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

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As Head of the Discipline of Public Health within the School of Population Health at the University of Adelaide, I am very pleased to endorse this review of our Master of Public Health (MPH) program evaluated by the Public Health Indigenous Leadership in Education (PHILE) Network. An investigation of the ways in which Indigenous public health competencies are included in public health programs throughout Australia is timely. It provides an important resource for benchmarking and strategic improvement, as well as documentation of what we have all achieved so far. As the reviewers also note, it is a difficult time for MPH programs as a result of the Commonwealth funding withdrawal.

The reviewers’ documentation of the continued development of our MPH course on Indigenous Health (previously titled Aboriginal Health Policy), from an elective established in 1994 to a core course in our MPH in 2007, is a significant part of our history as a public health discipline within this university. More recently, from 2002 to 2009 this happened in conjunction with input from Indigenous academic staff in the Yaitya Purruna Indigenous Health Unit (YPIHU) set up in 2001.

Since 2010 – and the amalgamation of the disciplines of General Practice, Rural Health and Public Health along with the YPIHU into a School of Population Health – the Indigenous academic staff in the Unit have taken over the leadership and coordination of the MPH’s Indigenous Health course. This is part of the expansion of YPIHU and its overall contribution to the School, as it moves from an Indigenous student support focus to a major involvement in teaching, curriculum development and research.

The reviewers’ recommendations in relation to adequate support for Indigenous academic staff is important and noted, along with the continuing need for horizontal integration of Indigenous content across the whole MPH program. We thank the PHILE Network for this review and look forward to further collaborations.

Associate Professor Dino L. Pisaniello
Head, Discipline of Public Health, School of Population Health
The University of Adelaide
July 2013
# Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<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>DoHA</td>
<td>Department of Health and Ageing (Australian Government)</td>
</tr>
<tr>
<td>HREC</td>
<td>Human Research Ethics Committee</td>
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<td>IPHCB</td>
<td>Indigenous Public Health Capacity Building</td>
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<tr>
<td>MPH</td>
<td>Master of Public Health</td>
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<tr>
<td>PHERP</td>
<td>Public Health Education and Research Program</td>
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<tr>
<td>PHILE Network</td>
<td>Public Health Indigenous Leadership in Education Network</td>
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<tr>
<td>SELT</td>
<td>Student Experience of Learning and Teaching</td>
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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 the University of Adelaide in February 2012.

The review was based on a qualitative design although some quantitative data, which focused on a series of interviews with staff from the University of Adelaide, 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 each of the six core Indigenous public health competencies has been integrated into the curriculum. The University of Adelaide has adopted a model primarily based on vertical integration, with Indigenous Health changed from an elective to a core course in 2007. Since then horizontal integration has continued to occur, demonstrating an ongoing commitment to Indigenous health as a priority area for the curriculum, although its level of integration varies depending on subject matter and staff expertise.

The University of Adelaide has also demonstrated its commitment to integrating Indigenous health content by creating and staffing an Indigenous Health Unit within the Faculty of Health Sciences. The Unit leads the integration of Indigenous content and competencies in the curriculum and ensures that Indigenous staff are teaching Indigenous health content. There were, however, concerns that there remains insufficient resourcing within this unit to undertake the scope of work required.

The following recommendations to strengthen the integration of the Indigenous public health core competencies are therefore provided:

- Ensure that university, faculty and school policies articulate the need to increase the number of Indigenous academic staff numbers in the long term.
- Ensure appropriate retention strategies and adequate support systems are in place for Indigenous staff.
- Revise the current policy, which states that all Indigenous health content must be taught by Indigenous staff, to more accurately reflect their role in supporting other staff to teach such content.
- Recognise those staff who are providing horizontal integration of content in units other than the Indigenous health course.
- A need for Aboriginal and Torres Strait Islander competencies to blend more with methodological subject areas, including epidemiology and biostatistics courses.
- Encourage staff to share ideas so as to enhance cultural competency across the entire school.

Despite these recommendations for improvement, the University of Adelaide program should be commended for:

- Demonstrating a commitment to Indigenous health through the creation of the Yaitya Purruna Indigenous Health Unit to support the faculty generally and the MPH program specifically.
- Demonstrating a commitment to the inclusion of Indigenous health content with the establishment of Indigenous Health as a core course in the MPH program.
- Achieving vertical and horizontal integration of the Indigenous public health core competencies into other courses within the MPH curriculum.
2. Introduction

2.1. Public Health Indigenous Leadership in Education Network

Indigenous health workforce reform is a foundation plank of current policy initiatives to ‘Close the Gap’ in Indigenous health. The PHILE Network is a coalition of leading national academics and professionals in Indigenous public health formed from the National Indigenous Public Health Curriculum Network. This network was established in 2003 in response to an identifiable need to provide a forum to exchange resources, ideas and develop policies and programs of relevance to teaching and learning activities in Indigenous public health. It is part of the broader Indigenous Public Health Capacity Building (IPHCB) project funded by the Australian Government’s Department of Health 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>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>January – June</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 University of Adelaide MPH was conducted from 16–17 February 2012.
3.4. Data analysis

All semi-structured interviews were recorded and subsequently transcribed. Transcripts were then cleaned and all information relating to the interviewees was removed. 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 the Leximancer qualitative content data analytical software tool, which assesses the semantic and relational dimensions of text (Smith & Humphreys 2006) and is able to draw out objectively the key themes and concepts. Such a process is designed to minimise the effect of predetermined perceptions of researchers on interpretation, and to increase consistency across the reviews – given it is a national review process being conducted by a diverse team.

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

The discussion threads (or pathways) that form the content of the Leximancer-generated conceptual pathways are discussed in the Results section. 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 the University of Adelaide has the following structure:

• 1.5 years full-time or three years part-time study; and
• six core courses and either six electives; or two electives plus a dissertation; or four electives plus a practicum.

4.2. Delivery mode
The core courses are delivered face-to-face, as are some electives. Other electives are delivered either online or by mixed mode.

4.3. Enrolments

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

<table>
<thead>
<tr>
<th>Year</th>
<th>MPH enrolments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>18</td>
</tr>
<tr>
<td>2008</td>
<td>24</td>
</tr>
<tr>
<td>2009</td>
<td>22</td>
</tr>
<tr>
<td>2010</td>
<td>20</td>
</tr>
<tr>
<td>2011</td>
<td>39</td>
</tr>
</tbody>
</table>

4.3.2. Indigenous student enrolments
There has only been one Indigenous student enrol in the MPH over the past five years, and that was in 2009. This student successfully graduated from the program in 2010.

4.4. Indigenous staff
The University of Adelaide hosts the Yaitya Purruna Indigenous Health Unit, which is staffed by two academic staff, one Indigenous student support officer and an administrative officer – all of whom are Indigenous.
5. Results

5.1. Mapping of integration of core competencies

The University of Adelaide public health programs prospectus outlines two graduate attributes that are already embedded in the curriculum. These are:

- An ability to apply effective, creative and innovative solutions, both independently and cooperatively, to current and future health problems, including the capacity to deal with Indigenous health issues.
- An awareness of ethical, social and cultural issues and their importance in the exercise of professional skills and responsibilities in the field of public health, including Indigenous health.

The University of Adelaide MPH program also has Indigenous Health as a core course. This course addresses all six of the Indigenous health core competencies. Additionally, a review of the objectives and content of five other courses (two cores and three electives) confirmed that the Indigenous core competencies are also embedded in other courses. The results of this mapping of the competencies in the six courses are summarised in Table 3 below.

From the questionnaires filled out by the MPH Coordinator and Unit Coordinators it was reported that Indigenous health content covered:

- Aboriginal health and history.
- Aboriginal people and the justice system.
- Current health status of Indigenous people including mortality and morbidity rates, non-communicable disease, chronic disease and notifiable diseases.
- Evaluating health interventions and technologies.
- Indigenous culture, knowledge and concepts of health.
- Indigenous health policy.
- Indigenous health research ethics, methodologies and community engagement.

Table 3: 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>Yes 3, No 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>Yes 2, No 4</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>Yes 1, No 5</td>
</tr>
<tr>
<td>4. Critically evaluate Indigenous public health policy or programs.</td>
<td>Yes 2, No 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>Yes 3, No 3</td>
</tr>
<tr>
<td>6. Demonstrate a reflexive public health practice for Aboriginal and Torres Strait Islander health contexts.</td>
<td>Yes 3, No 3</td>
</tr>
</tbody>
</table>
• Indigenous health service delivery, including the Aboriginal community controlled health sector.
• Indigenous men’s and youth health.
• Indigenous mental health and social and emotional wellbeing, including addictions.
• Indigenous peoples’ health comparisons globally, nationally and locally.
• Indigenous women’s and children’s health.
• Resource allocation to Aboriginal health services.
• Social determinants of Indigenous health.

5.2. Analysis of interview content

As shown in Figure 1 below, the Leximancer conceptual analysis drew out nine key themes in order of frequency, with ‘health’ as the most frequent and ‘level’ as the least. Within the ‘health’ theme, ‘Indigenous’ and ‘health’ are the most frequent key words contained in this concept.

Taking the key words most frequently occurring within the Leximancer conceptual analysis, and those most relevant to the research objectives, the following four conceptual pathways were created and sub-themes drawn out through the hermeneutic reading under each of these pathways:
- Indigenous to health.
- Indigenous to MPH.
- Indigenous to examples.
- Indigenous to communities.

Additional areas of learning, which were identified through the second thematic analysis, are outlined following the discussion of the five conceptual pathways, including:
- Evaluation of the curriculum and teaching.
- Teaching approaches.

5.2.1. Indigenous to health

The first conceptual pathway identified was contained within the most prominent theme and relates directly to Indigenous health and its integration into the curriculum.

Figure 1: Concept map showing themes from interviews at the University of Adelaide
5.2.1.1. Process for integration of Indigenous health core competencies

There appeared to be a high level of awareness among interviewed staff of the history and process of integration of the Indigenous health core competencies within the curriculum.

Because we had a discussion at a curriculum meeting about needing to try and include Indigenous examples in our courses, okay.

The Public Health Education and Research Program (PHERP), which funded development of the core competencies for MPH graduates (ANAPHI 2009), was instrumental in informing recent curriculum changes.

I mean there was quite a debate at ANAPHI for some years about trying to get various aspects of Indigenous health into MPH curriculum... But what we did was the last time there was a review of PHERP they came out with a set of core courses that they wanted taught. We adopted all those core courses and took the titles direct. One of the titles was Indigenous Health so from that time on we’ve had a core course in Indigenous health.

Integration of the competencies has also been institutionalised within the MPH through a mapping against the graduate attributes.

We do map it against university graduate attributes... So the ones that we would look at specifically referring to Indigenous health would be an awareness of ethical, social and cultural issues within a global context and the importance of exercising professional skills and responsibilities. We’d probably relate a commitment to the highest standards of professional endeavour to that as well because we’d say if you’re going to be a competent and appropriate researcher you have to be very aware of the issues associated with different communities.

5.2.1.2. Indigenous health as a core course

The key statements from the Leximancer discussion thread particularly focus on the Indigenous health course that is offered as a core course within the MPH and has been since 2007. Prior to that, an elective course was offered with the title Aboriginal Health Policy. The core Indigenous health course is regarded by all of the staff members interviewed as an important component of the MPH that should remain compulsory for all students.

Perhaps we should just record that this is in the context that we do things differently from most of the other courses in the MPH in Australia. We actually have a core course in Indigenous health and we’ve done that for many years now.

Something that has only really hit me, actually, in the last few months is how many of our international MPH students come here hoping they’ll stay. So for a while there I was wondering if we could have international health as an option that they could choose rather than Indigenous, doing it in a core, but given how many are actually hoping to stay that just says to me, again, absolutely no way. We keep that as the core for all of our students, domestic and international.

One of the pieces to the jigsaw puzzle is when we do have Indigenous health as a core within our program what does this mean for our international students? That’s something that we ask ourselves each year but we are satisfied that it’s very helpful for the international students as well because even if they come from a dominant group within their own society there will be the minorities, Indigenous minorities. There is just so much, particularly around the post-colonial stuff or post-conflict stuff. I mean, even if they’re defining it differently – the post-colonial stuff – that will be relevant.

Several reasons were given for this, but the most commonly discussed was the importance of the issue in Australia and the need for students to understand the significance and be able to contextualise the causal factors.

But I think that making the Indigenous health course compulsory as part of the MPH was a really useful thing to do and it’s important to keep it there... But to get that feeling of what the state of Aboriginal health in Australia really is today, you don’t really get that from those sorts of things. You really need a course like it and you need the background, you need to know the background.

Given the importance afforded to the issue, staff expressed the need for confidence that the content was being taught well, hence the decision to have the core course rather than relying on integration of content across other core courses. In addition, the university has a policy that Indigenous health content is taught by Indigenous people, and it was felt that logistically it is easier for this to occur within a contained core course.

The decision was made that rather than relying just on integration into all of the core courses we would have a dedicated
Indigenous health course as core required within the degree. It felt that that was the only way to be really sure that Indigenous health would be covered well because it’s easy for course coordinators to say, well, yes, I use these examples and this part of the assessment and that kind of thing. But because… we don’t look closely at the program year by year at that level of detail we wouldn’t know that in fact that was the case. We also have a policy of, if at all possible, having Indigenous people teach Indigenous health. That, of course, is much more difficult when it’s a bit here and a bit there integrated into the other programs. So that they were the two main factors that we decided we had to have a core topic.

5.2.1.3. Integration of Indigenous health content
Despite the decision to have Indigenous health as a core course, numerous references were made to the inclusion of and need for Indigenous health content in other courses and programs. As the statement below exemplifies, Indigenous health content is still integrated in other courses.

Just this morning… I was talking with one of our lecturers who does teaching to the MPH… who is setting up a course in ethics, professional ethics, for [another] course. She was saying that she was alarmed to see that in last year’s course there was no attention paid to Indigenous issues and the sensitivities… and the ethics around that. So the fact that she saw that, and is making sure that’s in there and putting in the right people to do that, says to me I’m not wrong in thinking that this awareness remains there.

Several interviewees also reflected on the need to expand the notion of Indigenous health to include a global context and discussion of other Indigenous peoples’ issues and needs, as this should improve its relevance for international students.

We need to look at who’s doing Masters degrees in Australia and the issue around international students. I think that needs to be looked at and what the implications are for that, how we can teach better and how we can, perhaps, get [or] have that focus on international Indigenous peoples and their needs.

However, not all interviewees were currently integrating Indigenous health content into their courses. In some cases, this was because the courses were methodology rather than issues focused. Staff, therefore, did not see any relevance for Indigenous health content.

My course wasn’t seen to be one of the ones that could really strongly do something about Indigenous health issues because it’s not an issues-based course, but I thought I could put some examples in and see how I go and try and strengthen that...

So I hadn’t even thought about – I didn’t think Indigenous health had much direct relevance to the course. Until I received your stuff and then thought, well, actually I could probably put in a couple of examples there, even if it’s not the methodology.

I don’t do a focussed comparison across a range of health indicators for Aboriginal and Torres Strait Islander people and that’s because… it’s an introduction to epidemiology, it is very classically disease-oriented. It doesn’t move into measures of wellness or capacity… or community strengths or indices that you could measure that tell you about the positives. So it’s all about mortality, morbidity and then moving into risks and how you calculate them and other things like that… But I think there are broader health indicators that give a more complete picture. I don’t do that in this course for any group, I don’t think, because it’s a very traditional, classical, disease-focus view of health.

As this last comment indicates, some staff were also concerned that including some Indigenous content in their curriculum would be counterproductive when there was a tendency to use examples that portrayed Indigenous health negatively without the opportunity to contextualise and provide balanced information.

I’m really aware that my discipline… comes from an epistemological basis that’s actually – has in some ways abused people rather than supported them. So I just don’t want to add to that and so I feel like I need examples of where work in this vein has been used in a positive way to help Indigenous health and that Fred Hollows line: no surveys without service. Well, here I am always talking about surveys and how to coerce people into doing them.

So I feel I’m trying to meet a lot of needs in a course in a short space of time. When I think about what I could do around Indigenous health, because it’s very basic describing the health of a population using statistics, you could – and I have some small examples – present really dramatic gaps in health between Indigenous people and others. But there isn’t time in the course
to then talk about that. So it worries me that you leave people thinking there’s this huge problem and that you can’t say anything positive about it or contextualise that or whatever because that’s the way the course works. So I hesitate to do that because I don’t want to feed into: Indigenous people have these massive problems that are intractable. In this kind of [environment] I don’t think that’s a helpful thing to do. So when I do, I find with the examples that I have used there’s a bit of room for contextualising...

In other cases, staff didn’t see a need to include Indigenous health content in their courses because of the existence of the core course.

I hadn’t even thought of it, I just didn’t think. Because we’ve got an Indigenous Aboriginal health component of our MPH anyway as a course.

This was supported by statements made by one of the lecturers interviewed.

I am doing some guest lectures – not within the MPH. I think because Indigenous health is a core course people don’t ask me to go into the rest of the MPH.

The thematic analysis identified a suggestion made by one interviewee to ensure that all staff continue to consider the integration of Indigenous health content, and address the core competencies in their courses though the annual updating of course profiles.

Well, maybe there could be something in the course profile. So if you’re a course coordinator you’ve got to fill in your course profile every year to say what’s going to be included in it. Just have one question in there saying does it address any of the core competencies? Or have you thought about addressing these core competencies – or at least one of them. That’s all it would need because you’ve got to fill it in every year, so that would be a way to implement it I would think. I’m thinking about it now.

5.2.1.4. Indigenous health content

Specific areas of Indigenous health content and examples were also discussed. Several interviewees referred to the inclusion of the historical context of Indigenous health and other social determinants.

So a lot of it in the Indigenous course is learning about the colonial history, the issues that have influenced the social determinants of health that impact on Indigenous people today and where they’ve come from. What Indigenous health today is… so they’re all learning that sort of thing.

So an overview of Aboriginal affairs policy was part of that. Also an overview of analysis of Indigenous perspectives on history, on culture...

I’m teaching this at the moment as it happens and we’re just in the area of social determinants. As we’re having an ongoing discussion about social determinants we’re looking at [at] social determinants of Aboriginal health as well as health of people at different levels of socioeconomic status in Australia.

Well, the material I talk about is poverty in Australia followed by an understanding of socioeconomic status in Australia, followed by use of the ‘Social Health Atlas of South Australia’ to look at the relationship and association between information about standards of living and the like, health risks and health outcomes.

Others also referred to content relating to the health system, including policy, resource allocation and services pertaining to Indigenous health.

So I tend to engage in the issues around power in relation to the health system, the issues around policy, the issues around surveillance and… certainly the social determinants of health… The community development aspect of primary health care, which is often overlooked, is where I focus.

In the course on equity one of the key examples is the equity of resource allocation to Aboriginal health and the notions of horizontal and vertical equity.

We look at Aboriginal women living in rural and metro – it’s actually about services, the example.

Another content area commonly discussed was Indigenous health research, its ethical considerations and the need for community involvement in research.

There’s parts of the ethics lectures… which talks about factors that would impact on – how health technology might impact on an Indigenous group.

That’s reflected, making people aware that it’s reflected, in NHMRC guidelines. That having been part of a NHMRC working committee, for example, that anything that’s got the words prisons on it in a research project flags Indigenous content so those researchers have to actually address
Indigenous issues whereas they may have just ignored that in the past. So I think there’s been substantial change over the past 20 years; I think the competencies reflect that.

How – the possible ways that you can develop your partnership with Aboriginal people, those sorts of things we cover. Certainly we refer to the guidelines that are there, ARC or... the Australian Institute for Aboriginal and [Torres] Islander Studies in Canberra, those sorts of ethical guidelines that have come out of there as well.

Indigenous concepts of health, measurements of health and health issues experienced in the Indigenous population were also covered.

So we begin by talking about: what do you mean by health? There is some mention of Aboriginal spirituality views about it but the next hour is spent talking about the basics of measuring population health. The example I use is comparing and contrasting the health of non-Indigenous people in Australia with Indigenous people in Australia. So that whole lecture goes down in parallel. This is the non-Indigenous; this is the Indigenous mortality rates and so on. Then that’s followed up with a tutorial on Aboriginal mortality, how it’s measured and what its meaning is in terms of what the measures... mean in terms of the underlying experience of Aboriginal health. So that’s essentially it.

5.2.2. Indigenous to MPH
This conceptual pathway linked a series of key words including ‘Indigenous’, ‘health’, ‘course’, ‘students’, and ‘MPH’. The key statements from the Leximancer discussion thread particularly relate to system or structural issues associated with the MPH program, and the challenges these create for students and staff.

5.2.2.1. Program structure
The most common of these discussion threads relates to the actual structure of the program and the focus on public health research rather than practice.

The orientation of our MPH is actually to public health research rather than practice. We see ourselves as having expertise in that area and... we’ve actually pulled back on the practice-type courses that we’re offering because the uni was pressuring us with budgets. So we have six core courses... Then most students will only do two electives and then do a dissertation. There is the capacity to complete it with all coursework, which means they would be doing six electives or there’s a capacity to do a practicum, which is the equivalent of two courses. So [the] dissertation’s equivalent to four courses, practicum is equivalent to two and so if they do the practicum they do four electives. Those electives we try and shape – try and help them choose according to the area that they know they’re going back into...

More specifically, the discussions related to how the Indigenous Health course sits within the structure of the program in the second semester of the MPH, and some of the advantages and disadvantages that this timing poses for application of learning in other courses.

The timing of it is also not that helpful. Indigenous Health happens in second semester and in first semester the full-time students are doing their basics... which means that the kind of awareness that gets raised when they do the Indigenous Health course – they’re not applying when they’re doing those... But in another way it works well because they’re then applying it when they’re doing their dissertation, which [means that] some – and probably more – choose to do further research in Indigenous Health than if it was earlier in the course.

So in the Qualitative Research Methods course they may or may not have done Indigenous Health. If they’ve done Indigenous Health it’s much easier for them because they sort of know where we’re coming from when we start. But we don’t assume that anyone knows anything so we do a very, very brief sort of background of things.

5.2.2.2. Program viability
The next most common discussion thread in this conceptual pathway relates to concerns raised by the recent conclusion of the PHERP funding, which has created uncertainty around the viability of the MPH, and its aforementioned focus on improving the curriculum and ensuring that the integration process has been successful.

There was quite a bit of disquiet when the PHERP funding was going to cease and there were a lot of meetings about whether the program was actually viable or not viable – were we going to keep it going or not. So those discussions about – can we actually afford to run this and how are
we going to do it – I think displaced other conversations that we could have been having about the curriculum.

So [the students are] no longer subsidised by the Commonwealth and they have to fork up. It’s quite a massive amount of money...

So, again, that conversation around who do we write letters to, how do we fight this off, that’s dominated the conversations and I don’t think we’ve had the time to return to the curriculum... So, again, that’s thrown the future of the program into question and that’s what makes it hard for people to engage with broader curriculum issues, which we certainly were doing. We had a big round of it when the revised PHERP guidelines came out... and we really did try and reorient our courses in that direction... It’s like that constant ‘here we go again’ around the uncertainty. Really does make it hard to go – well, now, can we strengthen the content in these or these areas.

I guess this all has to be seen in the context of what the hell’s happening to Master of Public Health courses. We are by no means confident that we’ll be able to continue the Master of Public Health course in this university because the Commonwealth has withdrawn all funding.

Well if DoHA is listening, the decision to defund the PHERP program has had a major impact on the teaching of public health in Australia.

The result of the withdrawal of funding and subsequent raising of course fees reportedly had a notable impact on local student enrolment numbers as students could not afford the resulting fee increases.

But then the university issued an edict to say the fees for all coursework masters will be something shocking, which we think is going to mean, and has meant, that people who have lower incomes, for example, are just not going to be able to afford to take it, which probably impacts on an Indigenous person, who was considering [it], not being able to take it.

It also means that Master of Public Health degrees are increasingly being priced out of the reach of ordinary health workers. You know, the going rate for a Master’s degree in a university like this tends to reflect what a Master of Business Administration student would pay in a course – [and] they’re going to make quite a considerable increase in salary on the basis of [the course] they’ve done.

An additional impact of the loss of external funding, which was identified through the manual thematic analysis, was an increase in the teaching loads of staff.

Weaknesses? Trying to run a program on a shoestring – which means that each of our course coordinators and lecturers is really time-strapped. When you’re time-strapped you are less likely to make the time to invite other people to come and share teaching with you.

This has even prompted thoughts of merging proximate MPH programs.

You’ve got a small staffing body trying to teach quite a lot of stuff, yeah, so historically there’s been talk on and off that Adelaide and Flinders should combine. Politics means that doesn’t happen. In theory it would be a way to offer a richer Masters with more choice.

5.2.2.3. International students

This decrease in local student enrolments has resulted in an increased dependency on full fee paying international students to sustain the program.

So that was the main issue that came up for me last year is around international students and the fact that public health at this university does have difficulty in getting numbers. I think that’s been affected by all sorts of things but certainly the viability is dependent on international students so how you work across that is important.

It was noted by some of the interviewees that this diversity of students – with differing expectations related to academic standards, and the additional challenges experienced by students with English as a second language in meeting the required standards – has created new challenges for teaching. As the following quotes illustrate, there has been a recognised need for greater support of these students.

So – I think a number of students were quite appreciative of actually being referred for the first time to the Teaching and Learning Unit.

In first semester [we’ll be] doing a lot more work with them on critical use of resources and appropriate quotation citing, so trying to help them develop their writing skills more.
5.2.2.4. Indigenous students

An increased cost to students was not the only barrier to enrolments under discussion: Indigenous student enrolments associated with a lack of clear educational and career pathways were also discussed.

[The students] tend not to be Indigenous but they tend to – they've often come from a particular workplace setting...

We have the agency which is supposed to support Indigenous people once they're here but we need to get them here in the first place. I've been teaching for years and years. I was tutoring in ethics in the medical program and in all that time I only had one student that identified as Indigenous.

A lot more people wanting to get into Aboriginal health work who come from an Indigenous background go to the TAFE course here in South Australia.

If we have a way of providing a clear path for Indigenous students, in say the Bachelor of Health Sciences, and thinking about some end points for them in Indigenous health, that would be our absolute ideal.

5.2.2.5. Staffing

Staffing of the program was another discussion thread. Staff sensitivity to Indigenous health issues and support of Indigenous content in the curriculum was clearly identified.

Quite a number of our Level A, Level B type staff have worked in remote settings for at least a couple of years and so there is enhanced sensitivity.

This commitment by staff, and the university as a whole, to Indigenous health was seen as a real strength of the program by all staff interviewed. In particular, the employment of Indigenous staff within the program, and the establishment of the Indigenous Health Unit within the faculty, was highlighted as evidence of this commitment.

Commitment. Placement of the Indigenous staff, that actual physical placement... Yeah, I see those sorts of strengths.

However, a number of interviewees also expressed concern at the significant workload imposed on Indigenous staff as a result of the policy that limits the teaching of Indigenous health content only to Indigenous staff.

I can’t see how [they] can do everything that needs to happen in indigenous health in the medical program in MPH in our undergraduate degree. I am concerned that without proper resourcing it’s a bit tokenistic... and because [they’re] on every committee you can think of... how can you do that - the outreach, the mentoring, the teaching within courses - they’ve been talking about a dedicated stream. I mean, that's an impossible workload for those two people...

The manual thematic analysis also identified that employment of appropriately experienced and qualified staff to teach the Indigenous Health course has been an ongoing challenge.

Finding someone who was competent to teach it and when that person was no longer available, finding someone else. That's always an issue.

5.2.3. Indigenous to examples

This conceptual pathway linked a series of key words – including ‘Indigenous’, ‘people’, ‘work’, ‘issues’ and ‘examples’. Unlike the first conceptual pathway that focused on the actual content within the program, this one focuses on the link between content and people, and, more specifically, on what individuals bring to, or gain from, the Indigenous health content in the program.

5.2.3.1. Student knowledge

The first of these discussion threads relate to the pre-existing knowledge, or the lack thereof, that students have of Indigenous health.

I think that’s a real awakening for many students, doing that course, because many have no concept of the issues around Indigenous health.

Given the increasing numbers of international students, interviewees indicated that a lack of knowledge of Australian Indigenous health issues is not unexpected.

We also have a lot of international students who we wouldn’t expect really to know a lot about it. But they often have a significant interest because many of the countries they come from have significant Indigenous populations as well.

But I think the issues for the background of international students is that some come from very privileged backgrounds and don’t understand issues around equity and equality. They don’t – they haven’t unpacked ideas about race, so on and so forth.
5.2.3.2. Relevance of content
Consequently, interviewees discussed the need to ensure that Indigenous health content is presented in a way that is relevant for all students – both local and international.

But overall the course has to be about Indigenous health – but I keep my mind on lessons that have universal application, that have global application in other countries.

There’s international students; and I’ve been really working hard to make an international flavour to my examples and content.

Equally, interviewees discussed the need for content to be relevant for students from a broad range of professional backgrounds, including the various health disciplines as well as professions from other sectors.

So I did that with the psych. students the first year they joined the course, which is how I know they like psych. examples and don’t want other ones. So I started to put glossaries in around two questions and assignments for people [because] you can’t assume they’ve got a health or medical or anything like that background.

So we’ve got environmental health officers, we’ve got medical practitioners, we’ve got some nurses who’ve been working in hospitals. We’ve got people interested in social policy, I think there’s an allied health worker or two in there and so on – you know, they come from a range of backgrounds.

5.2.3.3. Staff expertise
The other discussion thread in this conceptual pathway relates to the staff and the links they have to other people and workplaces that contribute to and enhance the Indigenous health content in the program. The first aspect related to staff drawing on their own work and expertise to strengthen the content.

So even though some of our key contacts are not themselves Indigenous people, they are working constantly with Indigenous people and so [are] able to assist us in that way.

So since there’s no money for that – we’ll have guest speakers on that – but it would be, I think, really good if a third of the module was tightened up to actually represent the clinical work being done around the State. We’ve got some really good people that could just do that.

The second aspect was the value that guest speakers add to the program and the ‘real’ workplace examples they bring to the course.

She’s been involved in education for the last 20 years – talk about education and the global connections in relation to those strategies for educational content and workforce. So that’s at both school level and university levels and other workforce areas.

So we’ve had organisations that we visited… outside the health sector like the organisation called – well, it’s part of Uniting Care Wesley – that do the advocacy for the Anangu Pitjantjatjara in terms of the social issues faced by people there. Housing is a big factor but drug and alcohol, transport are really important issues and so he gave an overview of the work that they do.

So getting people to come into here to talk about research is also important and bringing it back to their workplace is also important for me. Last year we had someone talking about ‘Health in All Policies’ and one of the students was actually involved in that project… So we were able to tie things across and say yes, well, so this is why we’re… going to have a visit from someone talking about housing and this is why we’re having someone talking about nutrition or the justice system, why are we doing that.

So that’s a very important aspect of the course. Policy where you certainly look at the Aboriginal Health Partnership within South Australia – and we had the Commonwealth, State and the Aboriginal Community Controlled Organisation come and talk about that and what their priorities in policy are.

I’ve certainly got broad networks and people that I bring in have… got really good credentials and background in Aboriginal health so the students benefit from those networks.

5.2.4. Indigenous to communities
This conceptual pathway builds on the previous one. It linked a series of key words including ‘Indigenous’, ‘people’, ‘talk’ and ‘communities’. The key statements from this discussion thread relate to links with the Indigenous community. In a similar vein to the previous discussion, the first aspect relates to the links staff have with communities through their own work.
I've got my own research project on the social determinants in Port Augusta. So I'm back — I feel like I'm back connected with the ground, with the health — with people on the ground.

A research fellow I look after has a major interest in Indigenous health... I just try and really support her getting her projects done. She's very into the capacity building, so as part of that she will be trying to employ Indigenous research assistants and other people on her projects.

The second aspect also mirrored the previous discussion thread as it outlined the role that members of the community have in providing guest lectures within the program.

His contacts — because when he set up the course he brought in an awful lot of people from the community to talk about the various aspects of Indigenous health and the students found that really helpful.

The last aspect in this discussion thread related back to the content in the course and the ethics, principles, methodologies and outcomes of research in Indigenous communities that are taught within the curriculum.

Action research, we talk about it a fair bit. We talk about that not just in the Australian context either because there's a lot of action research they've done with Indigenous communities in Canada and New Zealand and places like that.

In our ethics session we talk about the importance of getting specific ethics approval for any research done with Indigenous communities. We talk about the South Australian Aboriginal Health Council ethics process.

They had obviously grasped some of the principles we were trying to talk about but then in other things they obviously had no concept of what it was to work with an Indigenous community.

We talk about the negative impacts to say this is what you don’t do. You know, this is what you do, you involve people and it has to be of use to the community, it has to do all of those things.

I think that’s one of the strengths that come from this, is that level of community engagement that is required and that people need to understand.

5.2.5. Evaluation processes

The manual thematic analysis, which was undertaken in addition to the conceptual Leximancer analysis, also identified discussions related to the processes used to evaluate the MPH program. It was noted that the university conducts formal student surveys as the standard evaluation process, but staff did not view this data as valuable information.

The formal way is that theoretically each of the courses has a student evaluation of learning and teaching. This has been the theme that the university has placed most emphasis on and it's something that I actually have personal difficulty with because it seems to me the student experience is not the primary thing that I should be concerned about when it comes to quality control.

We use SELTs [Student Experience of Learning and Teaching], the university evaluation mechanism, students’ feedback — and that’s very general, there’s nothing specific in that... as I say they’re very general. They don’t ask you about any specific element of the course.

In addition, a move by the university to conduct this process on-line is adding to staff concerns about its effectiveness.

We are needing to change our way of the evaluation because the uni’s going to an online version and we know that that will give us nothing.

Instead, staff rely on informal feedback from students, graduates and industry partners to evaluate the program.

The piece that makes more sense to me is the feedback we get from (a) the professionals that are already working in the field and what they’re saying about the course and how it further develops them, opens more doors, whatever; and (b) a year or two down the line when graduates — and particularly the internationals — have then found work in public health and what they are saying in terms of how the course actually prepared them. I also... take the pastoral care side pretty seriously in terms of trying to make sure that the... students are managing, students are coping, and that gives me a lot of informal feedback about how they perceive the courses that they’re doing, how they’re getting on.
Last year, because it was the first year that we had run, we totally revised the course. We actually did a session with the students asking them specifically for feedback, that we then wrote up into lessons for this year’s course.

I use the university’s student evaluation of learning and teaching forms. Occasionally I’ve had a session with students to get feedback.

5.2.6. Teaching approach

The thematic analysis also identified several comments relating to the interactive teaching approach used in this program.

Well, they like the interactive approach to the courses actually. In this discipline we’ve always prided ourselves on interactive face-to-face teaching. So everybody gets an opportunity to express their ideas and opinions on a regular basis in the course, so [the students] like that.

We run for three hours so we have a lecture followed by discussion and practicals on the same day... we’re probably just old fashioned but we prefer to do some of the stuff face-to-face because some of the concepts are quite difficult. We like to have that opportunity for people to discuss things.
6. Findings, Commendations and Recommendations

The University of Adelaide’s MPH program demonstrates a commitment to the integration of the Indigenous core competencies into the program. This next section will summarise how this has been achieved according to the research questions guiding this review. It will also discuss areas where opportunities for strengthening the integration of Indigenous health content were identified.

6.1. Integration of the Indigenous competencies

The quantitative data outlined in Section 5.1 clearly show that all six of the Indigenous core competencies have been integrated in this curriculum. The integration has primarily been vertical, although horizontal integration was also considered for a time.

They were working on a model of trying to have some in each element of the course.

However, it was agreed early on in the history of this program that Indigenous health content was needed in the curriculum, and that for this content to be taught well there needed to be a dedicated Indigenous Health course. Initially this was delivered as an elective course.

She’d been running [the Indigenous Health course] for quite some time, probably at least 10 years. But it wasn’t a core course at that stage, it was an elective.

When the Indigenous core competencies were developed through the PHERP project, it was agreed that the Indigenous Health course should be made a core course as already outlined in Section 5.2.1.1. The competencies were also institutionalised through a mapping against the graduate attributes.

The commitment to including Indigenous content has continued to have an impact in some other areas of the course as was demonstrated in the qualitative and quantitative data. An element of horizontal integration therefore remains despite the decision to focus on a model of vertical integration.

6.2. Innovations to integrate the Indigenous competencies

This commitment to integration of Indigenous health content has also clearly been demonstrated by the creation and staffing of an Indigenous Health Unit within the faculty to lead the integration of Indigenous content and competencies in the curriculum, which has been a key strength of this program.

Because we have two... of the staff from [the Indigenous Health Unit] based here with us that’s great. As soon as [the Unit staff] was on board things changed… immediately there was someone that was a different kind of contact point.

Similarly, the university has chosen to promote quality of teaching for Indigenous health content through the creation of policy that stipulates Indigenous Health courses are taught by Indigenous staff. This was not exclusively a management decision but was supported by all staff.

It was a consensus decision by staff... and is strongly supported at all levels including [and] up to [the] Head of School.

6.3. Improving integration of the Indigenous competencies

These strategies have created some challenges for the integration of Indigenous content, namely, the imposing of unreasonable workloads on Indigenous staff as already highlighted in Section 5.2.2.5. Despite the commitment to recruitment
and retention of Indigenous staff in the Indigenous Health Unit, which is commendable, it was noted that further increasing the number of Indigenous academic staff would assist in providing additional program support and sharing of the workload. However, it was also noted that recruitment and retention of Indigenous staff is difficult in light of national workforce shortages. Nevertheless, insufficient resourcing creates a tension for Indigenous staff, who have competing and onerous demands on their time, and there is a danger that current strategies will be seen as ‘tokenistic’ instead of commendable. Adequate support for these staff is, therefore, critical.

Secondly, the aforementioned policy and vertical integration model, previously commended for the commitment it demonstrates, does risk creating apathy in some staff who may view any ongoing work to integrate the core competencies comprehensively as irrelevant or not their responsibility. Further discussions regarding strengthening the curriculum and integrating the competencies would be beneficial, as would staff training and the development of teaching resources.

In light of the withdrawal of government funding, resourcing and subsidisation of the program also needs to be reviewed. This would enable staff to focus on the important aspects of their teaching and learning roles, instead of on their concerns regarding the viability of the program, thereby reducing further barriers to student enrolment.

6.4 Commendations

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

- Demonstrating a commitment to Indigenous health through the creation of the Yaitya Purruna Indigenous Health Unit to support the faculty generally and the MPH program specifically.
- Demonstrating a commitment to the inclusion of Indigenous health content with the establishment of the Indigenous Health course as a core course in the MPH program.
- Achieving vertical and horizontal integration of the Indigenous public health core competencies into other courses within the MPH curriculum.

6.5 Recommendations

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

- Ensure that university, faculty and school policies articulate the need to increase the number of Indigenous academic staff numbers in the long term.
- Ensure appropriate retention strategies and adequate support systems are in place for Indigenous staff.
- Revise the current policy, which states that all Indigenous health content must be taught by Indigenous staff, to more accurately reflect their role in supporting other staff to teach such content.
- Recognise those staff who are providing horizontal integration of content in units other than the Indigenous health course.
- A need for Aboriginal and Torres Strait Islander competencies to blend more with methodological subject areas, including epidemiology and biostatistics courses.
- Encourage staff to share ideas so as to enhance cultural competency across the entire school.
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 Framework1; and,
- integrating these competencies within the key national 2010 MPH curriculum guide, Foundation Competencies for Master of Public Health Graduates in Australia2.

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.

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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 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 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

Review of the Integration of Indigenous Public Health Competencies within 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 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 audiotape them.

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

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

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

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

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

8.4. Consent Form

School Of Population Health
Consent Form

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

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 an semi-structured interview
   (ii) participation in a focus group interview

   and I agree that the researchers may use the results as described in the plain language statement.

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

Signature        Date

(participant)

7 HREC #: 1034186.3
8.5. MPH Coordinator questionnaire

Questionnaire for MPH Program Coordinators

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

Name of participant: _______________________________________________________________________
Email contact: ____________________________________________________________________________
Department: ______________________________________________________________________________
Institution: ______________________________________________________________________________

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

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

3. Please estimate number of prescribed formal contact hours devoted to Indigenous Australian health within your MPH program:
4. Please number identified Indigenous Australian MPH program enrolments (previous 5 years):

______________________________________________

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

______________________________________________

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

______________________________________________

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

______________________________________________

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

Key incentives for non-Indigenous students

Key dis-incentives for non-Indigenous students

Key incentives for Indigenous Australian students

Key dis-incentives for Indigenous Australian students
9. Please describe the input and status of Indigenous advisors to the Indigenous Australian health content within your MPH program:


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


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


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


Other comments:

Thank you for your participation
8.6. Unit Coordinator questionnaire

Questionnaire for Unit/Subject Coordinators

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

Name of participant: _____________________________________________________________
Email contact: ________________________________________________________________
Department: __________________________________________________________________
Institution: __________________________________________________________________

Subject/Unit Title: _____________________________________________________________

1. **Total formal contact hours for unit:**
   __________

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

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

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

5. **Please list areas of Indigenous Australian health covered by the subject/unit:**
6. Core Indigenous public health competencies covered by the subject/unit:

<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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<tr>
<td>4. Critically evaluate Indigenous public health policy or programs.</td>
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<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>
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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>
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<tbody>
<tr>
<td>Lecture (face-to-face on campus)</td>
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<tr>
<td>Tutorial (face-to-face on campus)</td>
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<td>Seminar (face-to-face on campus)</td>
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<td>Intensive Block (face-to-face)</td>
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<td>Placement/Field Visits</td>
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<tr>
<td>Online Interactive Forum (synchronous)</td>
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<td>Online Interactive Forum (asynchronous)</td>
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<tr>
<td>Online Podcast/Vodcast</td>
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<td>Self-directed/self-paced distance module</td>
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<td>Teleconference (incl. Skype or similar)</td>
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<tr>
<td>Other (please list)</td>
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</tbody>
</table>

Other comments:

Thank you for your participation