetiology, Treatment & Prevention** • Maternal & Child Health • Environmental Health • Sexual & Reproductive Health → • **Alcohol & Drug Issues (2) →** • **Nutrition →** • **Mental Health** • Communicable Diseases • Chronic Diseases ***Specific Population Sectors** • **Aboriginal Health (6)** • **Indigenous Culture & Healing (2)** • Community Health • Rural & Remote Health • Women's Health	***Public Health Equity Mechanisms** • Nil ***Public Child Health** • Maternal & Child Health ***Public Health Regulation** • Nil ***Public Health Surveillance & Control** • Epidemiology & Disease Control ***Public Health Education & Promotion** • Health Promotion • Health Education & Communication • ←Alcohol and Drugs • ←Sexually Transmissible Infections • ←Diet and Nutrition ***Health Policy and Planning** • **Health Policy (3)** • Health Management • Health Economics

Table 3 (above) lists the **key components** of the domain of public health* (in capitals) with **specific Aboriginal health subjects** (in bold) and **generic subjects with Aboriginal health sessions** in plain text. *(from Table 1)

Table 3 provides a national curriculum overview of how Aboriginal health is contextualised within the public health domain given that Aboriginal public health will not necessarily share identical themes with public health. The MPH is a generalist training program and, as such, some key generic public health subjects requiring further considerations about potential Aboriginal content include the following.

Disciplinary Foundations of Aboriginal Public Health

The question of a whether Aboriginal health has a unique disciplinary foundation that requires articulation arises. It is clear that within the setting of Aboriginal public health there are particular historical, social, cultural, economic and political health determinants. Likewise, unique principles, values and assumptions come into consideration. Deeper examination of these factors may suggest a foundational Aboriginal public health subject.

Aboriginal Public Health Research

Unique guidelines for ethical research within Aboriginal settings are already well established (NHMRC 2003b). Nevertheless, the imperatives of an Aboriginal research agenda, and processes directed toward empowerment, healing and self-determination, extend these ethical guidelines into the realm of Aboriginal epistemologies and methodologies. This implies a unique set of knowledges and skills under the auspice of a designated Aboriginal public health research subject where public health practice embraces an Aboriginal research agenda.

Aboriginal Health Policy and Planning

Comprehensive primary health care approaches to policy development and planning advocate participation, empowerment, self-determination and partnership. The acknowledgment and serious consideration of Aboriginal standpoints, knowledges and perspectives, alongside the imperative of Aboriginal Community Control, may transform the political science of Aboriginal public health into a particular and somewhat unique set of understandings.

Aboriginal Health Promotion

It is widely acknowledged that population-based health promotion strategies have unequal impacts on different sectors of the population. Over many years Aboriginal practitioners and participants have created, refined and adapted particular health promotion models and practices with particular relevance to Aboriginal communities. This body of knowledge may constitute a unique set of systematic understandings that together constitute a unique Aboriginal health promotion practice.

Aboriginal Primary Health Care

When comprehensive primary health care intersects with an Aboriginal holistic concept of health, a range of underlying assumptions, values and principles, particular objectives and ways of working emerge. This impacts upon a whole range of public health practice, including research, surveillance and monitoring, needs assessment, policy development, regulatory frameworks, program design, implementation and evaluation. This unique set of understandings may constitute a distinctive knowledge set within public health.

Emergent Question

- *What are the key gaps in Aboriginal health coverage within the national MPH curriculum?*

Student Participation in Aboriginal Health Components

Within the audit process, program managers were asked their perceptions about features of their courses that attracted Aboriginal students and, likewise, non-Aboriginal students, to enrol in the Aboriginal health components on offer.

Aboriginal Participation

While the data are not definitive (see Table 2), it is apparent that of about forty-two Aboriginal MPH enrolments in the past five years, there were just seventeen Aboriginal MPH student graduations.[3] Table 4 sets out the factors which enhance and inhibit Aboriginal student participation (from the perspective of non-Aboriginal managers of mainstream programs). It is evident that an up-front, clear commitment to an engagement with Aboriginal health issues is seen as paramount. Evidence of a commitment to Aboriginal people and their health through a mission statement or strategic goal,[4] specific Aboriginal course and subject titles, employment of Aboriginal teaching staff, recognisably relevant teaching materials and provision of Aboriginal student support together send a signal that Aboriginal students are welcome. Flexible entry and course delivery, recognition of prior learning into an articulated program, and availability of scholarships and bursaries are also factors that encourage Aboriginal enrolments.

- Of note is the isolation experienced by students within distance courses unsupported by intensive blocks. Deakin's IKE program appears to be the only MPH course that recruits an Aboriginal student cohort into a learning environment that fully responds to the above needs.

Table (4) Factors Affecting Aboriginal Participation in MPH Programs

Participation Enhancers:

- Clear indication of specific Aboriginal health focus through subject titles or descriptions.
- Recognition of Prior Learning entry provisions (previous courses, work and professional experience).
- Scholarships and bursaries.
- Flexible programs, offerings and delivery including intensives for working students.
- Articulated program from graduate certificate to doctorate.
- Aboriginal teaching staff members.
- Culturally relevant teaching materials and teaching approaches.
- Aboriginal staffed Aboriginal student learning support (mentors, tutors, library).
- Generic coverage of *all* areas of public health (not only Aboriginal health).

Participation Barriers:

- No explicit commitment by university or school to Aboriginal participation.
- No identified Aboriginal health stream or no specific Aboriginal subject provided.
- Lack of Aboriginal student support available (or perception of this).
- No indication that there is experience and expertise in teaching Aboriginal students and/or Aboriginal staff involved in selected subject offerings within the MPH program.
- Lack of access to Abstudy.
- Financial barriers (graduates enrol in the MAE at ANU because of the stipend offered).
- Limited Vocational options—medicine appears to have more clearly defined career outcomes.
- Relative educational disadvantage—inability to meet levels of literacy and numeracy required.
- Distance education format and studying in isolation.

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[3] *In the same period, thirteen of twenty-eight Indigenous students completed the Master of Applied Epidemiology program at NCEPH–ANU and two of four Indigenous students completed the Master of Clinical Epidemiology at the University of Newcastle.*

[4] *Rasmussen (2001) suggests evidence of an institutional commitment to Reconciliation is also helpful.*

Non-Aboriginal Participation

Rasmussen (2001) identified particular structural factors, levels of student awareness and specific teaching and learning methods that operate as barriers and enhancers to the engagement of undergraduate medical students with Aboriginal health issues. The audit tool used here simply asked program managers for their overall perceptions of incentives and dis-incentives for MPH student participation in Aboriginal health program components. As can be seen in Table (5), for Aboriginal students, identifiable Aboriginal streams and subjects and an Aboriginal staff presence were also important for non-Aboriginal students.

Table (5) Factors Affecting non-Aboriginal Participation in MPH Programs

Participation Enhancers:

- Semi-intensive courses that suit part-time students.
- Aboriginal staff member.
- Specific Aboriginal health content available.
- Relevance to current or future work.
- Scholarships.

Participation Barriers:

- Limited elective choice.
- Students with previous Aboriginal work experience wish to explore other areas of public health.
- No identifiable Aboriginal health stream/specialisation.

Emergent Questions:

- *In terms of teaching and learning, what advantages do seminars, distance/online and intensive blocks have when compared with each other?*
- *How can innovative assessment play a role in strengthening Aboriginal health content?*
- *In what ways can substantial and meaningful contact with Aboriginal people be structured into teaching and learning experiences?*

Pedagogical Approaches

In terms of the presentation of Aboriginal content, the data show that only two of the fifteen 'Indigenous health' subjects lacked the involvement of an Aboriginal staff member. Within eight Aboriginal health subjects, at least half of the content was presented by Aboriginal academics. Including the ANU course, the data shows that only three of the eleven subjects included field visits. Nationally, MPH programs presented eight of the Aboriginal health subjects in intensive block mode, four were offered in lecture, tutorial or seminar format and two through distance modules. The major assessment components for almost all subjects were written reports or essays while four included a presentation or viva. Excluding the ANU program, and those offered in distance mode, the formal contact hours for face-to-face subjects ranged from four to fifty. Generally, residential intensive block teaching offered students greater face-to-face contact than seminar series.

Viability of Aboriginal Health Content

Undertaking the audit also provided the opportunity to gain feedback from MPH program managers about which factors enhanced and detracted from the viability of Aboriginal health content in their programs. Although one program reported good enrolments in the Aboriginal health components (offered as intensive block), another reported that course enrolments were low, threatening the viability of Aboriginal health components (offered as weekly seminars). A summary of results is set out in Tables 6 & 7.

Table (6) Factors Enhancing the Viability of Aboriginal Health MPH Components

1. University support for Aboriginal health issues and students.
2. Staff and school committed to principles of equity.
3. Presence of a Faculty-wide Aboriginal health unit and core Aboriginal health teaching staff.
4. Flexible program offerings to attract students working in rural and remote areas.
5. Aboriginal content within core MPH subjects.

1. University support for Aboriginal health issues and students.
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5. Aboriginal content within core MPH subjects.

Table (7) Factors Inhibiting the Viability of Aboriginal Health MPH Components

1. Limited funding to expand with funding dependent on special program grants.
2. Limited Aboriginal staff with academic background or experience.
3. Competing demands for other course content.
4. Limited staff development.
5. Electives that teach to the converted.

On the basis of the perceptions of MPH program managers, it appears that leadership both from the university central administration and from within the particular school offering the MPH course is vital. Leadership expressed through a commitment to Aboriginal staff recruitment and further professional development appears essential to the viability of programs. Likewise, the availability of flexible programs for on-the-job training for health professionals already engaged within Aboriginal public health appears also to be a factor in sustaining enrolments.

Emergent Questions:

- *How can courses in Aboriginal health be made attractive to non-Aboriginal public health practitioners?*
- *What strategies need to be employed*

Aboriginal Advice to MPH Courses

Of the seventeen MPH programs audited, thirteen elicited Aboriginal advice concerning the Aboriginal health content of their programs. This advice took four different forms. Three programs relied on a single Aboriginal staff member for input, four drew on the expertise of a cohort of Aboriginal staff, two MPH programs had an Aboriginal member on their course advisory committee or board of studies, and four programs (Flinders University, JCU, ANU and the IKE) had an Aboriginal advisory committee guiding the inclusion of Aboriginal health content. While institutions teaching Aboriginal content employ several consultative mechanisms, it appears there is a range of perceptions about the necessity of consultation. How Aboriginal program advice is structured and supported may be an issue that requires further consideration.

A significant issue in this context is the location of the courses and potential partnerships with local Aboriginal people. The diversity of Aboriginal Australians and the necessity to work at the local level has been highlighted in the report. Rasmussen (2001) suggests input of a range of local voices to 'de-exoticise teaching' in Aboriginal health and enable students to develop meaningful relationships with Aboriginal people.

Emergent Question:

- *How can Aboriginal advice to MPH programs be structured appropriately?*

Staff Development in Aboriginal health

Almost half the MPH programs reported no professional development activities directed specifically towards enhancing the skills and knowledge of staff in the area of Aboriginal health (8 of 17). Two of the programs provided staff with specific Aboriginal health content while one program offered staff generic cross-cultural awareness training. Of the other programs, three suggested their staff have significant prior experience in the field and therefore need no training, and the other three advised that staff development was an informal learning process derived from day-to-day engagement with Aboriginal staff.

According to the NPHP guidelines on public health strategies in relation to Aboriginal people, '… the values and culture of public health professionals is a key factor in their provision of services' (NPHP 2002). Given the range of offerings within MPH programs by a highly diverse group of public health academics, it seems necessary to ensure that staff development is in place to enable some considered reflection concerning Aboriginal public health practice to ensure staff are abreast of contemporary developments. Emphasis within MPH programs on an ethical foundation for Aboriginal public health practice could also link to staff orientation programs.

Emergent Questions:

- *Is there a need for cross-cultural staff awareness training?*
- *What form should it take?*

NATIONAL INDIGENOUS PUBLIC HEALTH CURRICULUM WORKSHOP: AGENDA

The National Indigenous Public Health Curriculum Audit raised key issues concerning the education and training of future public health professionals, including:

- concerns about the geographic distribution of MPH programs with significant Aboriginal content;
- foundational content within Aboriginal public health;
- gaps in the teaching of Aboriginal public health;
- effective pedagogical methods; and
- Aboriginal advice to programs and staff development in the area of Aboriginal health.

The following questions, emerging from the audit, related to the issues and gaps and constituted an agenda for the *National Aboriginal Public Health Curriculum Workshop*:

Distribution

- What are the gaps in Aboriginal health coverage within the national MPH curriculum?
- How is it possible to ensure adequate Aboriginal health coverage in public health programs?
- Should all MPH programs have Aboriginal health content or should some key institutions specialise in Aboriginal health?
- If some institutions should specialise, is the current geographic spread adequate?

Content

- What are the foundational understandings necessary for a public health professional working in Aboriginal health?

Pedagogy

- How are these foundational understandings best transmitted? Is it through an Aboriginal specific subject, an elective, a core subject or as components of other public health subjects?
- What advantages do seminars, distance/online and intensive blocks have compared with each other?
- How can innovative assessment play a role in strengthening Aboriginal health content?
- How can substantial and meaningful contact with Aboriginal people be structured into teaching and learning processes?

Recruitment

- How can courses in Aboriginal health be made attractive to non-Aboriginal public health practitioners? What strategies need to be employed?

Aboriginal Input

- How can Aboriginal advice to MPH programs be structured appropriately?

Staff Development

- Is there a need for Aboriginal and cross-cultural staff awareness training? What form should it take?

NATIONAL INDIGENOUS PUBLIC HEALTH CURRICULUM WORKSHOP: FINDINGS

The national workshop was held in Brisbane on 27 September 2003. Twenty-five participants from all States discussed the audit outcomes presenting the views of the Aboriginal health workforce, Aboriginal Community Controlled Health Organisations and tertiary MPH programs (see Appendix 4). Discussion points around each of the key issues raised by the audit findings are presented below.

1. Geographic Gaps in Aboriginal Health Coverage within the National PHERP Program

The national audit identified significant coverage of Aboriginal health within mainstream MPH programs in Darwin, Townsville and Brisbane. Nevertheless, large numbers of the Aboriginal population live in cities—for example, Perth, Sydney, Adelaide and Melbourne—suggesting the need for greater Aboriginal health content within MPH courses in these locations.

Recommendation:

All MPH programs require Aboriginal content within compulsory subjects.

- To ensure wide exposure to Aboriginal health issues and raise awareness of the present Aboriginal health situation.
- To improve the knowledge and skills of the Aboriginal population health workforce.
- To further social justice, human rights and reconciliation goals as a specific strategy to overcome inequitable treatment of Aboriginal people.
- To provide local exemplars for teaching generic public health skills. Aboriginal examples can demonstrate the utility of the need within public health practice for:
  - more than just the medical paradigm;
  - a high-level awareness of cultural diversity;
  - a greater understanding of poverty and health; and
  - an appreciation of social and economic determinants of health.

Recognition of the many programs and approaches within Aboriginal health that are at the cutting edge of public health practice could also be facilitated. A key gap in Aboriginal health content within MPH programs is *how* and *why* Aboriginal health is the way it is.

Recommendation:

Ensure Aboriginal coverage in all MPH programs.

Proposed strategies to increase MPH staff knowledge of Aboriginal health

- Educate about the history of colonisation, history of public health education and the absence of an Aboriginal focus.
- Build capacity in self-reflexive practice.
- Value Aboriginal knowledge bases and respect what Aboriginal people already know about public health.
- Develop partnerships and networks with Aboriginal communities by asking them what they want, sharing this knowledge and encouraging two-way learning and knowledge transfer by:
  - including training for Aboriginal presenters;

- integrating local Aboriginal input into MPH curriculum development;
- developing local guidelines on how to consult the local Aboriginal community following the development of Aboriginal Terms of Reference; and
- finding out how to attract, retain and support Aboriginal students (including the need for Aboriginal academic units).

Proposed strategies to expand knowledge base re pedagogy and content

- Undertake an evidence-based review of how Aboriginal health is best taught and incorporated within MPH programs across Australia.
- Investigate MPH student knowledge and experience of Aboriginal health and gather feedback on how to better effect its presentation, especially that of knowledge of Aboriginal students.
- Study international data on MPH programs and the inclusion of Aboriginal health content.
- Investigate the professional development needs of employers including public health units, ACCHOs, Departments of Public Health, State and Federal offices of Aboriginal and Torres Strait Islander Health, Aboriginal and Torres Strait Islander Health Worker training organisations.

Proposed use of policy instruments

- Advocacy is required from NACCHO and its State affiliates, OATSIHS and State-based offices of Aboriginal and Torres Strait Islander Health directed towards universities and the PHERP secretariat.
- Funding policies need review of incentives for inclusion of Aboriginal content and of disincentives for its exclusion.

2. Minimum Foundational Aboriginal Health Content for all MPH students

The recommendation that all MPH programs require Aboriginal content within compulsory subjects, workshop identified foundational Aboriginal health content required by all MPH students.

Recommendation:
Key Foundational Content

i. Aboriginal health concepts

• Aboriginal health models	• Spiritual and emotional wellbeing	• Holism (also relevant to clinical practice)
• Community	• Community control	• Community development
• Equity	• Cultural security	• Federalism
• Self-determination	• Social justice	• Social capital
• Identity	• Social exclusion	• Stereotypes

ii. Aboriginal history

- Aboriginal social, cultural and political histories;
- links between present circumstances and the past; and
- trans-generational effects.

iii. Working with Aboriginal people

- communication style;
- knowing 'your place' as a non-Aboriginal person;
- relationships;
- the standing of knowledge and evidence;
- historical, physical, philosophical and cultural barriers to access;
- protocols of interaction with Aboriginal services and people;
- acknowledging differences between cultural values; and
- understanding and acceptance of the importance of oral culture, education and community within academic knowledge.

There was general recognition that insights gained from public health practice within an Aboriginal context are applicable to most aspects of public health. Aboriginal ways, practices and knowledge can work universally to enhance public health generally.

Recommendation:

Specific Aboriginal Content of Core MPH subjects

The foundational content, outlined above, should be embedded within core subjects and is locally relevant. *All* MPH programs should equip students to understand core issues in Aboriginal health and their broader relevance to work with marginalised groups.

Foundations of Public Health

- principles and practices of public health; and
- foundations of Aboriginal health to address colonisation, social determinant of health, Aboriginal Community Control and political economy (including the Aboriginal struggle for health and related infrastructure).

Health Policy & Planning

- policy development process;
- strategies of influence;
- strategies supporting wellness;
- holistic approaches rather than vertical policy and strategy;
- political activism skills;
- conflict resolution skills; and
- Aboriginal participatory decision making in the policy process and policy cycles National Aboriginal Health Strategy.

Health Economics

- reality of expenditure in Aboriginal health;
- debunking myths surrounding Aboriginal health spending; and
- links to justice and rights.

Sociology of Health and Illness
- increased understanding of social impact in public health;
- emphasis on the social in public health;
- identify humanitarian values underlying public health; and
- social theory including systems theory.

Epidemiology
- emphasis on social epidemiology covering; and
- inequality and socio-economic determinants.

Public Health Research
- recognition of Aboriginal knowledge and ways of knowing.

Comprehensive Primary Health Care
- recommendation that this be a core public health subject.

Environmental health
- exemplars from Aboriginal Practice Contexts.

3. Pedagogical Strategies for Foundational 'Content'

Participants unanimously endorsed the Community-Based MPH program tailored for Aboriginal cohorts at the Institute of Koorie Education, Deakin University. In particular, they endorsed the applied nature of the learning and its relevance to Aboriginal community health practitioners evidenced by an *80 per cent retention rate* together with its potential to double the national number of Aboriginal MPH graduates in two years.

Recommendation:
Aboriginal Student Cohorts

- Teaching strategies should address differences between learning styles of Aboriginal and non-Aboriginal students.
- A combination of flexible delivery with on and off campus and intensive residential blocks works well. These need to be backed up by telephone tutorials, on-line teaching and paper-based study resources.
- Community Based Delivery allows students to live and work in their communities while studying.
- The need for careful definition of entry standards to take into account lived experience.
- Assessment requirements to incorporate options of oral or written tasks.
- Consideration of place, pace, materials and assessment to ensure flexibility of program delivery.
- Both a core Aboriginal health subject and Aboriginal health as a component of all other MPH units.
- Require:
  - mainstream program content;
  - intensive face-to-face + on-line + open accessible support;
  - applying theory to practice back in the workplace;
  - involvement of ACCHOs;
  - content transmitted via different mediums such as guest speakers' video, role play, case studies;
  - maintenance of cultural identity through listening to students and showing respect for student and community ownership of the teaching space; and
  - respect/listening/safety.

A key issue emergent from the workshop was the need for on-going financial support for Community Based Delivery of MPH programs tailored for Aboriginal cohorts. This teaching approach is resource intensive and requires funding to be structured in to support the ongoing model.

Recommendation:
Aboriginal Students within a Mainstream MPH Cohort

- Be sensitive to student's background, community issues and the context of their personal learning environment.
- Be sensitive to Aboriginal students often being put on the spot to be the 'Aboriginal expert'.
- Consider mentoring strategies—social/community as well as academic.
- Consider gaining an introduction to the local community and elders.
- Consider the need for more flexibility and understanding that family and community comes before study.
- Consider ways of valuing Aboriginal narratives and knowledge systems.

Recommendation:
Non-Aboriginal Teaching and Learning Strategies

- Team-teaching with Aboriginal and non-Aboriginal presenters following a training component for each.
- Relationships with, and involvement of, ACCHOs.
- Well-managed field placements that resource ACCHOs.
- Students undertaking projects based on the community's agenda.
- RPL and training of field placement supervisors in academic supervision.
- Need to identify specific ACCHOs that will take on supervisory role.

4. Forward Action on Strategies

I. Develop a working group within the PHAA of public health professionals involved in Aboriginal public health education to carry through the workforce and education strategies recommended by the workshop.

II. Using the PHERP Innovations Project Co-ordinators, develop pilot strategies to include Aboriginal health content within core curricula in Victoria and disseminate to other states.

CONCLUSION

Over the past decade, national strategy in Aboriginal and Torres Strait Islander health has increasingly focused on health system reform. A key strategy within this broader context has been the development of the capacity of the health workforce to respond effectively to the health needs of Aboriginal and Torres Strait Islander Australians.

In this context, partnerships between Australian Federal and State governments and the National Aboriginal Community Controlled Health Organisation and its State affiliates, within a coherent national strategic policy framework, offers hope of greater progress to redress current health disparities. A central component of this strategic policy framework is building the capacity of the Aboriginal health workforce and, specifically, the public health workforce. In order to develop appropriate and effective education and training curricula in Aboriginal public health, an audit and national discussion of Aboriginal public health education and training was required.

The results of the audit and national workshop show a strategic focus on mainstream delivery of Aboriginal public health education only within Queensland and the Northern Territory. Recent surveys indicating that 30 per cent of the Aboriginal population lives in cities and 30 per cent in large rural towns signal that most public health professionals will work with populations that include Aboriginal Australians. Hence, the national workshop recommendation that Aboriginal health be included in all MPH core subjects.

The existing content of MPH subjects concerning Aboriginal health suggest minimal emphasis within curricula to the application of social science theory and cultural analysis to knowledge concerning the genesis and maintenance of Aboriginal health disadvantage. Most focus upon only broad generic content, specific risk factors (e.g. alcohol) or specific diseases (e.g. mental health). The disparities of power that operate in most Aboriginal health settings point to a need for public health practitioners to have powerful tools of analysis to illuminate the persistence of colonialism in policy and practice and, crucially, to have a keen understanding of the role of an ethical and self-reflexive public health practitioner.

A strategic focus on the education and training of Aboriginal students in public health theory and practice is confined to the Institute of Koorie Education at Deakin University in Geelong (although Aboriginal students nationally can access the program). As indicated previously, education of Aboriginal public health practitioners is a critical component of capacity building in Aboriginal public health for two reasons: first, a significant proportion of Aboriginal health trainees will work within their own community; and, second, projects to reorient the health system to work more effectively for Aboriginal people require the presence, in a systematic way, of Aboriginal health professionals as a reforming influence with their peers. Therefore, it is important that the professional training of Aboriginal practitioners also fosters empowerment and the capacity to engage with health system reform. Consequently, it is crucial that the IKE program and other MPH programs tailored specifically for Aboriginal cohorts are sustainable and, therefore, adequately resourced.

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APPENDICES

Appendix 1: Program Responses—All Institutions

- **UNIVERSITY OF ADELAIDE**

Accredited Program: Master of Public Health

Indigenous Health: Prescribed formal contact hours—nil reported (MPH is geared towards health policy, epidemiology and research methods and not towards a community health or primary care model).

Specific Indigenous Health Subject/s Offered:
Title: Aboriginal Health Policy
Formal Contact Hours: 38 (by an Aboriginal presenter)
Aims:
1. To analyse current public policy affecting the health of Aboriginals.
2. To reflect critically on the issues and dilemmas which constitute particular challenges to the development of policy which will advance the health of Aboriginals.
3. To increase their knowledge about a range of Aboriginal health programs and organizations.
4. To reflect on those personal, professional and community fears, prejudices and perceptions which may act as barriers to improving the health status of Aboriginals.

Other Subjects with Specific Indigenous Health Sessions:
Title: Rural Health Intensive
Formal Contact Hours (Indigenous Health): 5 (joint Ind/non-Ind presentation—including site visit to Aboriginal Health Service)

Title: Qualitative Research in Practice
Formal Contact Hours (Indigenous Health): 2

Indigenous Enrolments Previous 5 years: 2
Indigenous Completions Previous 5 years: 2

Indigenous Advice Available: One Indigenous staff member on Board of Studies

Incentives/Disincentives for Indigenous Enrolments:
+ve—semi-intensive course which often suits part-time students; Indigenous Australian staff member;
-ve—nil reported

Incentives/Disincentives for non-Indigenous Enrolments:
+ve—semi-intensive course which often suits part-time students; Indigenous Australian staff member;
-ve—nil reported

Staff Development in Indigenous Health:
Informal through appointment of Indigenous staff member

Evaluation Outcomes re Indigenous Health Content:
Student evaluation consistently indicates that students value learning about issues and dilemmas in Aboriginal Health Policy, that they feel more confident about what they might contribute to the area and about what are appropriate roles for non-Indigenous people through:

- being confronted with many different perspectives;
- learning from a range of people in a range of settings, some of them very different from what is usually offered in academia;
- visiting organisations and seeing 'policy in action';
- being exposed to good news stories and effective models of working and partnership;
- having the opportunity to discuss issues—often confronting and difficult—with presenters and fellow students, in an environment in which all views are respected and given space;
- being exposed—via non-Indigenous scholarship and Indigenous life stories—to the history of the impact of non-Indigenous policies on Indigenous health; and
- being required to complete a demanding course of carefully selected reading.

Some students regularly report that the course has strengthened their commitment to Aboriginal people and to working in the area of Aboriginal health.

Factors Enhancing or Detracting from the Viability of Substantial Indigenous Australian Health Content:
There are plenty of enrolments by non-Indigenous students so the program (and the particular Indigenous health course within it) we offer is quite viable.

• FLINDERS UNIVERSITY

Accredited Program: Master of Primary Health Care

Indigenous Health: Prescribed formal contact hours: on-line distance program

Specific Indigenous Health Subject/s Offered:
Title: Issues in Aboriginal Mental Health
Formal Contact Hours: online distance program
Aims: Understanding of social and emotional wellbeing issues of Indigenous Australians; pre-contact histories; past and present social experiences; struggles of Indigenous Australians to gain equity.

Other Subjects with Specific Indigenous Health Sessions:
Title: Context of Remote Health (& others at the DRH, Alice Springs)
Formal Contact Hours (Indigenous Health): 40 (joint Indigenous / non-Indigenous presentation)

Title: Community organisation for health
Formal Contact Hours (Indigenous Health): 4 hours (internal class)

Specific Program Aims re Indigenous Health:
The program's vision statement includes a specific focus on and critical examination of social and cultural determinants of health, and a commitment to reduce health inequities.

Indigenous Enrolments Previous 5 years: 3
Indigenous Completions Previous 5 years: 1

Indigenous Advice Available:
The Indigenous Health Professional Education Advisory Committee comprising a number of Indigenous community organisations, e.g. Health Council of SA, OATSIHS (SA) & ATSIC. Until last year in this department we had a member of staff from an Indigenous Australian background. Flinders University has a formal agreement with the Aboriginal Health Council of SA and this will enhance the ability of the Department to include Indigenous content in topics.

Incentives/Disincentives for Indigenous Enrolments:
+ve—specific Indigenous health content available: determinants re inequities; mental health; alcohol & drug issues.
-ve—nil

Incentives/Disincentives for non-Indigenous Enrolments:
+ve—specific Indigenous health content available: determinants re inequities; mental health; alcohol & drug issues.
-ve—nil

Staff Development in Indigenous Health:
From 1999 to 2001 we undertook a project funded by the CUTSD program to develop a program to increase Faculty of Health Sciences staff including MPHC staff awareness of Indigenous cultural issues. The project 'Kokotina' is now available to staff at: www.flinders.edu.au/kokatinna

Evaluation Outcomes re Indigenous Health Content: nil

Factors Enhancing or Detracting from the Viability of Substantial Indigenous Australian Health Content:

Enhancing
1. Staff and department committed to principles of equity.
2. University support for Indigenous health issues and students (Yugerrendi).
3. Good feedback from students undertaking topic devoted to Indigenous health issues.
4. Staff from DPH are involved in the CRC Aboriginal Health. The Head of Department is a theme leader for the CRCAH.
5. The formal agreement with the Aboriginal Health Council of SA.

Detracting
1. Limited staff with Indigenous background/experience.
2. Funding to expand academic offerings in Indigenous Australian health content.
3. Assistance with some aspects of public health issues related to Indigenous health.

• MENZIES SCHOOL OF HEALTH RESEARCH

Accredited Program: Master of Public Health

Indigenous Health: Prescribed formal contact hours: ~ 50

Specific Indigenous Health Subject/s Offered:
Title: Alcohol and other Drug Issues among Indigenous Australians
Formal Contact Hours (Indigenous Health): 4

Title: Nutrition in Aboriginal and Torres Strait Islander People
Formal Contact Hours (Indigenous Health): ~ 4

Title: Indigenous Society in North Australia
Formal Contact Hours (Indigenous Health):

Title: Tradition Law and Healing among Aboriginal Peoples of North Australia
Formal Contact Hours (Indigenous Health):

Other Subjects with Specific Indigenous Health Sessions:
Title: Applied Public Health Skills
Formal Contact Hours (Indigenous Health): 6

Title: Epidemiology and Control of Communicable Diseases
Formal Contact Hours (Indigenous Health): 4

Title: Introduction to Public Health
Formal Contact Hours (Indigenous Health): 5

Title: Approaches to Problems in Public Health
Formal Contact Hours (Indigenous Health): 6

Title: Introduction to Health Information and Health Research
Formal Contact Hours (Indigenous Health): 2

Title: Qualitative Research Methods
Formal Contact Hours (Indigenous Health): 3

Title: Sociology and Health
Formal Contact Hours (Indigenous Health): 6

Title: Prevention and Control of Non-Communicable Diseases
Formal Contact Hours (Indigenous Health): 3

Specific Program Aims re Indigenous Health:
'MSHR is committed to improving the health of people of Northern and Central Australia and regions to our near north, through multidisciplinary research and education' (MSHR Mission Statement). 'The program has evolved substantially since its inception (in 1994) and aims to provide education and training in public health that is broadly based, multidisciplinary and inclusive. The coursework program is focused on Indigenous, remote and tropical public health. The program addresses the major public health challenges in Northern and Central Australia and neighbouring regions. These include poverty, poor environmental conditions, infectious diseases, lifestyle related non-communicable disease and access to and acceptability of services' (MSHR Student Handbook 2003).

Indigenous Enrolments Previous 5 years: 4
Indigenous Completions Previous 5 years: 2

Indigenous Advice Available:
A strong working arrangement with the CRCAH. Its Indigenous education and training coordinator has served on our coursework advisory committee. The committee is currently being reconfigured to increase Indigenous input into the course.

Incentives/Disincentives for Indigenous Enrolments:

+ve
(i) Fully articulated nature of our program (from Grad Cert to Prof Doc).
(ii) Acknowledgment of prior learning rather than solely qualifications for entry.

-ve
(i) Level of support to Indigenous students is restricted.
(ii) The distance education issue and studying in isolation.
(iii) Geared towards non-indigenous students. The levels of literacy and numeracy required are barriers due to relative educational disadvantage.

Incentives/Disincentives for non-Indigenous Enrolments:
+ve—many students specifically choose Indigenous health subjects because of the work they are involved in at enrolment or hope to work in the future.
-ve—emphasis on Indigenous, remote and tropical issues.

Staff Development in Indigenous Health:
Staff are public health practitioners who have long experience working in Indigenous health and/or education about Indigenous issues. No training available about Indigenous learning styles.

Evaluation Outcomes re Indigenous Health Content:
The coursework program was re-accredited with the Northern Territory University in 2002 without any problems. The course has not been formally externally evaluated.

Factors Affecting Viability of Substantial Indigenous Australian Health Content:
The coursework program received a round 1 innovations grant in 2001 which will finish at the end of this year. The number of enrolments (and from this semester, the number of completions) have more than doubled during the three years. The funding will not be renewed, and the future viability of the course is in doubt. We are actively seeking alternative funding.

- **JAMES COOK UNIVERSITY**

Accredited Program: Master of Public Health

Indigenous Health: Prescribed formal contact hours: none reported in core subjects

Specific Indigenous Health Subject/s Offered:
Title: Aboriginal & Torres Strait Islander Health
Formal Contact Hours: 50
Aims:
1. understand current Indigenous health standards in historical, cultural and political context;
2. knowledge of health and demographic status and trends, including risk factors;
3. compare health status with general population and other Indigenous groups;
4. knowledge of the history, organisation and influences on Indigenous health policy, financing and service provision;
5. critically self-examine personal role in cross-cultural community work;
6. knowledge of issues relating to health promotion and service provision; and
7. familiarity with models of best practice in Indigenous health care.

Other Subjects with Specific Indigenous Health Sessions:
Title: Health Promotion
Formal Contact Hours (Indigenous Health): ~ 15

Title: Rural and Remote Public Health
Formal Contact Hours (Indigenous Health): ~ 20

Title: Managing Effective Health Programs
Formal Contact Hours (Indigenous Health): ~ 5

Title: Training Primary Health Care Workers
Formal Contact Hours (Indigenous Health): ~ 15

Title: Rural and Remote Environmental Health
Formal Contact Hours (Indigenous Health): ~ 15

Title: Maternal Health for Indigenous Health Workers
Formal Contact Hours (Indigenous Health): ~ 25

Title: Public Health Aspects of Chronic Diseases
Formal Contact Hours (Indigenous Health): ~ 15

Specific Program Aims re Indigenous Health: Indigenous health is part of School Mission Statement.

Indigenous Enrolments Previous 5 years: 12
Indigenous Completions Previous 5 years: 5

Indigenous Advice Available:
A faculty-wide indigenous health unit. The School Indigenous health advisory committee.

Incentives/Disincentives for Indigenous Enrolments:
+ve—Flexible programs, offerings and delivery;
-ve—Loss of Abstudy

Incentives/Disincentives for non-Indigenous Enrolments: none identified

Staff Development in Indigenous Health: no programs available

Evaluation Outcomes re Indigenous Health Content: No evaluation of this content specifically done, however general content has been viewed very favourably

Factors Affecting Viability of Substantial Indigenous Australian Health Content:
+ve—Presence of a faculty wide indigenous health unit and core indigenous health teaching staff

• UNIVERSITY OF QUEENSLAND

Accredited Program: Master of Public Health (Indigenous Health)

Indigenous Health: Prescribed formal contact hours: 45

Specific Indigenous Health Subject/s Offered:

Title: Issues in Aboriginal and Torres Strait Islander Health
Formal Contact Hours: 26 (30% Indigenous presenter)
Aims: 1. provide an overview of the current social, cultural, political and environmental issues contributing to the health and well being of ATSI people;

2. exploring ideas of health from both an Indigenous cultural perspective and a population health perspective; and

3. policy and program responses to these issues.

Title: Aboriginal Health Policy
Formal Contact Hours: 26 (100% Indigenous presenter)
Aims: 1. to provide an understanding of the process of policy development in Indigenous Health, and to explore policy responses to key health issues in the Indigenous community, and models of implementation.

Title: Indigenous People and Alcohol and Drug Problems
Formal Contact Hours: distance learning module
Aims: 1. introduce non-indigenous health professionals to an indigenous perspective on alcohol and drug problems; and

2. improve capacity of non-indigenous people in supporting culturally appropriate approaches to alcohol and drug problems among Indigenous peoples.

Other Subjects with Specific Indigenous Health Sessions: nil recorded

Specific Program Aims re Indigenous Health: MPH (Indigenous Health) aims to provide an understanding of health and illness in Indigenous Australia, and develop the capacity to plan and manage effective public health solutions through improved service delivery.

Indigenous Enrolments Previous 5 years: 2 (Generic MPH 3)
Indigenous Completions Previous 5 years: 2 (Generic MPH 3)
Indigenous Advice Available: Three Indigenous staff members

Incentives/Disincentives for Indigenous Enrolments

+ve—Many Indigenous students already have a population health perspective. MPH is a recognized qualification that does not limit students to Indigenous health alone.
-ve—Financial disincentives: 5 graduates of our BAppHSc(IPHC) have enrolled in the MAE because of the stipend offered by ANU. Vocational options: several grads of BAppHSc(IPHC) enrolled in MBBS courses, as medicine appears to have more clearly defined career outcomes

Incentives/Disincentives for non-Indigenous Enrolments
-ve—Limited elective choice in MPH Program. Students entering MPH course with experience in Indigenous health are often ready for a transition out into other areas, and may feel that they have acquired enough knowledge from previous work experience.

Staff Development in Indigenous Health:
Current staff engaged in teaching Indigenous health have extensive experience; informal exchanges around teaching are the most appropriate strategies at present. New staff are given an induction process to orientate them towards Indigenous learning styles

Evaluation Outcomes re Indigenous Health Content:
Internally reviewed and found to be 'the best program of its kind in Australia'.

Factors Affecting Viability of Substantial Indigenous Australian Health Content:
Course enrolments are low, threatening viability of courses.

• QUEENSLAND UNIVERSITY OF TECHNOLOGY

Accredited Program: Master of Public Health

Indigenous Health: Prescribed formal contact hours: nil

Specific Indigenous Health Subject/s Offered: nil reported

Other Subjects with Specific Indigenous Health Sessions:

Title: Intervention Design and Theories of Change
Formal Contact Hours (Indigenous Health): 3 (Indigenous presenter)

Title: Concepts and Settings for Health Promotion
Formal Contact Hours (Indigenous Health): 2 (Indigenous presenter)

Title: Health Promotion Strategies and Evaluation
Formal Contact Hours (Indigenous Health): 2 (Indigenous presenter)

Specific program aims re Indigenous Health:
Within the MPH a focus on social/cultural knowledge is emphasised and a core unit on Social and Behavioural Determinants of Health is undertaken

Indigenous Enrolments Previous 5 years: 1
Indigenous Completions Previous 5 years: 1

Indigenous Advice Available:
A dedicated Indigenous Health Lecturer whose role is to oversight Faculty of Health curricula, teach across a number of courses. Indigenous support unit has dedicated academic advisers.

Incentives/Disincentives for Indigenous Enrolments
+ve—support through the enrolled programs
-ve—none

Incentives/Disincentives for non-Indigenous Enrolments
+ve—content on Indigenous health research and issues addressed across specific subjects
-ve—nil reported

Staff Development in Indigenous Health:
Indigenous academic consults widely with staff about both Indigenous health and learning styles and does the majority of content lecturing.

Evaluation Outcomes re Indigenous Health Content:
Currently undertaking an assessment of its total post-graduate package with respect to Indigenous content across postgraduate.

Factors Enhancing or Detracting from the Viability of Substantial Indigenous Australian Health Content:
Enhancing factors are: dedicated Indigenous lecturing staff.
Detracting: possibly staff development.

- **GRIFFITH UNIVERSITY**

Accredited Program: Master of Public Health

Indigenous Health: Prescribed formal contact hours: in process

Specific Indigenous Health Subject/s Offered:

Title: International Indigenous Health
Formal Contact Hours: 26 (50% Indigenous presenter)

Aims:
1. Describe the changing nature of Indigenous living conditions and ways of life within Australia;
2. discuss the impact of Western society on the social, spiritual, physical and emotional well being of Indigenous peoples of Australia;
3. discuss the basis for further study of cultural contact, race relations and health issues relating to Indigenous peoples Australia;
4. discuss Indigenous health from an historical perspective to highlight the interaction between health, well being, economic sustainability, cultural preservation and community development for Indigenous Australians;
5. discuss Indigenous health and Western medical practices, focus attention upon the interaction between health, health care professionals and para-professionals and Indigenous health care practices in Australia; and
6. discuss cultural safety as a strategy for non Indigenous professionals working in collaboration with Indigenous people.

Other Subjects with Specific Indigenous Health Sessions:
Title: Community Health & Disease
Formal Contact Hours (Indigenous Health): 2 (Indigenous presenter)

Specific program aims re Indigenous Health: nil

Indigenous Enrolments Previous 5 years: 2
Indigenous Completions Previous 5 years: 0

Indigenous Advice Available:
School of Public Health collaborates with the Griffith University Murri and Torres Strait Islander Centre (Gumurri), which also provide Indigenous teaching expertise.

Incentives/Disincentives for Indigenous Enrolments: nil reported

Incentives/Disincentives for non-Indigenous Enrolments
+ve—attracts people with an interest in Indigenous Health

Staff Development in Indigenous Health:
SPH has run several staff development workshops (2 X 6 hrs) aimed at developing staff skills at working with students from different cultural backgrounds. Both workshops had an Indigenous input from Gumurri staff.

Evaluation Outcomes re Indigenous Health Content:
Students have appreciated the contact with Indigenous lecturers who presented the lectures often in an informal and communicative style this contact helped student better understand issues such as colonial impact on health and impact of racism on health as a ongoing life experience of many indigenous people.

Factors Enhancing or Detracting from the Viability of Substantial Indigenous Australian Health Content:
Courses are elective and we tend to teach the converted, the school is working toward making courses core within the program this would place people who are non interested and yet in constant contact with Indigenous people as clients and co workers.

- **UNIVERSITY OF NEWCASTLE**

Accredited Program: Master of Medical Science (Clinical Epidemiology)

Indigenous Health: Prescribed formal contact hours: nil

Specific Indigenous Health Subject/s Offered: nil reported

Other Subjects with Specific Indigenous Health Sessions: nil

Specific program aims re Indigenous Health: Courses are technique, methods oriented, and we do not have a specific course dealing with indigenous health among our postgraduate offerings.

Indigenous Enrolments Previous 5 years: 11 (p/grad enrolments)

Indigenous Completions Previous 5 years: 9 (incl. p/grad Dip. & Masters)

Indigenous Advice Available:
An Indigenous staff member employed by the faculty is available.

Incentives/Disincentives for Indigenous Enrolments: nil reported

Incentives/Disincentives for non-Indigenous Enrolments: nil reported

Staff Development in Indigenous Health: nil reported

Evaluation Outcomes re Indigenous Health Content: nil reported

Factors Affecting Viability of Substantial Indigenous Australian Health Content: nil reported

- **UNIVERSITY OF SYDNEY**

Accredited Program: Master of Public Health

Indigenous Health: Prescribed formal contact hours: nil; support for inclusion in 2004

Specific Indigenous Health Subject/s Offered:
Title: Aboriginal Health
Formal Contact Hours: 14

Other Subjects with Specific Indigenous Health Sessions:
Title: Environmental Health
Formal Contact Hours (Indigenous Health): 0.5

Title: Alcohol and Drug Issues and Health
Formal Contact Hours (Indigenous Health): 2

Specific Program Aims re Indigenous Health: nil (incl. in new draft strategic plan)

Indigenous Enrolments Previous 5 years: n/a
Indigenous Completions Previous 5 years: n/a

Indigenous Advice Available: Two Indigenous academics within the School one of whom designed MPH Indigenous health curriculum components and specific Aboriginal Health subject

Incentives/Disincentives for Indigenous Enrolments:
+ve—Indigenous staff members; scholarships and bursaries available; Koorie Centre offers culturally supportive environment; library; tutorial support.
-ve—no explicit commitment by university or school to Indigenous participation or reconciliation; little promotion of Indigenous student support available

Incentives/Disincentives for non-Indigenous Enrolments: none reported

Staff Development in Indigenous Health: The most effective means of developing staff's capacity in Indigenous Australian health or Indigenous learning styles has been viewed as working with Indigenous colleagues. There has

been limited formal staff development aimed at non-Indigenous staff – and no policy to guide or point to the need to expand or adapt curricula or teaching/learning styles.

Evaluation Outcomes re Indigenous Health Content: none reported

Factors Affecting Viability of Substantial Indigenous Australian Health Content:
Indigenous staff appointments; Commitment within Strategic Plan to:

- Incentives and strategies to recruit Aboriginal and Torres Strait Islander students;
- Curriculum development and curriculum adaptation within existing programs to include both new Indigenous content and perspectives and to adapt existing courses to encompass Indigenous-specific content and perspectives;
- Incentives and strategies to support and further the career development of current Indigenous academic and administrative staff;
- Incentives and strategies to support recruitment of more Indigenous academic staff;
- Demand from graduates and current students in the Graduate Diploma in Indigenous Health Promotion for an Indigenous-specific Masters program;
- Appointment of a new Pro Vice Chancellor who is committed to developing the College of Health Sciences as a significant centre of excellence in Indigenous health teaching, research, and community service.

• UNIVERSITY OF NEW SOUTH WALES

Accredited Program: Master of Public Health

Indigenous Health: Prescribed formal contact hours: 2

Specific Indigenous Health Subject/s Offered: nil reported

Other Subjects with Specific Indigenous Health Sessions:
Title: Introduction to Public Health
Formal Contact Hours (Indigenous Health): 2

Title: Delivering health Care in the Community
Formal Contact Hours (Indigenous Health): 1

Title: Research n Disadvantaged Populations
Formal Contact Hours (Indigenous Health): 1.5

Specific Program Aims re Indigenous Health: nil specific
General include:

- Commitment to social justice, equity, diversity and multiculturalism
- Recognition of the valuable roles of different perspectives, disciplines and approaches to addressing emerging problems as well as poorly addressed existing problems

Indigenous Enrolments Previous 5 years: nil reported
Indigenous Completions Previous 5 years: nil reported

Indigenous Advice Available:
An Indigenous Health staff member, who has an undergraduate role, will soon focus on developing a new Indigenous Health course for our postgraduate program.

Incentives/Disincentives for Indigenous Enrolments:
-ve—the two courses in Indigenous Health ceased nearly four years ago

Incentives/Disincentives for non-Indigenous Enrolments
-ve—the two courses in Indigenous Health ceased nearly four years ago

Staff Development in Indigenous Health: nil reported

Evaluation Outcomes re Indigenous Health Content: nil reported

Factors Affecting Viability of Substantial Indigenous Australian Health Content:
When we did have Indigenous Health courses they were well attended. Because our program is available flexibly we have many students in remote and rural areas and this guarantees a strong demand for them. Unfortunately our School has just gone through a period of rationalization, and only now are we able to redevelop that area with new staff.

• AUSTRALIAN NATIONAL UNIVERSITY

Accredited Program: Master of Applied Epidemiology—Indigenous Health

Indigenous Health: Prescribed formal contact hours: 160/480 within the intensive 3wk blocks(x4) (50% Indigenous presenter); + 84 weeks of indigenous related field placement with host institution; + NCEPH supervision

Specific Indigenous Health Subject/s Offered:
Title: Indigenous Health Specialty
Formal Contact Hours: 160 (of 480hrs classroom contact)

Specific Program Aims re Indigenous Health:
- To strengthen Indigenous Public Health capacity;
- To improve networking and infrastructure; and
- To produce outputs in Indigenous health services research and evaluation by providing students with Masters level skills and experience in applied epidemiology.

Indigenous Enrolments Previous 5 years: 28
Indigenous Completions Previous 5 years: 13

Indigenous Advice Available:
One Indigenous lecturer in the MAE program. Indigenous advisory board to the MAE program that meets every 6 months; reps from OATSIHS, NACCHO etc.; majority Indigenous members.

Incentives/Disincentives for Indigenous Enrolments:
+ve—scholarship to enrol; experience equivalent to u/grad degree is taken into consideration
-ve—few students have required qualifications; placements may require students moving interstate

Incentives/Disincentives for non-Indigenous Enrolments
+ve—generous scholarships to enrol in the program

Staff Development in Indigenous Health:
No formal strategies—staff involved in Indigenous research projects

Evaluation Outcomes re Indigenous Health Content:
Formal evaluation 1999 very supportive—suggested strategies to assist students with commenced with less formal qualifications.

Factors Affecting Viability of Substantial Indigenous Australian Health Content:
-ve—Competing demands for other course content given a fixed number of teaching hours; Combining the MAE (IH) with the environmental health and communicable diseases streams may mean there is less Indigenous emphasis.

- **CURTIN UNIVERSITY**

Accredited Program: Master of Public Health

Indigenous Health: Prescribed formal contact hours: nil reported

Specific Indigenous Health Subject/s Offered: nil reported
Title:
Formal Contact Hours:
Aims:

Other Subjects with Specific Indigenous Health Sessions: nil reported
Title:
Formal Contact Hours (Indigenous Health):

Specific Program Aims re Indigenous Health: nil

Indigenous Enrolments Previous 5 years: nil reported
Indigenous Completions Previous 5 years: nil reported

Indigenous Advice Available: nil reported

Incentives/Disincentives for Indigenous Enrolments: no response

Incentives/Disincentives for non-Indigenous Enrolments: no response

Staff Development in Indigenous Health: nil reported

Evaluation Outcomes re Indigenous Health Content: nil reported

Factors Affecting Viability of Substantial Indigenous Australian Health Content: nil reported

- **UNIVERSITY OF WESTERN AUSTRALIA**

Accredited Program: Master of Public Health

Indigenous Health: Prescribed formal contact hours: n/a

Specific Indigenous Health Subject/s Offered: none currently

Other Subjects with Specific Indigenous Health Sessions: n/a

Specific Program Aims re Indigenous Health: Specific consortium aim

Indigenous Enrolments Previous 5 years: 1
Indigenous Completions Previous 5 years: 1

Indigenous Advice Available: UWA Centre for Aboriginal Medical and Dental Health

Incentives/Disincentives for Indigenous Enrolments: Aboriginal Health Research Apprenticeship Scheme; fees scholarships

Incentives/Disincentives for non-Indigenous Enrolments: none reported

Staff Development in Indigenous Health: Consortium workshops for staff on understanding indigenous culture

Evaluation Outcomes re Indigenous Health Content: n/a

Factors Affecting Viability of Substantial Indigenous Australian Health Content:
Lack of sufficient funds to employ a specialist in the area.

- **UNIVERSITY OF MELBOURNE**

Accredited Program: Master of Public Health

Indigenous Health: Prescribed formal contact hours: nil

Specific Indigenous Health Subject/s Offered: (four new subjects commencing 2004)
Title: Aboriginal Primary Health Care and Policy
Formal Contact Hours: 24
Aims: social, economic, political cultural, demographic factors impacting on Koori health status historically and in the present; health transition: implications for policy; partnerships; ethical practice.

Other Subjects with Specific Indigenous Health Sessions:
Title: Principles of Research Design
Formal Contact Hours (Indigenous Health): 1 (Indigenous presenter)

Title: Health Ethics and Society
Formal Contact Hours (Indigenous Health): 2 (Indigenous presenter)

Title: Child Public Health
Formal Contact Hours (Indigenous Health): 1.5 (Indigenous presenter)

Title: Determinants of Women's Health
Formal Contact Hours (Indigenous Health): 2

Title: Culture Health & Illness
Formal Contact Hours (Indigenous Health): 2 (Indigenous presenter)

Title: The Body Social: Key Concepts in Humanities and Social Sciences
Formal Contact Hours (Indigenous Health): 2 (Indigenous presenter)

Title: Advanced Topics in Medical Anthropology
Formal Contact Hours (Indigenous Health): 3 (Indigenous presenter)

Title: Sexual & Reproductive Health
Formal Contact Hours (Indigenous Health): 1

Title: Health Ethics and Human Rights
Formal Contact Hours (Indigenous Health): 2 (Indigenous presenter)

Title: Population Health in the General Practice Setting
Formal Contact Hours (Indigenous Health): 1 (Indigenous presenter)

Specific Program Aims re Indigenous Health: nil specific (developing strategies to ensure equity in the health system and interventions to promote the health of disadvantaged groups)

Indigenous Enrolments Previous 5 years: 0
Indigenous Completions Previous 5 years: 0

Indigenous Advice Available:
Indigenous subjects offered as of 2004 are coordinated by Indigenous staff

Incentives/Disincentives for Indigenous Enrolments:
+ve—MPH can articulate with other programs including the Grad Cert of Social Health providing entry pathways specifically tailored to Indigenous applicants from an applied health background
-ve—No identified stream. Entry requirements for the advanced standing 12 subject MPH program require formal tertiary training. No Indigenous student support explicitly linked to MPH program. No indication that there is experience and expertise in teaching indigenous students and/or Indigenous staff involved in selected subject offerings within our MPH

Incentives/Disincentives for non-Indigenous Enrolments:
+ve—Identifiable Indigenous Health subjects
-ve—no identified Indigenous stream

Staff Development in Indigenous Health:
Access to training programs in cross-cultural teaching skills through the University staff development programs. Mentoring of inexperienced staff by those (Ind & non-Ind) experienced in Indigenous teaching

Evaluation Outcomes re Indigenous Health Content:
No recent evaluation of content

Factors Affecting Viability of Substantial Indigenous Australian Health Content:
The small number of teaching staff who are experienced in Indigenous Health and/or in teaching Indigenous students. This limits the opportunities for the development of appropriate teaching materials and delivery methods. That said, this is slowly changing with recent appointments and the acquisition of experience by existing staff. Also, there is strong in-school support for the Indigenising of our teaching programs under Professor Ian Anderson.

• LA TROBE UNIVERSITY

Accredited Program: Master of Public Health

Indigenous Health: Prescribed formal contact hours: nil

Specific Indigenous Health Subject/s Offered: nil

Other Subjects with Specific Indigenous Health Sessions:
Title: Public Health Policy
Formal Contact Hours (Indigenous Health): 5

Specific Program Aims re Indigenous Health: nil

Indigenous Enrolments Previous 5 years: 1
Indigenous Completions Previous 5 years: 0

Indigenous Australian Advice Available: nil

Incentives/Disincentives for Indigenous Enrolments:
no specific Indigenous subject provided

Incentives/Disincentives for non-Indigenous Enrolments
no specific Indigenous subject provided

Staff Development in Indigenous Health: nil

Evaluation Outcomes re Indigenous Health Content: n/a

Factors Affecting Viability of Substantial Indigenous Australian Health Content: n/a

• MONASH UNIVERSITY /BURNET INSTITUTE

Accredited Program: Master of Public Health

Indigenous Health: Prescribed formal contact hours: nil

Specific Indigenous Health Subject/s Offered:
Title: Aboriginal Health
Formal Contact Hours: 35 (Indigenous presenters)
Aims:
1. have an understanding of the social, economic, cultural and political context of health in the Aboriginal community;
2. be introduced to a brief epidemiology of the major health problems in Aboriginal communities;
3. understand the essentials of holistic health care services for Aboriginal communities and the network of community controlled services that facilitate or deliver care;
4. have a good understanding of the principles of appropriate health care and the role of community controlled services;

5. have an introduction to the public health management of major diseases that affect Aboriginal communities; and

6. have an understanding of the place of research concerned with Aboriginal health issues.

Other Subjects with Specific Indigenous Health Sessions:
Title: Health Policy & Information Management
Formal Contact Hours (Indigenous Health): ~2 (1/2 a module online)

Specific Program Aims re Indigenous Health: n/a

Indigenous Enrolments Previous 5 years: n/a
Indigenous Completions Previous 5 years: n/a
Indigenous Advice Available: n/a

Incentives/Disincentives for Indigenous Enrolments: n/a

Incentives/Disincentives for non-Indigenous Enrolments: n/a

Staff Development in Indigenous Health: n/a

Evaluation Outcomes re Indigenous Health Content: n/a

Factors Affecting Viability of Substantial Indigenous Australian Health Content: n/a

- **DEAKIN UNIVERSITY (1) Mainstream Program**

Accredited Program: Master of Public Health

Indigenous Health: Prescribed formal contact hours: nil

Specific Indigenous Health Subject/s Offered: Since 2001, Deakin has concentrated its efforts on working with the Institute of Koorie Education to establish the MPH Koorie cohort studying in Community Based Mode. With the experience gained from the IKE program, and with the learnings from this PHERP funded project, increased effort will be made in 2004 to integrate and enhance mainstream MPH Indigenous content.

Other Subjects with Specific Indigenous Health Sessions: none reported

Specific Program Aims re Indigenous Health: none reported

Indigenous Enrolments Previous 5 years: nil
Indigenous Completions Previous 5 years: nil

Indigenous Advice Available:
Staff at Institute of Koorie Education, VicHealth Koori Health Research and Community Development Unit and VACCHO

Incentives/Disincentives for Indigenous Enrolments: no particular incentives or disincentives

Incentives/Disincentives for non-Indigenous Enrolments: no particular incentives or disincentives

Staff Development in Indigenous Health: Mentoring of inexperienced staff by those (Ind from Institute of Koorie Education & non-Ind) experienced in Indigenous teaching

Evaluation Outcomes re Indigenous Health Content: Students in mainstream MPH units taught by Deakin have requested specific Indigenous health content to be included. We aim to negotiate appropriate content and providers, for 2004

Factors Affecting Viability of Substantial Indigenous Australian Health Content:

- Curriculum development and curriculum adaptation within existing programs to include both new Indigenous content and perspectives, and to adapt existing courses to encompass Indigenous-specific content and perspectives;
- Incentives and strategies to support current academic staff especially tutors;
- Learnings from PHERP project will build capacity and inform Indigenous health teaching to mainstream units.

- **DEAKIN UNIVERSITY (2) Institute of Koorie Education**

Accredited Program: Master of Public Health

Indigenous Health: Prescribed formal contact hours: 120 + (more in process). Overall it is anticipated when all units delivered that 50-60% will be formal contact.

Specific Indigenous Health Subject/s Offered: nil

Other Subjects with Specific Indigenous Health Sessions:
Title: Principles and Practices of Public Health
Formal Contact Hours (Indigenous Health): ~ 36

Title: Research Methods
Formal Contact Hours (Indigenous Health): ~ 15

Title: Introduction to Biostatistics
Formal Contact Hours (Indigenous Health): ~ 15

Title: Contemporary Health Issues and Policies
Formal Contact Hours (Indigenous Health): ~ 10

Title: Health Education and Communication Strategies
Formal Contact Hours (Indigenous Health): ~ 15

Title: Health Promotion Program Planning and Evaluation
Formal Contact Hours (Indigenous Health): ~ 15

Title: Health Promotion
Formal Contact Hours (Indigenous Health): ~ 15

Specific Program Aims re Indigenous Health:
Increase the participation of Indigenous Australians in the Masters of Public Health program through the development, delivery and evaluation of a public health training program drawing upon an Indigenous community based pedagogy.

Specific Goals:

- To identify a culturally appropriate public health curriculum and pedagogical framework for Indigenous Australian students,
- To implement the newly developed framework that informs best practice in public health teaching and learning for Indigenous Australian students.

Indigenous Enrolments Previous 5 years: 11 (program commenced 2001)

Indigenous Completions Previous 5 years: 0 (program commenced in 2001—there will be 3 graduates by late 2003)

Indigenous Advice Available: The Board of the Institute of Koorie Education manages The Institute of Koorie Education and it comprises of both community representatives and Deakin University representatives and works to regulation 2.9 (14) of the Deakin University statute (2.9). A Steering Committee comprising of Indigenous and Non-Indigenous health specialists oversees the overall project. The Committee includes the Director of IKE, Director of VACCHO, VAEAI and VKHRCDU plus representatives from Menzies School of Health Research, Tropical and Aboriginal Health CRC, Macfarlane Burnet. Joint management principles apply.

Incentives/Disincentives for Indigenous Enrolments:
+ve: studying with Indigenous students in a culturally inclusive environment. Adherence to and respect for culturally relevant teaching materials and teaching approaches. The community-based delivery model in place at IKE, Deakin University, recognises it is imperative for Indigenous Australian students to continue to live and work in their communities whilst accessing tertiary education. Community Based Delivery addresses the impact of non-educational needs including financial and family issues that impact on a student's ability to succeed and complete their course. Students maintain cultural integrity through the development of Indigenous pedagogy whilst at the same time developing the knowledge and skills to further their work in their communities with the Indigenous health community and in the public health field. Ongoing evaluation of the community-based pedagogical approach is through a collaborative inquiry process involving students, lecturers, participating Indigenous communities and unit

co-ordinators. A report reflecting the Indigenous pedagogy and curricula will be produced. A number of students have been successful in gaining scholarships.

A further incentive is the ongoing support and collaboration of the Deakin University School of Health and Social Development through the coordinator of the Masters of Public Health in accordance with joint management principles.

Incentives/Disincentives for non-Indigenous Enrolments: In the longer term it is anticipated that the project outcomes will produce positive outcomes for non-Indigenous students in relation to their access to culturally appropriate curriculum and involvement in Indigenous health

Staff Development in Indigenous Health:
There are a multitude of staff development opportunities including working closely with Indigenous health staff, and an Indigenous Steering Committee. Working with students and having the opportunity to visit community settings provides ongoing and highly valuable experience in Indigenous health. Joint management principles apply which allows for an exchange of knowledge and skills.

Evaluation Outcomes re Indigenous Health Content:
There is ongoing informal evaluation after each teaching session, which informs the opening up of the curriculum to the Indigenous Australian learner towards understanding Western knowledge systems in a culturally appropriate context. This involves both student feedback and a critical self-evaluation. Evaluation indicates that the students value learning in an environment that is inclusive of Indigenous knowledge systems and find beneficial the dynamic process of applying knowledge to their community and work experiences.

Factors Affecting Viability of Substantial Indigenous Australian Health Content:
The most significant factor involves respect for the social contexts of Indigenous knowledge systems. An environment is created in which students feel comfortable and confident to share their own community and lived experiences, which shapes classroom learning and contributes to their work back in their communities and subsequently furthers their knowledge of Indigenous health.

Appendix 2: Existing National MPH Coverage of Aboriginal Health

Stand-alone Indigenous subjects

Area of Public Health	Name of Subject & Institution	Formal Contact Hours	Specific Focus re Indigenous Health	Presenter	Delivery Format	Assessment
Indigenous Health	Aboriginal Health Policy (Adelaide)	38 (of 38)	Public policy — historical analysis; comparative international Indig. studies; current health status, needs, programs	Indigenous	Intensive & Field Visit	Essay & Critical analysis of video
	Indigenous Health Stream (NCEPH/ANU)	160 (of 480)	Historical & social context; current health stats; research methods; ethics; applied epidemiology	Indigenous & non-Indigenous (1/2—1/2)	Intensive (4 x 3wk x 40hrs); lecture; seminar; placement; field visit; distance modules	Bound volume of four projects; viva
	Issues in Aboriginal Mental Health (Flinders)	Distance 100%	Social & emotional wellbeing; pre-contact & contemporary history; land; kinship; colonisation, dispersal, cultural oppression; removal of children, racism	?	Distance modules	Essay Module exercises
	International Indigenous Health (Griffith)	20 (of 26)	International Indig. health; traditional health practices; men's health; culture, treaties, and health; discrimination, alienation & neglect; epidemiology; socio-economics; drugs & violence; psychosocial trauma; land & health; social capital; Indigenous knowledge; partnership; ethics & research	Indigenous & non-Indigenous (1/2–1/2)	Lecture & tutorial Field Visit	Essay Scenario problem-solving

Area	Subject & Institution	Contact Hours	Specific Focus	Presenter	Delivery Format	Assessment
Indigenous Health (cont)	Aboriginal Health (Monash/Burnet)	35 (of 35)	Colonisation; traditional health; Aboriginal concept of health; govt policy & funding; current health status; common problems; ACCHOs; partnership; Indig. health promotion models; cultural remoteness; research, ethics, community protocols; use of data	Indigenous	Intensive block	Essay Scenario problem-solving Demonstration
	Issues in Aboriginal and Torres Strait Islander Health (UQ)	45 (of 45)	Emerging debates in both popular and medical press; Aboriginal health status; research; futures; self-determination; cultural identity; governance; Indigenous control; ethics; stolen generations; substance use; injury and violence; STIs	Indigenous & non-Indigenous (30–70)	Seminars	Essay Lecturer assess preparation Self-assess participation
	Indigenous People and Alcohol and Drug Problems (UQ)	Distance 100%	Patterns of drug use; mortality, morbidity; policy responses; drug use and culture; community approaches; history; structural violence; alcohol & violence; drug use and young Indigenous people; Indigenous responses; treatment issues	Non-Indigenous	Distance	?
	Aboriginal Health Policy (UQ)	26	N/A	Indigenous	N/A	N/A

Area	Subject & Institution	Contact Hours	Specific Focus	Presenter	Delivery Format	Assessment
Indigenous Health (cont.)	Aboriginal Health (Sydney)	14 (of 14)	Traditional history & lifestyle; colonisation impacts; HP principles, strategy, development & delivery; partnerships; research & evaluation re good practice	Indigenous & non-Indigenous (85–15)	Seminars	Essay Demonstration
	Aboriginal and Torres Strait Islander Health (James Cook)	50 (of 50)?	Social, cultural, historical factors; pre-contact/post contact social organisation & culture; policy/decision-making; health status/demography; key PH problems — intervention Health Promotion; Community Development; communication	Indigenous	Block	Assignment Presentation Written exam
	Aboriginal Primary Health Care & Policy (Melbourne)	24 (of 24)	Social economic political cultural demographic factors impacting on Koorie health status historically and in the present; health transition: implications for policy; partnerships; ethical practice	Indigenous	Seminars	Essay Assignment
	Nutrition in Aboriginal and Torres Strait Islander people (Menzies)	~4 (of 6)	Nutrition issues; context, policy, programs; urban & rural comparison; disorders/conditions re life phases; risk factors, monitoring, intervention strategies, evidence	Indigenous & non-Indigenous (15–85)	Intensive and online modules	Short Answer Demonstration & other?
	Indigenous Society in Nth Australia (Menzies)	N/A	N/A	N/A	N/A	N/A
	Tradition Law & Healing of Aboriginal Peoples in Nth Australia (Menzies)	N/A	N/A	N/A	N/A	N/A
	Alcohol & Drug Issues re Indigenous Australians (Menzies)	4 (of 6)	Public health approaches to substance abuse + Indigenous people; key	Non-Indigenous	Intensive and online modules	Essay

Specific Indigenous Content within Generic MPH Subject

Area of Public Health	Name of Subject & Institution	Formal Contact Hours	Specific Focus re Indigenous PH	Presenter	Delivery Format	Assessment
Foundations of Public Health	Approaches to Problems in Public Health (Menzies)	~6 (of 10–intensive & distance modules)	Case studies in Indigenous health; problem-solving in management and public health; health policy cycle	Non-Indigenous	Intensive and online modules	Essay Scenario problem-solving
	Introduction to Public Health (Menzies)	5 (of 8) (intensive & distance modules)	Aust. Indig. concepts of health, social determinants; cross cultural communication; AHWs; colonisation impacts; Aust. health system; partnerships; Indig. health promotion; empowerment	Indigenous & non-Indigenous (10–90)	Intensive and online modules	Essay Database search
	Applied Public Health Skills (Menzies)	6 (of 12)	Generic skills unit, with direct applicability to Indigenous health	Non-Indigenous	Intensive and online modules	Essay Demonstration
	Principles and Practices of Public Health (IKE/Deakin)	36 (of 36)	History of Indig. public health; determining priorities; DALYs; health status, priorities & structures; models of PH (Indig. eco. etc.)	Indigenous & non-Indigenous (10–90)	Intensive block Dialogic, adult-learning	Essay Scenario problem-solving
Rural & Remote Health	Rural Public Health Intensive (Adelaide)	5 (of 30)	Cultural awareness; health status; service usage; Aboriginal Health Services	Indigenous and non-Indigenous	Intensive & field visit	Essay
	Context of Remote Health (Flinders DRH)	40 (of 40)	Culture, practice & wellbeing; prejudice, power & oppression; cultural safety; history	Indigenous & non-Indigenous (80–20)	Intensive	Essay

Area	Subject & Institution	Contact Hours	Specific Focus	Presenter	Delivery Format	Assessment
Rural & Remote Health (cont.)	Rural and Remote Public Health (James Cook)	30 (of 50)?	Health status; priorities; policy; consultation; role of heath professional; RAP role of technology	Indigenous & non-Indigenous (20–80)	Intensive block Online module Field visit	Individual reports Group report
Research Methods	Qualitative Research in Practice (Adelaide)	2 (of 48)	Paradigms, world views; bias & assumptions of research instruments; community consultation	Non-Indigenous	Lecture, seminar	Essay
	Research in Disadvantaged Populations (UNSW)	1.5	Ethics of research in Indigenous settings; interpreters, employment of local staff, management of projects by Indigenous people	Non-Indigenous	Lecture & tutorial	Research plan
	Principles of Research Design (Melbourne)	1 (of 35)	Research methods; ethics; consent; consultation; participation; dissemination of outcomes; process	Indigenous	Intensive	Essay Ethics form
	Introduction to Health Information and Health Research (Menzies)	2 (of 16)	Access & interpretation published health information and research reports (quant. & qual.) with a focus on Indigenous health	Indigenous & non-Indigenous (30–70)	Intensive and online modules	Short Answer Multiple choice Scenario problem-solving
	Qualitative Research Methods (Menzies)	3 (of 12)	Ethics; research as a political process; ethnography and interview methods in Indigenous contexts	Non-Indigenous	Intensive and online modules	Essay Scenario problem-solving

Area	Subject & Institution	Contact Hours	Specific Focus	Presenter	Delivery Format	Assessment
Research Methods (cont.)	Research Methods (IKE/Deakin)	10 (of 20)	Ethical practice in Indig. health research; critical appraisal from an Indigenous standpoint; research resources	Indigenous & non-Indigenous (15–85)	Intensive block Dialogic, adult-learning	Essay Scenario problem-solving
	Introduction to Biostatistics (IKE/Deakin)	15 (out of 35)	Health service reporting mechanisms; info collection on Indigenous health; AHWs	Non-indigenous	Intensive block Dialogic, adult-learning	Short answer Multiple choice Q Calculations Scenario problem-solving
Community Health	Community Health & Disease (Griffith)	2 (of 26)	History and Social Determinants	Indigenous	Lecture & tutorial	?
	Delivering Health Care in the Community (UNSW)	1 (of 28)	Access to PHC; cultural appropriateness; ACCHOs as a model of comprehensive PHC and community participation	Non-Indigenous	Seminar PBL	Essay
	Training Primary Health Care Workers (James Cook)	25 (of 50)	CHW history/practice/ experiences; adult experiential learning in Indigenous settings; planning, T & L methods	Non-Indigenous	Block	Assignment Presentation Project
Health Policy	Public Health Policy (La Trobe)	5 (of 39)	History; socio-economic context; Indigenous health initiatives; service delivery; Indigenous experience; partnerships; health spending	Indigenous	Intensive block	Essay Scenario problem-solving Presentation

Area	Subject & Institution	Contact Hours	Specific Focus	Presenter	Delivery Format	Assessment
Health Policy (cont.)	Health Policy & Information Management (Monash)	Online distance–1/2 module out of 11 modules	Health status and health risks of the rural and Indig. communities; policy implications; current policy	Non-Indigenous	Online modules	Online exercises
	Contemporary Health Issues and Policies (IKE/Deakin)	10 (of 21)	Getting on the agenda; media; lobbying; policy development process; Indig. case studies in policy development	Indigenous & non-Indigenous (15–85)	Intensive block Dialogic, adult-learning	Essay Scenario problem-solving
Health Promotion	Intervention Design and Theories of Change (QUT)	3 (of 36)	Positive community interventions; analysis of community-based strategies; principles of Indigenous health promotion	Indigenous	Intensive Block	Essay
	Health Education and Communication Strategies (IKE/Deakin)	15 (of 35)	Role of health communication & education in Indig. health promotion; teaching & learning theory; Community Development; advocacy; critical appraisal of appropriate HP strategies; Indig. case studies	Indigenous & non-Indigenous (10–90)	Intensive block Dialogic, adult-learning	Essay Scenario problem-solving Presentation
	Health Promotion Program Planning and Evaluation (IKE/Deakin)	15 (of 28)		Indigenous	Intensive block Dialogic, adult-learning	Essay Scenario problem-solving
	Health Promotion (IKE/Deakin)	15 (of 35)	Critical appraisal HP concepts and approaches; Indig. HP program development process	Non-Indigenous	Intensive block Dialogic, adult-learning	Essay Scenario problem-solving

Area	Subject & Institution	Contact Hours	Specific Focus	Presenter	Delivery Format	Assessment
Health Promotion (cont.)	Health Promotion (James Cook)	25 (of 50)	Development (design, plan, implementation, evaluation) HP activities in Indig. contexts; barriers; strategies, case studies; X-cultural approaches	non-Indigenous	Intensive block	Exam Assignment Presentation
Environmental Health	Environmental Health (Sydney)	0.5 (of 28)	Indigenous environmental health issues; aetiology; current programs	Non-Indigenous	Lecture and tutorial	Essay Scenario problem-solving Short-answer
	Rural and Remote Environmental Health (James Cook)	?	Environmental Indig. health problems; social justice implications PH engineering & ethical problem solving re Indig. contexts; negotiating diff. physical & cultural landscapes in planning	Non-Indigenous	?	Reports Examination
Alcohol & Drug Issues	Alcohol and Drug Issues and Health (Sydney)	2 (of 12)	Link b/w D&A use & social disadvantage, dispossession and disempowerment; grief and loss; prevalence D&A use; control in Aboriginal populations; urban & remote contexts	Indigenous and non-Indigenous (20–80)	Lecture and tutorial	Essay
Sexual & Reproductive Health	Sexual & Reproductive Health (Melbourne)	1 (of 24)	Sexually transmissible infections in Indig. Australians	Non-Indigenous	Lecture and tutorial	Short-answer
Medical Anthropology & Sociology	Advanced Topics in Medical Anthropology (Melbourne)	3 (of 22)	Historical context; Aboriginal model of health; epi. profile; access; Indigenous narratives; appropriate practices	Indigenous and non-Indigenous (30–70)	Seminar	Essay Website evaluation Reader evaluation Participation
	The Body Social: Key Concepts in Humanities and Social Sciences (Melbourne)	2 (of 36)	Historical context; epi. profile; access; Indigenous narratives; Indig. research; change processes; family separations & health	Indigenous and non-Indigenous (50–50)	Lecture and tutorial	Essay Website evaluation Reader evaluation Participation

Area	Subject & Institution	Contact Hours	Specific Focus	Presenter	Delivery Format	Assessment
Medical Anthropology & Sociology (cont.)	Culture Health & Illness (Melbourne)	2 (of 24)	Health land and relationships; self-determination; embeddedness of health; problems re institutional services; access; compliance	Indigenous and non-Indigenous (50–50)	Seminar	Essay Website evaluation Reader evaluation Participation
	Sociology and Health (Menzies)	6 (of 12)	Applying sociological concepts to Indig. health; social & cultural determinants; class, gender and ethnicity; inequality and racism; Aboriginal wellbeing policy; Indig. social capital; co-ord care; alcohol & drugs	Non-Indigenous	Intensive and online modules	Essay Demonstration
Women's Health	Determinants of Women's Health (Melbourne)	2 (of 24)	Physical and mental health problems; effects of culture, poverty, violence and unpaid caring work; how the above social determinants impact upon the health status	Non-Indigenous	Lecture, seminar	Essay
Maternal & Child Health	Child Public Health (Melbourne)	1.5 (of 40)	Historical perspective & experiences of an Aboriginal Elder; hospital ALOs experience of family difficulties e.g. access, racism; poverty, disadvantage	Indigenous	Intensive	Essay Oral presentation
	Maternal Health for Indigenous Health Workers (James Cook)	30 (of 40)?	Clinical background & experience re mgt high-risk pregnancy; epi. patterns; PH programs; obstetrics, anatomy, physiology ante-natal care; mgt re out of hospital delivery	Indigenous	Intensive block Placement	Examination Project Demonstration

Area	Subject & Institution	Contact Hours	Specific Focus	Presenter	Delivery Format	Assessment
Health Ethics	Health Ethics and Society (Melbourne)	2 (of 28)	Ethical approaches to Aboriginal health research and practice; history; status; Aboriginal model of health & initiatives; access; epi. profile; Aboriginal experience	Indigenous	Seminar	Essay
Epidemiology & Disease Control	Epidemiology and Control of Communicable Diseases (Menzies)	1 (of 4)	Common diseases in Indigenous populations eg diarrhoeal disease, tuberculosis and immunization	Non-Indigenous	Intensive and online modules	Essay Short answer Scenario problem-solving Role play
	Prevention and Control of Non-Communicable Diseases (Menzies)	3 (of 6)	Social determinants, cult perspective; epi. of chronic disease; life course approach; control—ethics, barriers; evidence base and systems approach within Indig. health	Non-Indigenous	Intensive and online modules	Essay Participation
	Public Health Aspects of Chronic Diseases (James Cook)	?	Health transition — Community Development; epi. — measures risk factors, aetiology, social determinants; PH interventions; economic impact; health systems approach	Indigenous and non-Indigenous (10–90)	Intensive block	Essay Short answer Scenario problem-solving
Health Management	Managing Effective Health Programs (James Cook)	?	Needs analysis; screening & prevention planning; evaluation; workplace reform	Non-Indigenous	Distance modules	Workbook Assignments

Appendix 3: Nine Principles for Improvement in ATSI Health

From the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NATSIHC 2003: 2)

- 'Cultural respect: ensuring that the cultural diversity, rights, views, values and expectations of Aboriginal and Torres Strait Islander peoples are respected in the delivery of culturally appropriate health services.
- A holistic approach: recognising that the improvement of Aboriginal and Torres Strait Islander health status must include attention to physical, spiritual, cultural, emotional and social wellbeing, community capacity and governance.
- Health sector responsibility: improving the health of Aboriginal and Torres Strait Islander individuals and communities is a core responsibility and a high priority for the whole of the health sector. Making all services responsive to the needs of Aboriginal and Torres Strait Islander people will provide greater choice in the services they are able to use.
- Community control of primary health care services: supporting the Aboriginal community controlled health sector in recognition of its demonstrated effectiveness in providing appropriate and accessible health services to a range of Aboriginal communities, and its role as a major provider within the comprehensive primary health care context. Supporting community decision-making, participation and control as a fundamental component of the health system that ensures health services for Aboriginal and Torres Strait Islander peoples are provided in a holistic and culturally sensitive way.
- Working together: combining the efforts of government, non-government and private organisations within and outside the health sector, and in partnership with the Aboriginal and Torres Strait Islander health sector, provides the best opportunity to improve the broader determinants of health.
- Localised decision making: health authorities devolving decision-making capacity to local Aboriginal and Torres Strait Islander communities to define their health needs and priorities and arrange for them to be met in a culturally appropriate way in collaboration with Aboriginal and Torres Strait Islander specific and mainstream health services.
- Promoting good health: recognising that health promotion and illness prevention is a fundamental component of comprehensive primary health care and must be a core activity for specific and mainstream health services.
- Building the capacity of health services and communities: strengthening health services and building community expertise to respond to health needs and take responsibility for health outcomes. This includes effectively equipping staff with appropriate cultural knowledge and clinical expertise, building physical, human and intellectual infrastructure, and fostering leadership, governance and financial management.
- Accountability for health outcomes: recognising that accountability is reciprocal and includes accountability for health outcomes and effective use of funds by community-controlled and mainstream services to governments and communities. Governments are accountable for effective resource application through long-term funding and meaningful planning and service development in genuine partnership with communities.'

Appendix 4: Participants—National Indigenous Public Health Curriculum Workshop

Indigenous MPH student Delegates

Marilyn Nicholls	Institute of Koorie Education, Deakin University, Vic.
Eddie Mulholland	Menzies School of Health Research, NT
Jenine Bailley	James Cook University, Qld

Indigenous Community/Workforce Sector Delegates

Alwin Chong	Aboriginal Health Council of South Australia
Mark Lutschini	Wathaurong Co-op., Vic.
Donna AhChee	Aboriginal Medical Services Alliance, NT
David Brockman	Victorian Aboriginal Health Service

Indigenous Higher Education Delegates

Petah Atkinson	Institute of Koorie Education, Deakin University, Vic.
Di Fitzgerald	Institute of Koorie Education, Deakin University, Vic.
Lorna Murakami-Gold	CRCAH, Darwin, NT
Ian Anderson	University of Melbourne, Vic.
Barbara Henry	Curtin University, WA
Patricia Neal	University of Newcastle, NSW

Non-Indigenous Workforce Delegates

Patricia Fagan	OATSIHS, Canberra
Greg Jordan	PHERP. Department of Health and Ageing, Canberra
John Boffa	Aboriginal Medical Services Alliance of the Northern Territory
Tim Leahy	WAACCHO & Office of Aboriginal Health, Health WA

Non-Indigenous Higher Education Delegates

Janice Jessen	Institute of Koorie Education, Deakin University, Vic.
Helen Keleher	Deakin University, Vic.
John Coveney	Flinders University, SA
Priscilla Robinson	La Trobe University, Vic.
Bev Snell	Macfarlane Burnet Institute, Vic.
Bill Genat	University of Melbourne, Vic.
Paul Kelly Menzies	School of Health Research, NT
Elizabeth Parker	Queensland University of Technology, Qld