Review of the La Trobe University
Master of Public Health Program

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

Public Health Indigenous Leadership in Education Network
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This national review is a component of the Indigenous Public Health Capacity Building Project funded by the Australian Government Department of Health and Ageing
Definition

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

Sharing knowledge – a community learning circle around the campfire
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Acknowledgments

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

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The School of Public Health and Human Biosciences at La Trobe University has a strong commitment to the inclusion of Indigenous health as an integral part of its public health academic program. As such, we are delighted to have had our Master of Public Health (MPH) program evaluated by the Public Health Indigenous Leadership in Education (PHILE) Network as a part of its investigation into the ways in which Indigenous public health competencies are included in public health programs throughout Australia.

The MPH is designed to enable students to achieve the Australian public health graduate competencies (outlined in the Introduction to this report), which specifically include Indigenous health. Participating in this review has helped us to consider how best to ensure that our MPH has the necessary depth in content and learning for staff and students to achieve this.

The outcomes of the evaluation show that our teaching is student focused, with appropriate Indigenous content in most of the extensive core program. It also shows that our interest in Indigenous health is founded in La Trobe University’s philosophy of valuing social justice. Most of our teaching is didactic with students able to select assessment tasks that provide opportunities to explore topics of interest in more depth, and these are frequently about Indigenous health. We are also pleased to see recognition of our commitment to using positive, rather than negative, examples of Indigenous health programs – that is, what works rather than what is wrong.

The University has recently appointed a Director of Indigenous Strategy and we expect this appointment will lead to a more coherent strategy, and greater support, for Indigenous academic programs. We are optimistic that it will assist us in addressing identified weaknesses, such as the lack of an Indigenous member of staff. We also expect that a coordinated University approach will be taken to evaluating and designing our Indigenous teaching content and approach.

The School would be happy to share its resources with the broader public health teaching community. We would like to thank the PHILE Network for this report, which both acknowledges our commitment to Indigenous public health teaching and provides practical suggestions for improvement.

Professor Sandra G. Leggat
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La Trobe University, Melbourne
June 2013
# Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMS</td>
<td>Aboriginal Medical Service</td>
</tr>
<tr>
<td>ANAPHI</td>
<td>Australian Network of Academic Public Health Institutions</td>
</tr>
<tr>
<td>AQF</td>
<td>Australian Qualification Framework</td>
</tr>
<tr>
<td>HREC</td>
<td>Human Research Ethics Committee</td>
</tr>
<tr>
<td>IPHCB</td>
<td>Indigenous Public Health Capacity Building</td>
</tr>
<tr>
<td>MHA</td>
<td>Master of Health Administration</td>
</tr>
<tr>
<td>MID</td>
<td>Master of International Development</td>
</tr>
<tr>
<td>MPH</td>
<td>Master of Public Health</td>
</tr>
<tr>
<td>PHERP</td>
<td>Public Health Education and Research Program</td>
</tr>
<tr>
<td>PHILE Network</td>
<td>Public Health Indigenous Leadership in Education Network</td>
</tr>
</tbody>
</table>
1. Executive Summary

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

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

The results found that La Trobe University has taken a horizontal model approach to the integration of Indigenous content, ensuring that all graduates will have received training in the core competencies. A thorough mapping of the curriculum against the competencies during its development means that Indigenous health content permeates the La Trobe curriculum in line with best practice, and a regular review of this content maintains its currency and relevance. However, the documentation of informal content identified in the review needs to be included in formal curriculum documents to ensure that appropriate recognition is given to the substantial integration of content. It is timely that this should occur with the alignment of the curriculum with the new Australian Qualification Framework (AQF) requirements.

Indigenous health content is presented from a positive and solution-based approach rather than a deficit, problem-based viewpoint, which aligns with the social justice philosophy that drives the La Trobe University program. The use of various field trips to enhance the delivery of teaching is an exemplary aspect of the program. These have been designed to provide experiential learning that deepens understanding, and to facilitate learning from the community with whom graduates will be engaged as practitioners. La Trobe University staff have also been involved in creating innovative case study examples for integration into both their curriculum, and for delivery into courses at one other Melbourne-based university.

The review also noted that those students who wish to undertake further studies in Indigenous health are encouraged to do so through cross-institutional enrolment at other universities. This effectively balances the challenge of ensuring core competencies delivery within La Trobe’s MPH curriculum while allowing students to progress their interest in specialised Indigenous health subjects. In the current Australian higher education political climate that fosters competition, such a strategy is commendable.

Strengthening the institutional priority given to Indigenous health, and resourcing it both to enable and to recognise quality teaching of Indigenous health content, were identified as key areas for improvement. The review showed that there is a clear need to fund an identified position or, alternatively, provide sufficient funds to remunerate Aboriginal community members appropriately when they contribute to the program as either guest lecturers or curriculum advisors. Strategies to improve the curriculum further, and to encourage staff development, were also discussed.

The review at La Trobe also identified broader issues of national importance for consideration by stakeholders of the Indigenous Public Health Capacity Building (IPHCB) Project. One of these related to the competencies and whether they are
applicable to the public health workforce need and achievable within MPH curriculum. The second issue was the need for adequate and appropriate resources to enable staff to teach the competencies. The review team therefore recommends:

- A national workforce survey of MPH graduates to assess application of the competencies and graduate outcomes and their relevance to workforce need.
- A review of the competencies to ensure they are realistic, measurable and achievable within MPH curricula nationally.
- Development of a bank of Indigenous health case studies and resources or teaching tools for teaching staff.

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

- Consistently treat Indigenous workforce development as an institutional priority.
- Appropriately resource Indigenous staffing positions and/or remunerate community members to contribute to curriculum development and/or teaching.
- Undertake a systematic curriculum mapping exercise to ensure all of the Australian Network of Academic Public Health Institutions (ANAPHI) and Indigenous health core competencies are covered, and to align the curriculum with the AQF requirements.
- Increase the documentation of informal Indigenous health content to reflect the extent of its integration into the formal curriculum.
- Ensure that ongoing staff development and support for the teaching of Indigenous health content is adequate.
- Provide incentives for quality teaching to support the integration of specialised content in the curriculum.

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

- Their ongoing commitment to the horizontal integration of Indigenous health content and the associated core competencies.
- Their approach to teaching Indigenous health content within a social justice framework that utilises innovative field trips in a societal rather than a culture-specific setting.
- Ensuring that Indigenous health and other content is topical, constructive and relevant to students, thereby enhancing learning.
- Providing students with an opportunity to explore specialised studies in Indigenous health through cross-institutional enrolment options.
- The student-focused ethos of the program that encourages active engagement and experiential learning in a supportive environment.
- The use of varied feedback and evaluation mechanisms above and beyond the standard university evaluation mechanisms to inform ongoing quality improvement.
2. Introduction

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

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

2.2. Indigenous public health core competencies

The Indigenous public health competencies are a core component of the Foundational Competencies for MPH Graduates in Australia (ANAPHI 2009), a curriculum framework which integrates the six core competencies in Indigenous public health that are expected of every MPH graduate nationally. The core Indigenous health competencies expected of graduating students are the ability to:

1. Analyse key comparative health indicators for Aboriginal and Torres Strait Islander people.
2. Analyse key comparative indicators regarding the social determinants of health for Aboriginal and Torres Strait Islander people.
3. Describe Aboriginal and Torres Strait Islander health in historical context and analyse the impact of colonial processes on health outcomes.
4. Critically evaluate Indigenous public health policy or programs.
5. Apply the principles of economic evaluation to Aboriginal and Torres Strait Islander programs, with a particular focus on the allocation of resources relative to need.
6. Demonstrate a reflexive public health practice for Aboriginal and Torres Strait Islander health contexts.

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

2.3. National review of competencies integration into MPH curricula

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

Specifically, the research questions for the review are:

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

3.1. Ethics application

The ethics application for the national review was submitted and approved by the Human Research Ethics Committee (HREC) at the University of Melbourne in October 2010: Ethics ID# 1034186. An amendment was approved in April 2011: Ethics ID# 1034186.2 to reflect changes to the principal researcher and other members of the research team that occurred at the end of 2010.

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

3.2. Participant recruitment timeline

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

3.3. Review design

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

3.3.1. Quantitative data collection

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

3.3.2. Qualitative data collection

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

Table 1: Participant recruitment timeline

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

The review of the La Trobe University MPH was conducted from 23–24 July 2012.
3.4. Data analysis

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

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

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

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

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

3.5. Report structure

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

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

4.1. Structure
The MPH program at La Trobe University has the following structure:

- Two years full-time or four years part-time study.
- Nine core subjects and one elective, with students completing in either research mode\(^1\) or practice mode\(^2\).

There are six specialised streams offered within the MPH program:

- Health policy.
- Health promotion.
- Global health.
- Health leadership.
- Workplace health and rehabilitation.
- Health and social care.

Students can also complete a double degree at La Trobe, combining their MPH with either a Master of Health Administration (MHA) or a Master of International Development (MID).

4.2. Delivery mode
The MPH program is offered through mixed modes of delivery. Subjects are taught in combinations of daytime, evening, block and distance education modes.

4.3. Enrolments

4.3.1. MPH enrolments
The number of commencements and completions over the past five years in the MPH, including both single and double degree options, are set out in Table 2 and Table 3 respectively.

<table>
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<th></th>
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</thead>
<tbody>
<tr>
<td>MPH</td>
<td>39</td>
<td>52</td>
<td>31</td>
<td>24</td>
<td>31</td>
</tr>
<tr>
<td>MPH/MHA</td>
<td>3</td>
<td>5</td>
<td>12</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>MPH/MID</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>42</td>
<td>57</td>
<td>43</td>
<td>32</td>
<td>45</td>
</tr>
</tbody>
</table>

It should be noted that the 2012 figures in both tables were correct as at 9 November 2012.

<table>
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<tbody>
<tr>
<td>MPH</td>
<td>30</td>
<td>27</td>
<td>25</td>
<td>47</td>
<td>9</td>
</tr>
<tr>
<td>MPH/MHA</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>28</td>
<td>25</td>
<td>49</td>
<td>10</td>
</tr>
</tbody>
</table>

4.3.2. Indigenous student enrolments
It is estimated that three Aboriginal and Torres Strait Islander students have enrolled in and completed the MPH over the past five years.

4.4. Indigenous staff
La Trobe University has no Aboriginal staff members employed in the Department of Public Health teaching into the Masters program.

---

1 Research mode consists of two core research subjects and a research project written as a minor thesis.
2 Practice mode consists of three specialist stream subjects and a practicum study.
5. Results

5.1. Mapping of integration of core competencies

This review examined the objectives and content of five of the eight available core courses within the MPH. The results of this mapping of the competencies, based on the results obtained through the Unit Coordinator Questionnaires and the subject outlines provided, are summarised in Table 4 below. From the questionnaires and learning objectives in the course outlines provided, it was reported that Indigenous health content covered in the courses examined:

- Health needs of Indigenous populations.
- Social and cultural determinants of health.
- Indigenous healing projects.
- Health inequities including the gap in Indigenous health status.
- Access to services.
- Evidence-informed approaches to improving health status.
- Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing.

It should be noted that further information about Indigenous health content was also obtained through the interviews, as outlined in the interview results section below.

5.2. Analysis of interview content

As shown in Figure 1, the Leximancer conceptual analysis drew out 10 key themes in order of frequency, with ‘health’ as the most frequent and ‘case’ as the least. Within the ‘health’ theme, ‘Indigenous’ and ‘health’ are the most frequent concepts. Taking the key words most frequently

Table 4: Indigenous health core competencies covered in courses

<table>
<thead>
<tr>
<th>Integrated Indigenous health core competencies</th>
<th>No. of courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Analyse key comparative health indicators for Aboriginal and Torres Strait Islander people.</td>
<td>3</td>
</tr>
<tr>
<td>2. Analyse key comparative indicators regarding the social determinants of health for Aboriginal and Torres Strait Islander people.</td>
<td>3</td>
</tr>
<tr>
<td>3. Describe Aboriginal and Torres Strait Islander health in historical context and analyse the impact of colonial processes on health outcomes.</td>
<td>3</td>
</tr>
<tr>
<td>4. Critically evaluate Indigenous public health policy or programs.</td>
<td>4</td>
</tr>
<tr>
<td>5. Apply the principles of economic evaluation to Aboriginal and Torres Strait Islander programs, with a particular focus on the allocation of resources relative to need.</td>
<td>2</td>
</tr>
<tr>
<td>6. Demonstrate a reflexive public health practice for Aboriginal and Torres Strait Islander health contexts.</td>
<td>3</td>
</tr>
</tbody>
</table>
occurring within the Leximancer conceptual analysis, and those most relevant to the research objectives, the following five conceptual links were created:

- Health to students.
- Health to teaching.
- Health to course.
- Health to issue.
- Health to case.

An additional theme identified through the manual thematic analysis was also identified:

- Integration of Indigenous competencies.

5.2.1. Health to students

This conceptual pathway directly linked the words ‘health’ and ‘students’, which also doubled as the two strongest themes. As would be expected, therefore, the key statements from the Leximancer discussion thread particularly relate to issues concerning students within the MPH. This would also seemingly suggest that the MPH program at La Trobe University is explicitly student focused in its ethos. The essence of the related discussions certainly supports this notion.

5.2.1.1. Student diversity and contribution

The diversity of backgrounds within the MPH student cohort at La Trobe University was commented on in terms of their place of origin and their work experience.

We have a student group of MPH students, between 30 and 50 in any one year, who come from a range of backgrounds; both local, national and international, and they have a diverse range of interests.

So they would span the health system. We actually haven’t had any consumer advocates who are in NGOs, but they’re often people in NGOs, local government, health departments, research institutes, clinical practice, both tertiary and primary.

This enriches the program because of the perspectives and contributions that the students bring to class discussions, either because of differing world-views or lived experience.

You can also talk about determinants of health because you can say things like – where are the factories and where are the hospitals and where are the roads? It’s only

Figure 1: Concept map showing themes from interviews at La Trobe University
ever the international students that think about the river as being a transport system. It’s the kind of thing that you can also say – ‘Well, I’m not sure about the answer to that question as it relates to Indigenous health but I’ll find out for you’ – because the other thing is that you forget the wealth of experience in that room. If it’s a particular thing about one aspect of Indigenous health sometimes someone else in that room [will know] – they’re the students but they’ve got bucket loads of experience.

5.2.1.2. Student interest in Indigenous health

As the previous quote illustrates, student contributions to discussions, particularly around Indigenous health, are often extremely useful and helpful. Interviewees also commented on the extent to which student interest in Indigenous health issues can inform the agenda of class discussions.

So they actually had a really good discussion on other factors – how they impact on the Indigenous health outcome. The purpose is not [so much] understanding why Indigenous health outcomes are poor – it’s understanding [that] many factors affect health outcomes rather than [that you] just… spend money on health services and then you solve the problem. During the discussion these issues do come across. The students we have – because these are online subjects, we have five online discussions – so students do raise the issue of poor Indigenous health and lack of access.

They know Indigenous health better than I do. So drawing on that class when questions come up – that’s the other thing that I see as my role at the front. Absolutely! Not only do they drive Indigenous health but it comes into the sustainability thing because [for] all young – even youngish – people environment is one of the top things in the media that people are interested in… So students drive a lot of the agenda at times [and] even if you haven’t decided to focus on a certain aspect, through an Indigenous lens or an environmental sustainability lens, someone will ask a question that forces you to think about it in that way.

The level of student interest in Indigenous health was largely explained by the social justice philosophy that students tend to bring to the MPH at La Trobe University. This may be attributed to its focus on policy, international development and program management versus programs with, for example, more focus on epidemiology and biostatistics.

But what does happen because I know a little bit about Indigenous health and the students are I reckon half of them and this is just a number I’ve plucked out of – they’ve probably chosen to come into public health because they understand things like health inequality and disadvantage and all that.

Back in the Consortium days there was a good slab of doctors and dentists, often [from] overseas, coming in from the University of Melbourne enrolment. Now we’re much more [focused on] Allied Health, and there actually is a little bit more social background to a lot of the people who come. … [In the Consortium classes you had to take a somewhat different approach because you were trying to take with you a group of people for whom the S word was a really alien idea and who even saw the introduction of a social agenda, which tended to relativise biomedical knowledge, as extremely threatening. [They] could become really anxious and resistant about it, so you had to be careful. We don’t have quite that same sort of set of responses and barriers to work around…

It was noted that this philosophy helps students understand the issues in Indigenous health in a constructive manner that assists their learning.

The students talk… quite naturally about Indigenous health in ways that indicate that they appreciate there are particular problems… and inequalities that need to be addressed in a way that I don’t experience as stigmatising. I don’t know whether an Indigenous person would but I don’t perceive them as kind of doing – ‘it’s all their fault’ – they’re not. There really is an appreciation that it’s a systemic problem with a variety of facets that isn’t going to be solved with any one particular pill or program or anything else and there needs to be systemic change. I do read that in my students when they’re just generally talking… Presumably it’s the way that they’re taught. I also think it might be the fact that we have – it’s public health – students come into public health because they’ve got a particular bent. So I think it’s not necessarily just our fantastic work or anything like that. I think it’s partly what they come along with…

5.2.1.3. Student learning process

The interviewees also indicated that the teaching and learning process is a key focus in the MPH program at La Trobe University, as plainly stated in the following quote.
The essays ranged from quite naive, I would say – and what I mean by that is thinking about improving Indigenous health through quite focused small-scale sorts of health promotion projects – through to students who have a very deep understanding of the complexities of the history of the Indigenous population and the consequences of that for their health, and for the health sector in terms of looking at how they may lead responses or support responses. So I think… the process is more important than outcome in a way; getting students to actually read material that deepens their understanding is really important.

The need to ensure that graduates have critical thinking skills was a goal articulated by nearly all interviewees.

What I see myself doing as a lecturer is even demonstrating a way of thinking through issues… taking hold of a body of material and thinking my way through it. I expect students not to necessarily accept my line, but at least be able to come back with a reason and argued response to it. So in that respect, to look at Indigenous health in that way is no different from looking at any other area. I’m not being an expert, but I am saying [that] with these resources… I come to it and I work through this stuff, and this is the sort of stuff I’m seeing, this is what it makes me think about, this is what it makes me feel, this is how it makes me respond to things like the Intervention or other disastrous social policies.

I guess it’s with other population groups as well. We’re trying to get them to be quite flexible and adaptable – and to be developing a critical set of thinking skills when they’re going out in the world as public health practitioners – to say well, who is the population group that we’re working with here?

In terms of applying these competencies in relation to Indigenous health, the need for judgment-safe practitioners was inexorably linked, by staff, to these critical thinking skills.

So we’re very keen to make sure that the reference material that we’re exposing students to is challenging and really gets them to rethink their own values and attitudes and beliefs and understanding, and that they’re not just compartmentalising Indigenous health as yet another population group that we might do something for in public health by using an Ottawa Charter-driven model.

5.2.1.4. Student choice

Students are also often encouraged to choose from a range of assessment tasks relevant to their background or areas of interest in the workplace.

Then they have to do ministerial briefing notes and there is always an Indigenous topic. That will always be there and it will shift. I had a question about priority actions for ‘Closing the Gap’. Then we have to recognise there are international students and we allow them to – if they’ve got Indigenous people in their own countries – focus on their own country instead.

Either they can choose a workplace one or they can choose a generic topic. Sometimes they get picked up by students who are looking at inequality and equity issues, but less commonly would they focus on Indigenous health.

As the previous quote indicates, this means that Indigenous health topics are not always covered by students. However, other staff noted that they include Indigenous health topic choices in those assessments commonly taken up by students.

In other words, what we do… is that there will always be an Indigenous health topic in the assessment, but it’s not necessarily done by all students.

So, students have to do two essays and do some work in class, [and] the second essay is the larger essay. [So] I’ve put two that might be considered to be relevant to Indigenous health and is commonly used by students to address an Indigenous health issue, but within the context of evidence-based public health.

Students commonly look at Indigenous health issues within that. It’s very common.

5.2.1.5. Student feedback

Interviewees noted that, according to feedback they have received, students appreciate these teaching approaches.

It’s really good, because they’re such wonderful students and they’re busy tackling some pretty serious problems in the health system, so it’s good to inspire them. I get pretty positive feedback on the subject, and they like learning new skills, which they can then apply to their area.

Several formal feedback mechanisms were discussed during the interviews, which were picked up as part of the Leximancer analysis and supplemented through the manual thematic analysis: the standard university questionnaires, individual
subject evaluation processes, student interviews and class discussions.

Students are invited – it’s a standard approach that the university applies… – to fill out those questionnaires. Certainly, in the last session we have an open discussion in class about... what they found most challenging, where they felt like they’ve got a much broader set of tools to be able to use in public health practice.

Also we have individual consultations, so the student will be able to raise issues during that. We do a survey at the beginning, a survey on their knowledge, and then do another again at the end.

So normally after the semester I would send an email to some of the students, [and] ask them [for] any specific comments because they don’t put those comments on the student evaluation at all.

The corridor chatter was also described as an additional informal feedback mechanism that provides an indication to staff of the level of learning occurring over time.

I do hear different words when I hear the corridor conversations because it's so small here. I often have the dentist waiting room effect outside my office and you just overhear what's going on. I do hear the language changing over time.

The manual thematic analysis identified that staff also use other mechanisms to evaluate their courses, in addition to student feedback. Staff debriefing sessions and assessments are also used as a means of evaluation to supplement the student feedback.

We also usually do a debrief with the tutors during the semester as well as at the end of the semester. The assessments have been a very, very important part of what we monitor because a lot of the learning comes from doing the assessments.

5.2.2. Health to teaching

This conceptual pathway linked a series of words together: ‘health’, ‘subjects’ and ‘teaching’. The key statements from the Leximancer discussion thread relate to the way in which Indigenous health content is taught at La Trobe.

5.2.2.1. Embedded content

Nearly all interviewees referred to the way in which Indigenous health is embedded in the curriculum at La Trobe.

Well, we don’t allocate hours for Indigenous health. We integrate content into lectures or we have special guest speakers, depending on the issues.

In this way, the curriculum or subjects form a framework in which examples, including Indigenous health examples, are applied as appropriate to enhance the learning.

One of the ways that... I think about it, is that Indigenous health is something that we want to appear in every subject... as one framework which you can [use when] teaching students... It’s a way of explaining outcomes in one way compared with another.

Students are, therefore, exposed to Indigenous health content through the different lenses of the staff, subject areas and practice.

I know that Indigenous health comes up and is viewed through a variety of different lenses. I can’t put my hand on my heart and say [it’s in] every subject because I can’t say that I’ve examined the subject outline or the content of every subject. But in the ones I know about it comes up.

I think often strengths and weaknesses are opposite sides of the same coin. The strength [at La Trobe] is probably that we touch on Aboriginal health in different subjects so that people hear it in different ways from different people in relation to different content and skill sets. The weakness is the other side, that they don’t get a focused dollop on it... because it’s taken as a more integrated part of the curriculum.

As one of the interviewees highlighted, the effect of this approach is to contextualise the issues around Indigenous health so that the focus is on the issues rather than any specific population group.

Well, it is embedded. [S]o given that the emphasis of the subject is on principles and practice of public health, what we’re trying to do with the subject is to ensure that the students come out with flexible minds about how they understand health issues and how they would work in a multidisciplinary setting, whether that’s in Government or elsewhere, to address those issues. … [F]or example, if we’re talking about evidence – the use of evidence in context – we would look at what evidence do we have around the effectiveness of some of the strategies that we’ve undertaken. So we’re not, again, looking at a population profile of Australia – we would look at Aboriginal populations in that context.

Several interviewees also commented that examples are chosen, not only because of their relevance to
a particular issue, but also because they vary each year depending on what issues are topical.

So, I try to choose something that is relevant to different groups in the community, Indigenous or non-Indigenous, different groups who may experience disadvantage in different ways, and then get them to think about, obviously, what evidence-based public health means in the context. So, I don’t have any topic material related to Indigenous health in the same way as I don’t have any related to mental health, tobacco, obesity. Systematically, across the years, I might just select a topical issue.

So specifically each year, I try to make it interesting, rigorous and timely… Postgraduate students are really on the ball. They know what’s important. They want to see something which is relevant to them now or with their workplace arrangement or with their studies. So I think it’s something we constantly need to do and we try to do.

5.2.2.2. Constructive approach
One of the challenges with this approach, as noted by interviewees, is ensuring that both examples and the course more broadly are constructive, and don’t promote Indigenous health, or indeed any health inequity area, within a deficit model that produces problem- versus solution-based thinking.

One of the challenges I find… is when students are looking at Indigenous public health within the context of evidence-based public health, they tend to give me essays which just summarise the problems… That focus is always on accumulating evidence of the problem. It’s not solely the problem of, or the topic of, Indigenous health, because they do the same when they’re considering health inequalities. I just think it’s part of the complexity of this area, of getting them to think about what some strategies are, and then how we might know those things are effective.

Staff at La Trobe are committed to ensuring that a constructive approach to addressing Indigenous health issues is promoted in their courses.

I think the main problem is there are many, many problems in public health, and the difficulty is getting your head around all of them, and feeling that you can make a contribution. So we try to keep the course fairly constructive.

People have always been very clear that including Indigenous content is a really important part of teaching public health. The issue is much more [about] identifying an appropriate and also a positive case study. I’m actually very diffident about just including something because it’s Indigenous if it’s actually not a really good quality piece of work, because there’s an awful lot of quite ordinary stuff that appears.

However, the challenge associated with the complexity of many of the issues, and the lack of time to find appropriate examples and to unpack the issues to achieve the desired positive learning outcomes, can result in some important content areas being avoided or excluded – particularly for staff who are less confident teaching this material.

It’s very hard to incorporate that in mainstream teaching. I think it should, it could, and it would strengthen the subject, but you need the time, you need the skills to develop that. And even I probably need to be taught or attend a course where this is a specific area of interest which could be incorporated and how best to do that. But I don’t think it’s something that I could just put on one slide and say – ‘Let’s go over it’… So the room to be able to be creative, and we are limited but we can and that’s an important issue to raise and we would, we should, give them that. Even research – in epidemiology or quantitative research – is really moving to population growth, migration [and] groups we’ve excluded up until now, which [is] having very important implications [as] to how we behave and [for] public health…

5.2.2.3. Informal content
Although Indigenous health content is certainly embedded in the MPH program at La Trobe, it was noted that not all of this content is formalised in the curriculum documents and learning outcomes. This is, in part, because this content is often driven by class discussions and student interest as previously highlighted. It is also because the learning objectives must reflect the technical skills or areas of expertise that graduates need to acquire. Therefore, they do not necessarily reflect the Indigenous health examples used to embody the learning, as the next quotes exemplify. Hence, it appears that a good deal of the Indigenous health content in the curriculum is not formalised.

It just doesn’t capture all the informal stuff. Which is exactly what, and I don’t know what others are doing but, that’s probably what we’ve been traditionally doing.
The [course outlines] will not specify Indigenous health because they are broad learning around social and cultural perspectives, but they will be applied to and grounded in Indigenous health in a variety of ways.

I want my students to be able to calculate incidences and prevalences and I want them to know what a risk ratio is – so Indigenous health is not part of my learning objectives. To be honest I don’t think it should be – not in this particular technical subject but being a public health person and interested in this I want my students to get as broader understanding of all the issues where I can fit them in... So you have these conversations that come up. I think that’s the appropriate place for Indigenous health to sit in this particular very technical squashed subject where we struggle to get them to be good at the things that I want them to be good at in the limited time that we’ve got available.

The latter part of the last quote also highlights the challenge experienced by staff to ensure all priority areas of public health, including Indigenous health, are covered in a curriculum that has limited teaching time available.

5.2.2.4. Cross-institutional enrolments
Consequently, La Trobe has chosen to focus its curriculum on the specific areas of expertise – that being policy, international development and health administration. Hence, for those students wanting to do further specialised studies in Indigenous health, La Trobe encourages students to access these subjects through cross-institutional enrolments at other universities that are able to provide these specialised kind of subjects, rather than dilute their own curriculum.

Well, some of my students do want to go and do like the Burnet Indigenous health subject because they want to do a specific slot on Indigenous health. But I don’t think that’s what I want to introduce into the program. That subject is there if they want to go and do it anyway. Because of the kind of policy orientation of this university I don’t think that would actually be helpful.

5.2.3. Health to course
This conceptual pathway linked a series of words together: ‘health,’ ‘people’ and ‘course.’ As would be expected, the key statements from the Leximancer discussion thread relate to who teaches Indigenous health content within the course at La Trobe University.

5.2.3.1. Lack of Indigenous staff
As the data from the questionnaires have already highlighted, there are currently no Aboriginal or Torres Strait Islander academics on staff within the Department of Public Health to teach into the MPH. This was also highlighted during the interviews and expressed as a weakness in the program by staff.

I think the issue that’s quite challenging – well, not challenging but it is probably an issue that La Trobe has grappled with over time – is the extent to which we would have Indigenous staff that would take on a greater role and focus versus everybody taking an interest in integrating... We got very, very close a couple of years ago [with] an emerging senior researcher who was interested to come [to La Trobe and] bring her Indigenous research staff as well as grants. We were all terribly excited and found money and commitment from various schools within the faculty. Then the Dean just decided it wasn’t his priority and it didn’t happen, and it was very sad because it would have given, I think, us a really good boost... What we try to do here is to think about how we can all integrate.

The manual thematic analysis identified that the lack of Aboriginal staff was a consequence of lack of funding. However, concerns were also expressed in regards to finding appropriate candidates, should an identified position be supported at La Trobe.

Well, if I had lots of money that would be easy. We’d make sure that we had access either to someone from [Onemda VicHealth Koori Health Unit at the University of Melbourne] to be formally part of the university to help teach some of those things or we would have an Indigenous member of staff in public health.

So even if you had money, which we clearly don’t, it’s not easy... finding people... You’d still have to find someone who has the right skills to give you what you need. You can’t just employ them because they’re Indigenous. So it’s hard.

While it was noted that most staff at La Trobe were quite comfortable teaching this content, it was acknowledged that they are not able to bring an Indigenous perspective to their teaching.

It’s not a question of people not being comfortable to teach about Indigenous health... If you’re teaching about things like breast cancer or anything really, there’s a whole other lens you can pass across about personal experience. I think for some topics it’s really good to have
somebody who has had some personal experience to underpin why things are written the way that they are.

My reservations would be about my capacity to properly represent the world-view because obviously I'm not Indigenous… Because one of my areas of work is spirituality, I have [a] particular sense that that is a fundamental construct and that to understand Indigenous health you have to stand in a different place in the world to even begin to comprehend what matters. It seems to me…, that to try to approach Indigenous health just through a health lens is rather missing the point.

Several options have clearly been considered and/or adopted as a means of filling this gap, as illustrated in the following quotes. These include shared networks, engaging someone who can assist with developing content or subjects but not necessarily teaching them, and the inclusion of guest lecturers.

Like it would be really good to have a person who's working in a unit [elsewhere] available to us for half a day a week, or a day a week on a permanent basis, so that we could get [them] to come in and help with various things in various subjects.

Maybe the key is just having a really strong network… [So] that we can all go, 'Well I've got this slot that I really want to focus on Indigenous health in this subject. Let me have a look at my little directory – let's see who's free', and we all share.

I think there's more opportunities that we could pick up on to directly involve people from Indigenous backgrounds in teaching, helping us develop or fine tune subjects, or reviewing subjects on a regular basis.

Whichever of the proposed options was taken up, staff clearly recognised the need to avoid having the same guest lecturers teach into various subjects and risking duplication of content.

It’s certainly not fair for the one person to do everything. I think that the integration is important but I think there’s a couple of different ways of doing it. One is if you have people who really think about effective teaching, curriculum, resources – someone who is a resource for other staff, that’s very helpful – and someone who can help develop the kind of integration [needed]. So what might be some really good articles to use in Biostatistics, for instance? … On the other hand, you could also think about, as a completely different approach, if you actually had someone who was across the span of public health – the core public health practice at the basic level. You could have someone who is a participant in each of the core things but in different ways. I mean, I think the worst thing to happen is you say, for every subject we’ll allocate a guest speaker slot, and then everybody gets the same one or two people, and everybody hears the same lecture several times over. That would be the worst pedagogically, you know?

5.2.3.2. Guest lecturers
The guest lecturer option is nevertheless taken up by several staff and is considered an important part of the program – not merely for the contributions they bring to the program, but also for ongoing, informal staff development.

We do – [and] it may change from year to year – get guest speakers in. So there’s certainly opportunity to get people with expertise in Aboriginal health to come in; so absolutely open to that. In public health policy, a couple of years ago, Mick Gooda came in and talked about some of the complexities of working at a policy level in Indigenous health. It was an outstanding presentation. It was extremely thought provoking for the students.

I’ve had both [Professor] Ian Anderson and Mick Gooda in the past. Ian talked about NIHEC [National Indigenous Health Equality Council] because that was the new thing at the time. I had Mick talk about the Intervention because that was the thing at the time. This year, we had Rhonda Galbally on the disability insurance [scheme], and she did it the week after the Federal Budget, so that’s just an example of how we do it. Then we also had Sharon Wilcox as a member of the Reform Commission when that Reform Commission was happening…

But obviously there’s a range of people who are interested in Indigenous health [already teaching at La Trobe]… I suppose I’ve usually had at least some input in the undergraduate programs that I operate, particularly through Penny Smith who was the [Stakeholder] Manager of the now Lowitja Institute? So Penny has usually done a session and she’s vaguely kept me up to the mark in terms of consciousness raising.

Staff also expressed that there is enough flexibility in the program, because of the way it is oriented,
that additional guest speakers can be sought out on topics of interest to students, including Indigenous guests, if the need arose.

So I think there’s huge benefit in getting guest speakers along… as long as it’s appropriate for both parties, I guess, because we don’t just like to get people in to do a tap dance that’s a little bit removed… Almost inevitably feedback is something which you try to get negotiated in the following year, although I have got some flexibility. Let’s say, for example, I got some strong feedback in the first weeks of the semester… that there was a group of people who had a really strong interest in Indigenous health. Then when it comes to the social justice stuff – all the last couple of sessions – social justice, social transformation stuff, we go looking for an Indigenous contributor at that point so we can ramp up the engagement. We’ve got some flexibility still there.

However, the manual thematic analysis identified that accessing guest lecturers can be difficult in terms of their availability and also resourcing levels, particularly in relation to appropriately remunerating community leaders and Elders either financially or in kind.

Look, frankly, my problem is one of convenience and respect. I mean, does poor old Nellie get hauled in to yet another program and asked to truck into the city – I mean, poor woman, gee… We’ve done it on Bundoora campus where I’m asking Nellie to walk 200 metres rather than to spend a whole afternoon trucking into the city. If I had ready access or paid access, that would be terrific. I’d love it… Resources are an issue, both access and resources in that sense.

Give me some money for sessional lecturers, because I don’t like trading off the Indigenous sector, which is often the tendency. If that doesn’t come through then what I’d be doing is reviewing and looking at a range of [Indigenous] literature, hoping to properly represent [the issues]… and basically saying these are some of the resources, these are some of the people you can talk to.

I can’t do that this year, because as you can well imagine [there are] timetabling issues and so on and [hard] to get guests lecturers [when] you don’t pay them. Because we don’t pay them, they do this very much as part of their leadership and work in the discipline; I have to give them a significant amount of time.

5.2.3.3. Community engagement

The other teaching technique utilised in the course at La Trobe is that of field visits, which give students an opportunity to engage with and learn from those with whom they will eventually be engaging as practitioners.

The other things that I personally am really committed to at this university is getting people out into the community – public community. I’m not going to be able to redesign it the way that [I want to, though] I might tweak it in years to come.

5.2.3.4. Relevant experience

The manual thematic analysis also identified that the teaching staff at La Trobe have all worked, and in most cases are still engaged, in fieldwork. Therefore, they are able to apply practical examples of their work when teaching their areas of expertise, which assists in making content relevant for the students.

But I think it’s, again, what students relate to in terms of the way I teach it. It’s because I have a research background they see that it’s relevant to public health. It’s not a statistics lecturer coming in teaching them statistical thinking. They see the relevance; they see why it’s going to be important to them in the next couple of years.

5.2.4. Health to issue

This conceptual pathway directly linked the words ‘health’ and ‘issue’. The key statements from the Leximancer discussion thread particularly relate to issues and challenges associated with integrating Indigenous content in the curriculum at the institutional level.

5.2.4.1. Institutional priorities

As has already been discussed in Section 5.2.2.2, staff are often pressured for teaching time to cover the various content areas considered a priority. As the following quote illustrates, the interviewees pointed out that these priority areas need to be driven at the school, faculty or university level for staff to have the awareness and incentive to integrate content accordingly. Currently, this reportedly occurs inconsistently.

Within the Faculty I have no idea whether Indigenous research is important, whether it’s part of our new 2017 vision. What is discussed is never articulated… For me, for us, it’s about this is the subject, these are the students, this is what has to be taught. Again, maybe it’s because we are teaching it for the second year for the first time – all of this is new even for the top-end let alone where it’s filtered down. But if it’s a major
component, even if it’s 10 per cent of the MPH nationally, then that needs to be filtered down. We need to be having meetings with the coordinators of these core subjects to discuss some of these issues.

If the School heavily promotes an idea of addressing Indigenous issues then we can have one assignment structured in that way. Addressing the issues can be in health promotion... in education, in clinical intervention or improving the capacity of understanding the cultural issues. Then they need to... say it’s our focus. Everyone can change the focus easily, just [make it] more defined. So far I haven’t got the greatest level [of] incentive to make that change. I’m not saying that’s not important but, from the students’ perspective, that’s not the most important issue. Then... before this interview – it’s never been on the table to discuss that. So then we don’t have that great level of awareness that we should do something proactively to champion the idea of these important issues... It doesn’t mean we can’t do it. I may go back – this year we started to introduce the concept after I’d spoken to you.

If it’s incorporated into the competencies and someone says: ‘You have to have 10 per cent or five per cent or X per cent of your assessment or your material has to incorporate this, this, this', then we have to step back and say, ‘Oh, yes okay’... I don’t think it has been a priority. If it was a priority it would be in our syllabus assessment, our objective; and it hasn’t. [Anonymous] has given us the competencies – as in, ‘here’s the document, here are the competencies’ – to make sure that we’re not getting it all wrong. But this is the second year that we’re teaching something that traditionally the Consortium have done. So there are things we’ve never had to think about...

One interviewee pointed out that the focus on Indigenous health in the curricula at La Trobe tends to be at the undergraduate rather than the graduate level, which may help to explain the lack of priority mentioned by other staff.

I have to say that in relation to the Indigenous issues at La Trobe, the focus is much more at the undergraduate level. All the university resources in relation to Indigenous students and development is all oriented at the undergraduate level.

5.2.4.2. Integration of environmental health

Environmental sustainability is currently being driven at La Trobe as a key priority institutionally.

It’s about embedding environmental sustainability into the Master of Public Health. We had a workshop last week so we went through this process that you’re just going through with us. We went through that with all the coordinators and asked them all the questions you’re asking us – a bit about environmental sustainability.

This may have implications for the integration of Indigenous health content if staff are required to fit institutionally identified priority content areas into their already full curriculum, as alluded to here.

You have an X amount of hours and the key areas that you need to cover so that they can come out with a competitive MPH... and we have a set number of sessions… But, again, do we specifically have an hour or half an hour where we say environmental issues, which is really important – or Indigenous health? We don’t.

An alternative approach, which was broached by one interviewee, is to try and link the two priority areas.

We could get them to think about both issues seeing as they are really quite closely linked – Indigenous health and sustainability – [to] see if we could get some sharing of ideas and maybe some sharing of resources.

5.2.5. Health to case

This conceptual pathway directly linked the words ‘health’, ‘Indigenous’, ‘population’ and ‘case’. The key statements from the Leximancer discussion thread particularly relate to the Indigenous health content that is taught at La Trobe.

5.2.5.1. Indigenous health content examples

As has already been highlighted, overcoming health inequities through evidence-based approaches informs the orientation of the La Trobe MPH program.

We also look at broad societal issues like health inequalities and their relationship to public health, and at the topic of applying evidence in context.

Social and other determinants of health are subsequently a key part of the curriculum, and Indigenous health is addressed through this framework.

Indigenous health turns up, I suppose, in the broad context of social determinants and social gradients of health. So, in that sense, [it] mak[es] the point that the issues around
Indigenous health in other forms are more about social justice, social inclusion than the mere provision of health services.

We also look at changes over time in things like social, cultural and legal determinants of health in the population; so, again, contextualising, not just in the present day, but in terms of a macro history, if you like.

We gave them the quote from the social emotional wellbeing framework, [in] the mental health and social emotional wellbeing document, as a prompt to get them to think about the connectedness to land and the importance of land to wellbeing in that particular population group, but also for them to think about other population groups and how land and environment and so on affect health.

Due to the policy and health administration focus of the programs at La Trobe, the Australian health system is also a focus area – both broadly and in terms of how Indigenous health fits within the system, in relation to services, funding and policy.

It’s the issue of Indigenous health within the Australian context and it’s the way it fits, and fails to fit, within the Australian health system, and trying to understand that at a more fundamental level. It’s more than simply saying either that we haven’t got enough services or they don’t make proper use of those services – that [is a] superficial conflicting view.

What we would do is we would touch on the Indigenous issues in relation to, say, the Australian health system; the existence of the AMSs and how they came about, and so on and so forth. We might touch on the different structures through which policies are made. I mean, usually there may be a reference to the National Aboriginal Health Strategy just in terms of looking at the historical trajectories and how policymaking happens. There are certain reference points that would happen as part of a larger picture… We might talk about Aboriginal health expenditure, again as part of a larger discussion about policymaking, just like the National Aboriginal Health Strategy and AMSs and all that. It might come up in reference to, say, the initial Deeble Aboriginal Health Expenditure Study.

I teach another [subject], the Australian Health System… [and in that] when you talk about system design, they will talk about how to address those minority groups or disadvantaged groups. So when you talk about funding, that will explain how the funding imbalance happens, and why… special funding will fund… Indigenous health services. We even discuss why Kevin Rudd’s Bridging the Gap is impossible to achieve. So we will discuss that – how health is not just about health but other determinants for health as well.

For two years, we’ve given more emphasis to the establishment of the Preventive Health Agency, the Medicare Locals and the COAG reforms because that’s new. Next year, that’s not going to be the case because the reforms are going to be more consolidated. So that’s one aspect that we always get them to do is whatever is the current thing... If we’re getting movement forward in the policy realm on Indigenous health in the next 12 months, then there will be much more focus on policy.

Interventions and the different types of approaches used to improve access to services and interventions were content areas also highlighted by interviewees.

We also look at interventions that we may have undertaken in Australia in relation to risk factors, but also at-risk population groups. Indigenous Australians are included in that.

The second is evidence-based interventions with the focus on tobacco, nutrition and physical activity and alcohol, mental health and violence, and interventions with that risk population group such as Indigenous Australians and low income groups.

That’s the beginning [of the course,] with the art exhibition and then looking at Western Desert kidney health. That will involve looking at... the recent conflict between the way in which the project has evolved within the community with the use of art [to promote] access to the project etc., as against a bureaucratic response which says this stuff isn’t health.

Specific Indigenous methodologies are also covered.

Actually, that’s another one we’re into. There’s another session on narrative, which again has the capacity to pick up Indigenous narrative as well... Again, it’s looking at narrative frameworks, but also encourages people to go and look for stories.

Ethics are also covered as a preparation for the research component of the course.
We do a large slab on ethics and the ethics of working in other settings, in particular Indigenous settings.

5.2.5.2. Teaching resources

Resources used to assist the teaching of Indigenous health content were another key focus in this discussion thread. As previously mentioned, La Trobe includes a number of field visits in their MPH.

We went to the Immigration Museum and Eureka Tower. That day was really about getting students to think about people at the centre of public health practice; so being driven by the needs of population groups.

This year we couldn’t do it because it’s closed, but I would normally be including a slot at the Melbourne Museum in the Indigenous exhibition there.

In the Sociology subject we’re going down to Federation Square to look at the Western Desert exhibition.

They get a field trip in Environmental Health, and they go out to the Werribee Sewerage Plant and stuff like that, so it’s a different way of learning.

Several staff referred to readings, papers or journal articles that they use as illustrative examples or assessment tools.

I give them old maps of Melbourne and get them to think about what it was like when the First Fleet arrived, and how Indigenous people would have used the landscape and how has it changed as a result.

A lot of the material – and it’s not just stuff that’s in the Australian Institute of Health and Welfare documents, but records of lived experience… can really enrich a subject like this. We’re trying to get… the students to think about people at the centre of public health actions, as opposed to the health professionals being the ones that direct and determine and allocate resources and those sorts of things.

Then in terms of books for review, because everybody has to do a book review, there’s a mix of stuff on the possible books that ranges from things like Snake Cradle, through to Closing the Gap Report.

So we also have some reading materials posted on the website. We use Stephen Duckett’s book and [in] that Indigenous health is incorporated in many of the chapters already.

So last year we had an Indigenous health study paper that was critically appraised and that formed 30 per cent or 40 per cent of their assessment... It was one of the last things they had to do apart from the exam. They had to read the paper on Indigenous health properly and answer questions including questions to do with ethics.

I found the article, a published case study from somebody. You know, not many good case studies are actually published. I don’t create a hypothetical one. So I find… a real case study that provides me also [with] an evaluation report so then I can generate a rich case study for the students. So if, you know, something’s already available, fine.

What you can do [with] the case studies, [in] the exercise around those tools it would be important to add an Indigenous perspective… I don’t deliberately say here are the five tools and I’m going to add five exercises. However, I do have some exercises where we’re… critiquing a published article... It’s actually from the NT, so it’s probably dietary patterns comparing it to another group, for example. A lot of the time we do that. Again, it’s not because we’re trying to focus on Indigenous health, I’m trying to illustrate on topics, or areas of interest to our current students, statistical issues – so issues of sample size. Here is a finding, why do they articulate this outcome when in fact the main issue is power?

Then the other thing that we have them do, which is a hurdle requirement, is they have to maintain a media journal. They have to read the newspaper, pick out whatever is the issue of the day [and] write a policy-oriented reflection on that.

Perhaps another good example that I often use is how you define Indigeneity – just as an example because it’s bringing it back as a concept. So if you’re defining it as an outcome, how accurate, what are the classification issues, what are the biases? So it’s not a deliberate thinking [that] I’d like to incorporate, it’s very much [that] these are the issues which are relevant to our students and these are the case series or studies or exercises that we would include.

Other staff have created case studies that they use as teaching tools to build students’ skills for specialised content areas.

So some of those materials that are Indigenous specific that I designed... the brief was to really just try and bring
Indigenous health into the teaching of epidemiology. So when I teach something basic like prevalence or incidence I’ve designed a whole case study. Instead of just choosing any subject I’ve chosen it based in an Indigenous population. So it’s not anything too deep in terms of delving into all the issues about Indigenous health but it’s just I’ve designed an Indigenous mental health scenario where they get to calculate prevalence and incidence.

It was noted that, depending on the area of specialisation, case studies can be used repeatedly over time, or may need to be updated to reflect changes in the context or accepted practice.

You only need two or three really nice case studies and people will use them. People always want to update their stuff and bring things in... But even then I think, depending on what the particular topic area is... some things would be just perfect for 10 years unless something drastically changed. I mean there’s always that issue but some of the case studies that we use for the Master of Applied Epidemiology we designed 30 years ago and they’re brilliant.

How these are applied in the curriculum has yet to be systematically assessed or mapped and recorded, however. An exercise that would be considered useful for staff would be one where everyone is aware of who is using what resources.

So giving more attention to the resources that we draw on, I think, would be something that I would certainly welcome with this subject, and probably across subjects as well. So a little bit more systematically done there.

A bank of resources and case studies that could be drawn on was also considered something that would be helpful to staff.

If we had a bank of resources that you had access to and people would work together to develop them I guess that would make it happen... Someone would go, ‘Look, this has happened in Indigenous health about policy – I think here’s a great little one hour learning exercise we could design where people look at this issue and think about the responses. Let’s get a team of three to four people and you treat it like you’re writing a paper. Let’s sit down in a room and see what it would look like. That looks good, we could get this newspaper article and you just get things together.’ ... You just get organised and chat and email... you only need two or three really nice case studies and people will use them. People always want to update their stuff and bring things in.

If I had an Indigenous health handful of robust case studies that were readily accessible they would find their way into my course as I put it together each year.

I need the time to be able to extract relevant information which is of a priority for Indigenous health. Whether it’s health evaluation research, whether it’s service delivery, whether it’s issues of exposure and outcome, chronic disease. What is timely now? I need the time or the administrative support for someone to assist me to extract the relevant information so that I can put it in a format... I don’t think we need 300 examples. I think if we had 10 or five really good case series and then take it across the spectrum of public health teaching, I mean that would be highly valuable.

As the following quote illustrates, this could have the added advantage of providing some consistency across the various MPH programs.

But the other benefit is if you want some sort of uniformity between the MPHs, and know that there’s going to be some similarity in the way that certain competencies are delivered, well then... it’s a challenge but if you came up with a couple of really good case studies that everyone went, ‘Wow this is great’ – people would use it. So we’d all be using the same case studies. So you get that sort of consistency between the programs.

5.2.6. Integration of Indigenous competencies

The manual thematic analysis identified several other key learnings that are discussed in the following sections of this report.

5.2.6.1. Process of integration

Discussion of the process used at La Trobe to ensure that both Indigenous health content was embedded in the curriculum, and the required graduate competencies included, was outlined.

After the [Victorian MPH] Consortium finished we used the competencies document as an opportunity to really redesign the whole program. So a couple of people here... and myself were very much involved with taking the competencies, seeing what we already taught in the formal MPH program, seeing where our gaps were and then designing some courses [and] subjects around that. So we believe, with our hand on our heart,
that in terms of the core competencies for the core part of the document we **cover every competency —** at least the basic three or four levels and several of them better than that especially the ones that are policy related... [With] public health... each of the **course coordinators** was aware of this process happening and were pointed very firmly at the **Indigenous competencies** within the document. I don’t think they would all have this but they’ve all been presented with the other competencies document on multiple occasions. Every opportunity we have to bring it out we kind of say – ‘This is what it’s supposed to look like’. So there has been a really **firm commitment**. The other thing that we do that not every MPH does is the research component, the other underpinning competency, the kind of application one. So we have certainly a theoretical will to include Indigenous competencies across the board in **all of the subjects** as each of the competencies occurs in a subject.

However, it was also acknowledged that, since that time, course coordinators have redesigned their courses and teaching staff have not necessarily been monitored to ensure that Indigenous health content is continuing to be delivered.

*I don’t design every [course,] so I know what people say they do but I **haven’t sat in** every class. So I believe that for the most part people do what they say they will do and will include Indigenous competencies in the course content.*

Additionally, because staff tend to teach in isolation, it has been difficult to keep track of who teaches what content. There was an identified need to rectify this with regular staff workshops that enabled sharing of this information and provided staff development.

**Busy people are teaching these subjects in silos and we need to integrate stuff better... But one of the things that our department never has money to do is to let us all have a day talking from time to time. That would be excellent just to have a staff time as a function of the university — [there’s] certainly not a lack of will on the part of teaching staff.**

This sharing of information would assist in streamlining the Indigenous content in a way that is most appropriate for the different courses.

*It would be nice to be able, coming out of your exercise, to say ‘How do we do it better’? Not necessarily for each subject person, but be able to say **across the course,** where might it be because you wouldn’t necessarily do the same thing in each subject. In **different subjects,** you might have different things. You might give a **different emphasis,** and you might want to think about how you **string it together** across the subjects so that there’s a **narrative** that people get.*

However, systemic barriers to the suggested mechanisms for improving teaching were also identified. Not all staff are focused on teaching and, therefore, are not interested in teaching-related functions, nor are there incentives to become quality teachers. This was explained by universities’ emphasis on research over teaching.

*The reality is — this is my barrow and that’s that. There are some people who clearly are interested in **research**, and **teaching** is something they’re **forced to do** so you have to drag them kicking and screaming to the table... I could be the best teacher in the universe and do my job brilliantly as a teacher and it won’t account for anything really in terms of [my career]. It **doesn’t count** for jack [even though] universities on the one hand want you to teach well. Then someone else could be the worst teacher in the world, and get extra publications all the time... and they’re the ones that progress not me... I think it will eventually change because universities are depending on money from their students, and students are getting savvier and savvier and they will start to go to places that teach better. I mean they’re already doing it obviously, but I think eventually the university will click that they have to **reward** [teaching] and **encourage** it.*

### 5.2.6.2. Content versus competencies

Another issue that was raised during the interviews was the tension between content and competencies. Although the Indigenous content may be embedded in the curriculum, it does not guarantee that graduates achieve the intended competencies, or determine how well they are achieved.

*We’ve **integrated** it because it’s incorporated into the larger **lectures** as I’ve just given you. The question of whether they **achieve the competencies** is a different question, right? Certainly, there’s also a question of **how well** the competencies are achieved as opposed to [they’ve been achieved,] yes or no.*
6. Findings, Commendations and Recommendations

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

6.1. Integration of the Indigenous competencies

From the data presented it is clear that La Trobe University has taken a horizontal model approach to the integration of Indigenous content, ensuring that all graduates will have received training in the core competencies. Section 5.2.6.1 indicates that a thorough mapping of the curriculum was undertaken against the competencies during its development to ensure that it permeates the curriculum in line with best practice (Kai, Spencer & Wilkes 1999). The quantitative and qualitative data affirm the integration of Indigenous content across most of the core areas of study in this program.

The majority of staff interviewed also expressed an interest and passion in maintaining this content as a priority. They actively work to keep their content current and, therefore, relevant to students, as well as presenting Indigenous health content from a positive and solution-based approach rather than the deficit, problem-based approach. This is closely aligned with the philosophy that drives the La Trobe program in terms of focusing on a social justice agenda and overcoming health inequities.

In addition, for those students who want to undertake further studies in Indigenous health, La Trobe encourages cross-institutional enrolment at other universities that provide specialised subjects in the area. This allows La Trobe to continue to focus on providing content that reflects the areas of expertise of the current staff, while allowing students to explore their areas of specialist interest. Consequently, La Trobe balances the challenges of ensuring that core competencies are delivered within its MPH curriculum, while tailoring the program to reflect staff expertise and providing a program that addresses a niche area of need in public health training. It also allows students to progress their interest in Indigenous health without penalising students or impinging on an already full curriculum. In the current Australian higher education political climate that fosters competition (Quiddington 2010), this strategy is commendable.

Of note, as discussed in the preceding section, the importance of the competencies versus content areas covered was questioned: does teaching of the competency areas in curriculum actually guarantee achievement of the required graduate attributes or how well they achieve them? Although assessment can be used to measure the effectiveness of teaching in this regard, it only achieves short-term evaluation (Kai, Spencer & Wilkes 1999). The Indigenous core competencies rely on ‘increasing awareness, informing attitudes and encouraging reflective practice. The outcomes of these processes, unlike acquisition of knowledge and skills, pose considerable difficulties in terms of assessment,’ (Kai, Spencer & Wilkes 1999:621). Longer term evaluation is, therefore, needed but this is only possible post-graduation. As yet, it is still unknown how graduate attributes and competencies are impacting on the workforce. Thus, there is a need to ascertain whether graduates are gaining adequate and relevant skills and competencies that are of use to them once they (re)enter the workforce. While this could partially be determined through university graduate surveys, there is also a need for a broader national public health workforce survey to measure the types of outcomes that should be considered for future strategic action by stakeholders of the IPHCB Project.

6.2. Innovations to integrate the Indigenous competencies

The use of various field visits to enhance the delivery of teaching at La Trobe is an exemplary aspect of the
program. This is especially so given the innovative use of modern context and environment with creative use of supporting resources, versus the more traditional ‘on country’ style of Indigenous study field trips or cultural immersion programs utilised in many health professional education curricula (Crampton, et al. 2003; Jamrozik 1995; Kamaka 2001; Palmer 1997). The field trips have been designed to provide experiential learning that deepens understanding, and to enable learning from the community with whom graduates will be engaged as practitioners. These are critical components of curricula aimed at educating health professionals to become culturally safe practitioners (Kai, Spencer & Wilkes 1999). However, the field trips have also avoided the trap of acting as ‘a kind of “safari” experience’, which brief, ‘one-time visits provide’ (Wear 2003:553). Instead, they are embedded in a curriculum that tackles Indigenous health alongside other disadvantaged populations within a societal framework that aims to recognise problems and solutions for ‘all’ members of society, regardless of gender, race, ethnicity, religion, sexual orientation, language, geographic origin, or socioeconomic background’ (Kumagai & Lypson 2009:782) – as illustrated by the combined Immigration Museum and Eureka Tower visit described in Section 5.2.5.2.

In addition to the creative use of existing resources, La Trobe staff have been involved in creating innovative case study examples for integration in the curriculum, as outlined in Section 5.2.5.2. It was noted these examples have been integrated in the MPH teaching program within at least one other Melbourne-based university. Given the identified need for a library or ‘bank’ of such resources, as aforementioned in this report, La Trobe has provided a leading example of how to progress this piece of necessary work in the future.

6.3. Improving integration of the Indigenous competencies

Despite the commitment and effort to the integration of Indigenous health content in the MPH program expressed and demonstrated by most of the MPH staff during this review, it appears that this area of national priority is not necessarily reflected throughout the institution or senior management within the School and Faculty. As discussed in Section 5.2.4.1 the level of priority attributed to Indigenous health within the institution is inconsistent. This sends mixed messages to staff who would not otherwise see this as an area relevant to their teaching; hence comments by some of the staff that they had not considered integration of these competencies as a requirement until this review was conducted.

This lack of giving any institutionalised priority to Indigenous health is also reflected in the deficit of resources made available to the program and teaching staff to engage Indigenous personnel to lead or assist with curriculum development and/or teaching of Indigenous content. There is a clear need to fund an identified position or, alternatively, provide sufficient funds to remunerate Aboriginal community members appropriately to contribute to the program as either guest lecturers or curriculum advisors. Although it is acknowledged that Indigenous academic staff are in short supply nationally (Behrendt, et al. 2012) – making the ideal solution potentially difficult to achieve even if resources are made available – there were, nevertheless, several alternative strategies suggested by the interviewees that would provide feasible alternatives in the short term; yet these are not currently supported through funding either.

In terms of institutional priorities, another area of weakness – which is not unique to La Trobe but is nevertheless a barrier to the integration of specialised content in curricula – is the lesser priority often given to quality teaching versus research outputs by universities (Marsh & Hattie 2002). As outlined in Section 5.2.6.1, this provides a disincentive for research staff to participate in teaching-related activities or, indeed, to spend any significant time attempting to improve the curriculum or their own teaching practice. If integration of Indigenous health and other national priority areas of workforce development need are to be successful, incentives and support for staff development and quality teaching are needed (Kai, Spencer & Wilkes 1999). Strategies to improve the curriculum further and to contribute to staff development were also discussed during this review. These included peer review and mentoring, as the following quote illustrates, and in particular the opportunity for regular workshops to share information as outlined in Section 5.2.6.1.

So we talked about this way of integrating our curriculum better by buddying up with another coordinator and going through this stage-by-stage process of working in pairs to integrate something and get confident in there and then we’ll swap pairs and that sort of thing.

There is also the need to conduct regular reviews of the content being developed across the course. Although a mapping process of the competencies against the curriculum was used during the development of the current program, there appears to be some slippage from the initial curriculum content within some of the subjects where coordinators or teaching staff have adopted their own content, as outlined in Section 5.2.6.1. Given
that the new Australian Qualifications Framework (AQF Council 2011) must be implemented by December 2013, it is timely that these considerations are accounted for in any process undertaken to align the curriculum with the AQF.

It would also be advisable for informal Indigenous health content – which is quite substantial if the discrepancy between the documentary evidence outlined in Section 5.1 and the information about content obtained in the interviews is an accurate indication – to be documented formally in subject outlines, where possible, as part of this process. This would ensure that the extent of the integration of Indigenous health content and the associated competencies are formally reflected and acknowledged in the program documentation.

6.4. Commendations

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

- Their ongoing commitment to horizontal integration of Indigenous health content and the associated core competencies.
- The approach to teaching Indigenous health content within a social justice framework that utilises innovative field trips in a societal rather than a culture-specific setting.
- Ensuring that Indigenous health and other content is topical, constructive and relevant to students, to enhance learning.
- Providing students with an opportunity to explore specialised studies in Indigenous health through cross-institutional enrolment options.
- The student-focused ethos of the program that encourages active engagement and experiential learning in a supportive environment.
- The use of varied feedback and evaluation mechanisms above and beyond the standard university evaluation mechanisms to inform ongoing quality improvement.

6.5. Recommendations

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

- Consistently treat Indigenous workforce development as an institutional priority.
- Appropriately resource Indigenous staffing positions and/or remunerate community members to contribute to curriculum development and/or teaching.
- Undertake a systematic curriculum mapping exercise to ensure all of ANAPHI and Indigenous health core competencies are covered, and align the curriculum with the AQF requirements.
- Increase the documentation of Indigenous health content to reflect the extent of integration.
- Ensure that ongoing staff development and support for teaching of Indigenous health content is adequate.
- Provide incentives for quality teaching to support integration of specialised content in the curriculum.
- Conduct a survey of MPH graduates to assess relevance and applicability of the program to their workforce needs.

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

- A national public health workforce survey regarding application of MPH graduate outcomes to workforce.
- A bank of Indigenous health case studies and resources or teaching tools for teaching staff.
- A review of the competencies to ensure they are realistic, measurable and achievable within MPH curricula nationally.
7. References


8. Attachments

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8.1. Expressions of Interest letter

Indigenous Public Health Capacity Development Project

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

Call for Expressions of Interest

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

- identifying core Indigenous public health competencies for the MPH program;
- disseminating a curriculum guide for their inclusion in MPH programs, the National Indigenous Public Health Curriculum Framework3; and,
- integrating these competencies within the key national 2010 MPH curriculum guide, Foundation Competencies for Master of Public Health Graduates in Australia4.

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

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

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

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

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

8.2. Letter of Introduction

**Commencement of MPH Reviews**

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

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

Key outcomes of the previous work included:

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

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

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

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

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

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

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

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


8.3. Plain Language Statement

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

The Indigenous public health competencies are a core component of the ‘Foundational Competencies for MPH Graduates in Australia’ published by the Australian Network of Academic Public Health Institutions in early 2010. We have invited you to participate as you co-ordinate or teach in a subject that delivers Indigenous content within your MPH program and we are interested in your professional experience and perspectives on the delivery of this material.

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

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

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

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

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

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

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8.4. Consent Form

School Of Population Health
Consent Form

PROJECT TITLE: *Review of the Integration of Indigenous Public Health Competencies within MPH Curricula*[^9]

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

1. I consent to participate in this project being undertaken for research purposes, the details of which have been explained to me, and for which I have been provided with a written plain language statement.

2. I understand that my participation will involve (please check required box/s):
   (i) participation in a semi-structured interview [ ]
   (ii) participation in a focus group interview [ ]
   and I agree that the researchers may use the results as described in the plain language statement.

3. I acknowledge that:
   (a) I have been informed that I am free to withdraw from the project at any time without explanation or prejudice and to withdraw any unprocessed data I have provided.
   (b) I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements.
   (c) I have been informed that the small sample size may have implications for protecting the identity of participants.
   (d) I have been informed that the interviews will be audio-taped and I understand that audio-tapes will be stored at the University of Melbourne and will be destroyed five years after final completion of the project.
   (e) unless I request otherwise, my name will be referred to by a pseudonym in any publications arising from the research.
   (f) the organisation with whom I'm affiliated will be identified in the findings.
   (g) I have been informed that a copy of the research findings will be forwarded to me.
   (h) Once signed and returned, this consent form will be retained by the researchers.

Signature __________________________ Date ____________

(participant)

[^9]: HREC #: 1034186.3
8.5. MPH Coordinator questionnaire

Questionnaire for MPH Program Coordinators
Review of the Integration of Indigenous Public Health Competencies within MPH Curricula

Name of participant: _________________________________________________________________
Email contact: _________________________________________________________________
Department: _________________________________________________________________
Institution: _________________________________________________________________

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


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


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


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

______________________________________________

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

______________________________________________

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

______________________________________________

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

______________________________________________

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

<table>
<thead>
<tr>
<th>Key incentives for non-Indigenous students</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Key dis-incentives for non-Indigenous students</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Key incentives for Indigenous Australian students</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Key dis-incentives for Indigenous Australian students</th>
</tr>
</thead>
</table>
9. Please describe the input and status of Indigenous advisors to the Indigenous Australian health content within your MPH program:

<table>
<thead>
<tr>
<th>Response</th>
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10. Please describe current staff development strategies aimed at improving capacity in Indigenous Australian health or Indigenous learning styles:

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<tr>
<th>Response</th>
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</table>

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

<table>
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<tr>
<th>Response</th>
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</table>

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

<table>
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<th>Response</th>
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Other comments:

Thank you for your participation
8.6. Unit Coordinator questionnaire

Questionnaire for Unit/Subject Coordinators
Review of the Integration of Indigenous Public Health Competencies within MPH Curricula

Name of participant: __________________________________________
Email contact: ________________________________________________
Department: _________________________________________________
Institution: __________________________________________________

Subject/Unit Title: ____________________________________________

1. Total formal contact hours for unit: __________________________

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

3. Is it possible for the researcher to review the relevant course outline in order to ascertain content (please tick relevant answer):
   Yes                           No

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

   __________________________________________________________

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

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

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

### 7. Human Resources Utilised:

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

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

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

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

Other comments:

Thank you for your participation