Review of the University of Melbourne 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
First published August 2013

This work is one in a series of reports that forms a national review of Indigenous Public Health Core Competencies Integration into Master of Public Health programs. The review is a component of the Indigenous Public Health Capacity Building Project funded by the Australian Government Department of Health and Ageing.

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**Onemda VicHealth Koori Health Unit**
Centre for Health and Society
Melbourne School of Population and Global Health
Level 4, 207 Bouverie Street
The University of Melbourne
Victoria, 3010 AUSTRALIA

**T:** +61 3 8344 0813
**F:** +61 3 8344 0824
**W:** www.onemda.unimelb.edu.au

**Authors:** Wendy Anders, Melody Muscat and Janice Jessen
**Managing Editor:** Jane Yule @ Brevity Comms
**Design and Printing:** Inprint Design
**Artwork:** Shawana Andrews

**For citation**

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

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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 the review of the Master of Public Health (MPH) program at The University of Melbourne.

Review Team
Ms Wendy Anders Institute of Koorie Education, Deakin University
Ms Melody Muscat James Cook University
Ms Janice Jessen Institute of Koorie Education, Deakin University

The University of Melbourne
Professor Rob Moodie Ms Andrea Boudville
Associate Professor Shaun Ewen Ms Josie Atkinson
Dr Deborah Warr Ms Leanne Coombe
Dr Helen Jordon Mr Mitchell Anjou
Dr Louise Keogh Mr Paul Stewart
Dr Melissa Russell Ms Rosemary McKenzie
Dr Richard Chenhall

Project Reference Group
Professor Wendy Brabham Director, Institute of Koorie Education, Deakin University
Associate Professor Shaun Ewen Project Leader, Onemda VicHealth Koori Health Unit, The University of Melbourne
Ms Janice Jessen Project Co-Manager, Institute of Koorie Education, Deakin University
Ms Leanne Coombe Project Co-Manager, Onemda VicHealth Koori Health Unit, The University of Melbourne
Ms Tara Sklar Project Co-Manager, Onemda VicHealth Koori Health Unit, The University of Melbourne
Ms Wendy Anders Project Co-Manager, Institute of Koorie Education, Deakin University

PHILE Network Leadership
The PHILE Network Leadership Group at the time of publication of this report includes:
Ms Heather D’Antoine (Chair) Menzies School of Health Research, Charles Darwin University
Professor Dennis McDermott Flinders University
Professor Jenny Baker The University of Adelaide
Associate Professor Geoff Marks The University of Queensland
Assistant Professor Craig Allen The University of Western Australia
Dr David Paul The University of Western Australia
Dr Hassan Vally La Trobe University
Dr Priscilla Robinson La Trobe University
Mr David Sjoberg Flinders University
Ms Janice Jessen Institute of Koorie Education, Deakin University
Ms Leanne Coombe The University of Melbourne
Ms Melody Muscat James Cook University
Mr Paul Stewart The University of Melbourne
Mr Ray Mahoney Queensland University of Technology
Ms Tara Sklar The University of Melbourne
Ms Vanessa Lee The University of Sydney
Ms Wendy Anders Institute of Koorie Education, Deakin University
Foreword

The Melbourne School of Population and Global Health (MSPGH) thanks the Public Health Indigenous Leadership in Education Network for its timely and constructive review of the Master of Public Health program at the University of Melbourne as part of the national review of the integration of Indigenous public health core competencies in postgraduate public health education.

We are thrilled to have our MPH Indigenous health specialisation acknowledged for its in-depth coverage of the competencies and its innovative experiential teaching delivery. The outcomes of the review clearly identify that the Onemda VicHealth Koori Health Unit, located in the MSPGH, contributes greatly to this program, which is led by Indigenous academics but also draws on a strong community foundation that ensures student learning is both respectful and relevant.

The review was undertaken prior to an internal planning day for the MPH and hence informed recent developments to improve the program. Recognition of the need to integrate Indigenous health content across the core units of the MPH, as well as to document formally existing informal content, has led to a comprehensive mapping of core content against the Australian Network of Academic Public Health Institutions (ANAPHI) competencies. There has also been ongoing development of various modules that individually fit within relevant core units, and forms an ‘integrated core’ of content across the program that meets the Indigenous public health core competencies.

Marketing of the MPH Indigenous health specialisation as one of the flagship elements within the program at the University of Melbourne is also underway. Consequently, the specialisation has experienced significant increases in student participation and we anticipate that the program will continue to contribute significantly to workforce development in this area of nationally recognised priority.

Once again, the Melbourne School of Population and Global Health thanks PHILE for acknowledging our contribution to Indigenous public health teaching and for working to strengthen MPH curricula nationally through collaborative partnerships with academic institutions.

Professor Terry Nolan
Head, Melbourne School of Population and Global Health
The University of Melbourne
July 2013
Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANAPHI</td>
<td>Australian Network of Academic Public Health Institutions</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>MHSS</td>
<td>Master of Health Social Science</td>
</tr>
<tr>
<td>MPH</td>
<td>Master of Public Health</td>
</tr>
<tr>
<td>MSPGH</td>
<td>Melbourne School of Population and Global 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>
<tr>
<td>UQ</td>
<td>University of Queensland</td>
</tr>
</tbody>
</table>
1. Executive Summary

The Indigenous public health competencies are a core component of the Foundational Competencies for Master of Public Health Graduates in Australia (ANAPHI 2009), a curriculum framework that integrates the six core competencies in Indigenous public health expected of every MPH graduate nationally. The aim of this review is to investigate the integration of the core Indigenous public health competencies into the curriculum of MPH programs nationally in order to document and disseminate examples of best practice and to find ways to strengthen the delivery of this content. This report, one in a series, relates to the curriculum review conducted at the University of Melbourne in June 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 Melbourne, 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 the University of Melbourne has primarily adopted a vertical model of integration, with a specialisation in Indigenous health that is recognised as a strength of the program and an important component of the curriculum. Development and delivery of the suite of specialisation units in Indigenous health shows a level of commitment to ensuring Indigenous content is comprehensively covered and not just treated as a tokenistic add-on. The range of subjects offered ensures that each of the Indigenous health competency areas is explored in-depth rather than only superficially. However, low student numbers currently threaten the continuance of the Indigenous health subjects due to subject quotas. The practice of face-to-face and team teaching in the Indigenous health specialisation, and the use of a wide range of guest lecturers was seen as a real strength of the program. Such methods enable a rich, comprehensive and well-rounded experiential educational opportunity in a safe learning space for students.

The existing expectation on Onemda VicHealth Koori Health Unit (Onemda) staff to be responsible for teaching this content, and/or assisting in the development of subject materials for other staff, and whose positions are funded by external agencies for project work, places unnecessary pressure on these staff. Commitment, resourcing and appropriate recognition for the development and teaching of Indigenous content needs formal support from the School if it is to be effective and sustained.

In addition to the MPH program, the University of Melbourne offers a Master of Health Social Science (MHSS), in which a substantial portion of the student cohort is Aboriginal and Torres Strait Islander. The MPH Indigenous health specialisation subjects are also available to these students, which encourages interaction between the two programs. This promotes peer learning and maximises the...
advantages of sharing differing perspectives and world-views for both student cohorts. Much of this interaction is through web-based formats demonstrating the University’s willingness to embrace innovative technologies, to accommodate rural and remote student cohorts and to enhance student learning in an area of national workforce development need.

This review has also identified broader issues of national importance for consideration by stakeholders of the Indigenous Public Health Capacity Building (IPHCB) Project. There is currently a lack of evidence to show that Indigenous health education programs achieve their desired outcome – an improvement in Aboriginal health – or that the competencies and graduate attributes actually produce an effective and competent Aboriginal health workforce.

The team proposes the following recommendations to strengthen the integration of Indigenous health in the curriculum at the University of Melbourne:

• Make Indigenous health a core unit OR improve the integration of content and the application of Indigenous health competencies across existing core units.
• Provide School support for the funding of teaching positions contributing to Indigenous health subjects within the MPH.
• Place a higher value on content areas of national workforce development priority rather than student numbers.
• Develop and implement a recruitment and marketing plan for Indigenous health subjects and specialisation.
• Create a process for tracking enrolments of Aboriginal and Torres Strait Islander students.
• Establish channels for formal recognition and compensation of guest lecturer contributions by the MSPGH.
• Formally document Indigenous health content to reflect the actual level of integration of competencies throughout the curriculum.
• Set up a regular formal process of information sharing by course coordinators, and more broadly for all staff teaching into the MPH.
• Regularly review the content and mapping of the competencies across the curriculum.
• Build the capacity of staff for Indigenous health teaching and other identified areas of need.
• Develop a graduate survey to ascertain application of learning in the workforce.

The review team also commends the University of Melbourne for:

• Delivering a comprehensive vertical model of Indigenous health education within the MPH program.
• The face-to-face and team teaching approaches for Indigenous health subjects, which provide a culturally safe and experiential learning environment for students.
• Using a broad range of guest lecturers who provide different perspectives and real-life experience to enhance student learning.
• Developing the series of case studies that can be used by staff as a teaching resource.
• The innovative use of technologies to accommodate rural and remote students as well as peer learning.

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

• A library of teaching resources and case studies in Indigenous health be developed.
• A national workforce survey of MPH graduates to assess application of the competencies and graduate outcomes and their relevance to workforce need.
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 (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 principle researcher and other members of the research team that occurred at the end of 2010.

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

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

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

3.3.1. Quantitative data collection
Questionnaires were distributed to the MPH Program Coordinator (Attachment 8.5) and Course Coordinators (Attachment 8.6).

3.3.2. Qualitative data collection
Participation in the review involved completion of a 45-minute semi-structured interview.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<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 University of Melbourne MPH was conducted from the 19–20 June 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 the University of Melbourne 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 the University of Melbourne is structured:

- 1.5 to two years full-time or part-time equivalent, depending on whether students are eligible for Advanced Standing (based on previous studies or relevant qualifications).
- Six core courses (12.5 units each) and between six to 10 electives (12.5 units) depending on the length of degree, plus the choice of a capstone experience in lieu of additional coursework (25 units), including the choice of a research project or professional practicum.

There are eight specialised programs offered within the MPH program:
- Epidemiology and Biostatistics.
- Gender and Women’s Health.
- General Public Health.
- Global Health.
- Health Economics and Evaluation.
- Indigenous Health.
- Sexual Health.
- Social Sciences and Health.

4.2. Delivery mode
The MPH program is primarily offered internally through face-to-face teaching, but some courses are delivered through intensive or distance learning 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>New</th>
<th>Existing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>84</td>
<td>132</td>
<td>216</td>
</tr>
<tr>
<td>2008</td>
<td>110</td>
<td>132</td>
<td>242</td>
</tr>
<tr>
<td>2009</td>
<td>103</td>
<td>164</td>
<td>267</td>
</tr>
<tr>
<td>2010</td>
<td>80</td>
<td>190</td>
<td>270</td>
</tr>
<tr>
<td>2011</td>
<td>102</td>
<td>176</td>
<td>278</td>
</tr>
</tbody>
</table>

4.3.2. Indigenous student enrolments
No identified Aboriginal and Torres Strait Islander students have enrolled in and completed the MPH over the past five years. However, staff reported that they thought there had been two or three Indigenous students enrolled in the past five years but were unable to verify that this was the case.

As will be outlined in subsequent sections of the report, there is a cohort of Aboriginal and Torres Strait Islander students in the Master of Health Social Sciences who are able to take numerous subjects offered in the MPH program.

4.4. Indigenous staff
The University of Melbourne hosts the Onemda VicHealth Koori Health Unit. According to the questionnaire results, there are six Aboriginal and Torres Strait Islander staff members employed at Onemda who contribute to teaching within the MPH program.
5. Results

5.1. Mapping of integration of core competencies

The documentation relating to the MPH program learning objectives shows that Indigenous health is embedded in the program from the top-down. One of the MPH program objectives at the University of Melbourne clearly states that graduates should be able to:

Articulate the way in which age, gender, ethnicity and Indigenous status, society, culture, geography, the environment and socio-economic status influence health and public health practices.

The University of Melbourne MPH program also has a specialisation in Indigenous health, which offers three subjects: Indigenous Health and History; Indigenous Health – From Data to Practice; and Indigenous Health Management and Leadership.

Additionally, students are able to undertake Indigenous health specialisation courses offered by the University of Queensland (UQ) through cross-institutional enrolment arrangements. The courses currently offered by UQ include: Issues in Indigenous Health; and Substance Use and Misuse among Indigenous People. A third course, Indigenous Health Policy, is currently being developed and will be available from 2013.

A review of the objectives and content of 11 subjects confirmed that the Indigenous core competencies are covered in the curriculum. The results of this mapping of the competencies from data provided in the questionnaires are summarised in Table 3 below.

However, it should be noted that this included the three Indigenous health specialisation subjects, which are elective subjects and therefore are not taken by all students. While this data confirms

Table 3: Indigenous health core competencies covered in subjects at the University of Melbourne

<table>
<thead>
<tr>
<th>Integrated Indigenous health core competencies</th>
<th>No. of courses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>1. Analyse key comparative health indicators for Aboriginal and Torres Strait Islander people.</td>
<td>7</td>
</tr>
<tr>
<td>2. Analyse key comparative indicators regarding the social determinants of health for Aboriginal and Torres Strait Islander people.</td>
<td>6</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>9</td>
</tr>
<tr>
<td>4. Critically evaluate Indigenous public health policy or programs.</td>
<td>7</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>4</td>
</tr>
<tr>
<td>6. Demonstrate a reflexive public health practice for Aboriginal and Torres Strait Islander health contexts.</td>
<td>7</td>
</tr>
</tbody>
</table>
coverage of the competencies, it is not necessarily indicative of the extent of their integration across the curriculum. This aspect will be further explored in subsequent sections of the report.

From the questionnaires it was reported that the broad areas of Indigenous health content covered, include:

- Indigenous health status comparison.
- Ethical research in Indigenous communities.
- Ethnography of Indigenous communities.
- Evaluation of health interventions in Indigenous health.
- Social advantage in Indigenous communities.
- Health interventions in Indigenous settings.
- Comprehensive primary health care in Indigenous settings.
- Management issues in the Indigenous health sector.
- Policy, structures and programs within Aboriginal Community Controlled Health Services.
- Historical context of Indigenous health.
- Contemporary social determinants of Indigenous health.
- Data collection and methods in Indigenous health research.
- Information systems and reporting requirements for Indigenous health services and research.
- Indigenous health policy.
- Access to services in Indigenous health.
- Alcohol and other drug use in Indigenous communities.

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 'Indigenous' as the most frequent and 'sense' as the least. Within the 'Indigenous' 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 links were created:

![Figure 1: Concept map showing themes from interviews at the University of Melbourne](image-url)
• Indigenous to sense.
• Indigenous to interesting.
• Indigenous to guest.
• Indigenous to year.

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

• Indigenous health content.
• Student (dis)incentives.
• Staff development.

5.2.1. Indigenous to sense

This conceptual pathway linked a series of key words including ‘Indigenous’, ‘students’, ‘subject’, ‘teaching’ and ‘sense’. The key statements from the Leximancer discussion thread particularly relate to the Indigenous health subjects and integration of Indigenous health content, and the associated challenges to its integration within the course that relates to teaching and students doing the subjects.

5.2.1.1. Importance of Indigenous health

The University of Melbourne has Indigenous health as a specialisation in the MPH. Interviewees discussed the support given to the development of this stream within the program.

I think there has been quite a strong awareness of the importance of including Indigenous public health studies because we’ve got such a strong unit here. People like Leanne [Coombe] and Shaun [Ewen] have been directly involved in the development of the MPH so… their agenda is a shared agenda.

We had the Indigenous stream – that was sort of in the background as something that was being developed and I guess we were all very encouraging of that. That came through, that committee, to say: this is something that the coordinators are looking at and do you agree that it should be offered. We always definitely agreed that it should be offered. We always definitely agreed that it should be offered. Particularly from my perspective, I thought it was something that would be a real strength of the MPH for students. Even if they don’t want to take that whole stream [its good] to be able to take some Indigenous health subjects.

The manual thematic analysis also identified that staff are keen to see the integration of Indigenous health across the MPH more broadly and see this as important to the curriculum.

Whether that’s best through a specific subject or across the board – I think it’s better to be across the board.

Thus, there is an ongoing debate identified in the Leximancer analysis as to whether one of the Indigenous health subjects should be a core subject, to ensure that all students are exposed to this important content area, or whether students should be introduced to the content in core subjects and provided with the opportunity to further specialise should they so choose.

I have mixed feelings. Sometimes I think it’s great if the program has a core subject that’s focused on Indigenous issues. It’s a clear signal that we value these issues; that we think these issues are important and we think… it should be a core subject and the students should do it. I think that’s good. But I also think sometimes then maybe you end up with students who are going to do that subject no matter what, and you get a certain type of student who does that. Then there’s going to be this whole range of other students – maybe they’re international students – who don’t do it and then they miss out if it’s not across everywhere else.

If… there’s a lot of content across the whole curriculum everyone’s going to get that engagement. Maybe it’s to a lesser degree and people can then choose to go into it in more depth.

5.2.1.2. Challenges to integration

In terms of integrating content across the core courses, a number of challenges were discussed, Firstly, the time available to fit Indigenous health content within already full subjects is a major issue for many staff who were interviewed, as typified by these quotes.

I would be worried sometimes that you’ve only got a certain amount of time in your subject.

Both of those subjects, I should say, were created – in terms of their structure and a lot of their content – by the committee. The Foundation subject in particular probably has the lowest direct Indigenous content of all of the subjects I teach… I think it’s partly because there are 12 topics. We have 12 guest lecturers and I pull them altogether. They’re all quite senior lecturers in the School. [Professor] Terry Nolan gives an hour and a half walk through public health strategies and draws on global examples from all around the world. We cover the history of public health; we look at resource allocation, ethics; so it’s a very full course.

The big challenge is just fitting all the content in, I find. So probably it’s just a
matter of us trying to think of ways, even if we’re content full up already, of building Indigenous health awareness issues in by assignments, by tutorial topics and the guest lecturer is another good vehicle for teaching.

The manual thematic analysis identified that time issues equally relate to the time required for staff to develop the Indigenous health content that they are expected to teach, and to the time requirements involved in student supervision of the capstone experiences.

I can see why a lot of people don’t take it on because it’s just an extra thing. But unless it happens as a nation we’re not giving that rounded education that people at [the Masters] level require – to claim that title, to claim that pay cheque, people need that insight to be able to deliver what’s in their job description with a sound knowledge. I think we’ve got three students this year and we work with a professor who is just able to manage and coordinate it and disperse it. So with one student placement we would liaise with up to 10 different organisations to get those people involved. Then we’re asking people who have already got huge workloads.

An additional challenge for some staff, identified through the manual thematic analysis, is finding appropriate teaching resources or case study examples to use in their subjects.

So I often struggle probably more to have Indigenous examples and that’s why I do the research.

My limitation in doing that is actually finding stuff that I can teach with, in Indigenous health. That’s my limitation. I found this one article – and there’s lots of data, which is good, but a lot of it – because I’m teaching basic epi, a lot of it is comparisons between an Indigenous cohort and a non-Indigenous cohort, and it just gets too complicated for my students. So I have to look really hard to find something that’s actually of use... I looked for another article and I couldn’t find one in Indigenous health. I couldn’t find one that I could actually really [use] – a suitable one. It can take me days to find a good article. It’s hard work.

A suggestion put forward to overcome this challenge was developing a database of appropriate resources and teaching materials that staff could easily access.

The Indigenous examples really highlight those kinds of things but it [has] taken[n] me a long time to build [up these resources]. If I didn’t really know that kind of stuff it would take me a long time to build those examples. I almost see that it would be great to have some kind of database. If you’re going to do a lecture on alcohol... here’s the relevant papers, here’s some great YouTube videos you could show... Maybe the Indigenous Health InfoNet [also has good resources] – often I go there to look for the latest...

The Leximancer analysis identified that resourcing the Indigenous health specialisation, and specifically the staff positions to teach the Indigenous-specific content, is another issue. This is because funding for these staff is currently obtained from external sources through project grants, rather than from the University.

This is not a sledge at our School, but we couldn’t teach all of our Indigenous health subjects without external funding, be it from DOHA [Department of Health and Ageing], be it from VicHealth and a little bit from the Faculty – but mostly from DOHA and VicHealth, who fund a range of positions that we draw upon to contribute to the delivery. If those funding streams dried up the University and the Faculty would have to reconsider its approach to supporting what, in some context, it describes as a flagship offering of the School partly through Onemda – which is around Indigenous health teaching, learning and leadership within the MPH – and most of that is externally funded.

The major issue is this School and its investment into Indigenous content and its teaching. I say that [because] the School is getting a lot of good teaching staff for nothing, because we’re not funded through the School or the University. So the School is getting a nice little package, you could say, if that’s what we’re doing... So I say to the School when they come and talk about those key indicators of how we could do things better, one of those is they need to allocate teaching staff to this... So if you want this, the next thing is put your money where your mouth is. That’s what I see, in order for it to be sustainable.

5.2.1.3. Student enrolment quotas

A specific challenge apparent through the Leximancer analysis related to maintaining student enrolments in subjects. Quotas are used to determine the viability of the subjects, so they are discontinued if they do not meet these quotas. Hence, low student numbers currently threaten the continuance of those Indigenous health subjects that form the specialisation.
The challenges are getting student numbers that are high enough to make the subjects in a university context viable and that’s, I think, in part to do with both timetabling and interest and how students see it as being relevant. We’ve bounced around between eight and 13 or 14 or so in the core [Indigenous] subject for quite a few years now.

I actually don’t believe that the School values the subject and its contribution to population health as a whole. While our numbers are always low, I’m not keen for students to [have to do it] – I don’t want to make it compulsory [because] I don’t want people there who don’t want to be there…. So that number, whether it be 12 or whether it be five in some years, that’s five more, that’s 12 more people who have an interest in Indigenous health… So I think we’re always under the microscope in terms of that, I mean in our low numbers and our enrolment.

Interviewees interpret the reason for low student enrolments in these subjects as a lack of a perceived relevance to international students, who form a high proportion of the cohort and have expectations around the internationalisation of the content.

The Indigenous health subjects, we do struggle for students. I think that is probably the biggest issue. I guess we have quite a lot of international students too, for which the Indigenous health stream subjects aren’t [that popular]. They’d go and do global health or they do different things, but they don’t tend to do the Indigenous health subjects. They’re looking for international content within the core [curriculum]… A lot of the international students, they work in the big international organisations already and they have their job that they have to go back to. So… Australian Indigenous health isn’t what they’re probably looking for because they want to add to their job that they already have when they go back.

Conversely, the manual thematic analysis identified that the international students have, in fact, indicated an interest in Indigenous health content, which contradicts the previous assumption.

So we actually found our Indigenous content was strong in Public Health in Practice and it was just contemporary issues, so students really engaged with it and got right into it. Of course our international students start off being somewhat perplexed by why we have this huge gap between our Indigenous and non-Indigenous populations. Then by the end they worked out that there’s something seriously wrong that is embedded in our history and our culture. I think that’s quite an important learning for them.

What’s quite interesting is that when people do ask for it, it’s also not just Australian students who are doing it – it’s international students who are very interested in learning about this as well. So I think… given that a quarter of our students are international it’s also, how do you present this and present more issues and more good examples.

The Leximancer analysis highlighted that steps are being taken to rectify the low student enrolments in the Indigenous health subjects through targeted marketing of these courses, and of the Indigenous health specialisation as a whole, to those with an interest in the area.

We’ve also had a number of students volunteer to help us out with the marketing. I’ve already alerted you [to this] in a separate conversation but the current MPH brochure is in the process of being updated to include the new Indigenous health specialisation and the new subjects which weren’t in there previously. As part of that process a couple of the students have offered to be interviewed to have testimonials added into the marketing material to try and boost more student numbers around that, which for me is a really positive thing.

Certainly the Indigenous health stream is good in terms of the feedback. I’ve been talking with Leanne [Coombe] and Paul [Stewart] and Shaun Ewen about the better marketing of that… I mean, about 10 per cent come in wanting to do it and about 10 per cent go out wanting to do it so it’s about the same, actually. The question is how do you – do we – try and increase that or, where can you actually get a greater movement of people who want to come to an MPH, to say I will pick the Indigenous health specialisation?

5.2.1.4. Indigenous student enrolments

In relation to student enrolments, the Leximancer analysis also identified that the University of Melbourne has low numbers of Indigenous students in the MPH considering the high student enrolments overall in the MPH program.

I’m not aware of it in the big subjects… no one has pointed out to me Indigenous status or otherwise, so I’m honestly not
It appears that enrolment of Indigenous students is not formally tracked through the system so there was uncertainty expressed as to actual enrolments.

I did [look] at the start of the year, and we had one or two [Indigenous students] apply within the MPH, but I can’t remember exactly whether they took up the place or not. I don’t know. That’s probably something we’ll look at.

5.2.2. Indigenous to interesting

This conceptual pathway linked a series of key words including ‘Indigenous’, ‘work’, ‘people’ and ‘interesting’. The key statements from the Leximancer discussion thread particularly relate to how Indigenous health is embedded in the program, in a way that makes the content relevant and of interest to students.

5.2.2.1. Student choice

It was noted that assessments are often used as the mechanism by which to embed Indigenous content in subjects. Students are often given the choice of topics for their assessment pieces, which may include an Indigenous health option.

Then we set an assignment where we had two options: one was looking at alcohol use and interventions and policies in Sweden, because one of our lecturers had been head of the Institute of Alcohol in Sweden for 10 years, Robin Room, [and] the other one was around Indigenous alcohol use.

This approach enables students to choose areas that are of interest to them or of particular relevance to their work.

And in terms of the assessment, because it was very open, I just let people choose what they wanted to do. Sometimes I worry that they are recycling things and not really pushing themselves a little bit to learn, because I think a lot of the subjects are pretty similar... I can understand why too these people are interested in particular things that are relevant to their work so they want to pursue those ideas.

I thought that worked really well because some of the students based here... were working in Aboriginal health and they chose to look at those topics often through the prism of the work that they were involved in.

Similarly, students may choose to conduct research projects on Indigenous health topics as part of their capstone experiences.

[Of] my research project students, almost every year there’ll be at least one research project student who tackles an Indigenous health issue.

5.2.2.2. Student contributions

Students currently working in areas of, or with an interest in, Indigenous health also bring that perspective to the course through their contributions to discussion, hence contributing to the informal content of the course.

One of the good things is we’ve had a number of people who have been involved in Aboriginal health. We had a terrific young woman who was working out in Western Australia and who constantly brought [Indigenous health] back into the discussion.

It’s another thing, in terms of getting people to work on group issues around Aboriginal health, so there are lots of opportunities... In a sense we weren’t specifically talking about Aboriginal health issues but they’ll always come up... We also do a session on employment in health professions – so Aboriginal health services, Aboriginal communities. This is somewhere where you talk about Aboriginal health being, or Aboriginal communities being, or health services being places that people might...want to work.

Indigenous health always comes up as a research example. If we’re going to do a case study... there is a whole range of things that we would talk about, but Indigenous health would always be part of that kind of background... it’s an important aspect of population health.

It was noted that some of the MPH subjects are taken by the Master of Health Social Science students, who are presently based in Shepparton and are an Aboriginal cohort of students. This enables an opportunity for the MPH students to learn from the perspectives and differing world-view of the Aboriginal students and vice versa.

All of the Shepparton students chose to take an Indigenous perspective but I thought it was good because it provided an opportunity for the students here – the ones based in Melbourne – to hear the range of perspectives. I thought it was good too for the Indigenous students to hear a range...
of other perspectives. Even sometimes in conceptual frameworks that can also be used to analyse an issue.

I love what the students bring. I guess that is something that I really work hard to do and allocate them time... we'd really value learning about your country. It's great. So I guess having Indigenous students in the class is an added bonus to be able to get some information from them too.

5.2.2.3. Student learning
The Aboriginal student cohort and the move to embed Indigenous content throughout the course pose personal challenges for some staff, who seek assistance from Onemda staff to ensure that the content will be of interest and relevance to both student cohorts.

So they come and ask me... how do you teach Indigenous students? I just thought, well we teach every other [student here]. This is an international university – there’s no difference, they’re students. There’s the issue about embedding Indigenous content and how to do it respectfully, that’s the main issue I think some lecturers are scared of... So the key thing, I kept saying to them, is to keep students interested. You’ve got to give them things that they’re interested in. Now if you’ve got 20 students and nine of those are Indigenous, I’m sure you’d want to have an Indigenous case study or article...

As this last quote highlights, students need to be guided along their learning journey, particularly when dealing with sensitive topic areas or student preconceptions that require a certain skill. Hence, this is a challenge for some staff.

I think the real impact of how it works, and the real challenge – in particular [in] the Indigenous Health Past to Present subject, or [Indigenous] Health and History, whatever it’s now called – is the fact that you’re able to observe... changes in the students over a period of teaching. So you’ll often see at about ... 60 per cent of the way through a course... resistance to Aboriginal people. Why are Aboriginal people different? Why is Aboriginal health different? Why don’t we just do refugee health or whatever else, and I’m sure we’ve all heard that a thousand times. Particularly from a nursing perspective: I like to treat everyone the same so why should I be treating Aboriginal people differently? And what we often see, in terms of an answer to your question about how do we know it’s working, is in fact a move in the student journey of their responses to those kind of questions.

Nevertheless, many students undertaking the Indigenous health subjects are deeply affected and changed as a result of their learning experience.

We have in Indigenous Health and History a major assessment piece that requires them to reflect on their journey through the course. The content of a lot of those essays has been, to say the very least, quite profound in some instances. A lot of the students find it [to be] a life-changing experience going through this course, particularly those who have had no previous exposure to the area of Indigenous health or Aboriginal community more broadly.

5.2.2.4. Student inclination
It was noted that the students undertaking the Indigenous health specialisation subjects are often those who are working, or want to work post-graduation, in the Indigenous health sector.

We’ve had at least two examples of students who have come in to do the coursework in Indigenous health with a specific desire to get into the Aboriginal health sector as clinicians. One physio[therapist] and one psych[ologist], both of them went into the community health sector as part of their interest and supported by the coursework that they’d done.

Interviewees indicated that they believe these students are arguably more open to learning about Indigenous health than those who are forced to study Indigenous health through a generalist, integrated curriculum model.

You will find [students] probably better self-selected, so they’ve either got better experience or they’ve worked in Aboriginal communities or they understood it more or they’re politically just more savvy and more aware.

However, there is currently no evidence to support this notion, nor is there evidence that Indigenous health education actually achieves the desired health outcomes for Aboriginal communities, as this quote illustrates.

One of the challenges – [and] we talk about it in medicine as well – is the incorporation of Indigenous health content into an MPH or an MD or MBBS, whatever you want to call it. Most often the driver for it... that people articulate, is to improve outcomes for Aboriginal people. So your question about
what would be not working: actually we know bugger all about what’s working [in terms of] the link between education, the learner and the health outcome for patient or community. So, in fact, in answer to that question, we’ve got no idea. I guarantee you [that] any other institution you talk to has no idea as well, or if they have they haven’t published it.

5.2.3. Indigenous to guest

This conceptual pathway linked a series of key words including ‘Indigenous’, ‘work’, ‘communities’, ‘issues’ and ‘guest’. The key statements from the Leximancer discussion thread particularly relate to who is doing the teaching, the expertise they bring to the subjects and how this knowledge is applicable to practice and the workplace.

5.2.3.1. Team teaching

A great deal of the Indigenous content, and particularly the Indigenous health-specific subjects at the University of Melbourne, is taught by teams of staff.

Because we team teach we actually build that process into the subjects every year.

In terms of how we teach it we actually co-teach, team teach most of these subjects. So Indigenous Health and History [we] all teach into that and we also have a range of guest lecturers coming in from community... Indigenous Health Management and Leadership is very much again team taught and we have a whole range of different guest lecturers come in including staff from VACCHO. Some of the other Onemda staff who are working on specific projects in community [come] and talk about their management and leadership experiences in both health services and research.

5.2.3.2. Guest lecturers

As mentioned previously, guest lecturers are also used to provide a lived experience. In particular, it was noted that the community members and Elders who contribute to the Indigenous health specialisation subjects are a key feature of these subjects and are highly valued for their contribution.

There’s no books that can give it the human element. While we give them all these readings, it’s the human element that [guest lecturers] bring to the class to tell it how it is [which is so important], because it’s a lived experience. Now while we might go and get Professor A, B or C from other universities to talk about the flavour of the month, whatever that may be, these guys [the guest lecturers] are actually professors in their own right. So being able to articulate that within this University and its structure – [that] they’re on par with these guys – how do we truly acknowledge their contribution to this?

So my guest lecturers are my stars... two people that they’ve heard from, Aunty Joy and Aunty Walda... they talk about leadership... [Aunty Walda] talks about the climate of what it was like growing up in [Cummeragunja] where she actually witnessed children being taken away [and how] her father worked to keep the children... [alive]. [Putting it] in today’s modern context, well the key element is [that] these guys have created a legacy and this is why we are who we are today... So that’s why I describe them as the stars and my biggest [challenge] in all that is – how do I truly acknowledge that contribution.

The community members who support the teaching are also reportedly committed to the program because they recognise the importance of their contribution.

The other thing I think we know we’re doing well is that community continue to come and contribute to the teaching... at Onemda because they’re happy with the work that Onemda does and its engagement with the community... We get the senior Elders keep coming to contribute to our teaching and I think that’s an important part of [the] community’s reflection on what we’re doing.

Non-Indigenous guest lecturers who work in the field are also invited to provide a practical perspective where they have worked in communities as either practitioners or researchers, in both the Indigenous health and general subjects.

Then we finish off with two, usually two, non-Indigenous lecturers... they come and talk about their journeys into Aboriginal health ... [The students] want to hear from non-Aboriginal people about, well: so how did you get involved? What did you do, what was it?

We have other guest lecturers that work in Indigenous health who aren’t necessarily Aboriginal or Torres Strait Islanders but working in the field and bringing their own experiences in.

I think it works really well for me to have people who are experts come and do that.
I think we're lucky here how many people we have with that expertise and I think the students really value it. I guess the best are the people who have gone out into different communities and come back and really opened the students' eyes. I think that real stories, real researchers – that's I guess what I think works in teaching – rather than a whole load of dry content.

I also have an anthropologist give a guest lecture about doing ethnography in a drug facility in the Northern Territory and was involved with Indigenous communities. So again he talks a lot about how he did his research in that community and how long it took him to build trust and all those kinds of things.

In particular, they are valued for their ability to contextualise the theory provided by teaching staff, and illustrate how to apply the theory to practice.

I have a guest lecturer… Emma Kowal [who] talks about how theory can be used to understand people's attempts to improve the health of Indigenous communities… She talks about post-colonial theory and things like that as the theories governing that sort of health improvement behaviour, so that's a really interesting lecture.

I go through examples of theories with the students and then researchers come in and talk about how they've actually used theory in their work, so that they get both theoretical stuff but also how it's actually applied. At least two of the lecturers are researchers who have worked in Indigenous communities.

Guest lecturers are also a mechanism for integrating Indigenous content into general subjects.

About the Public Health Leadership…As I say, we've had people working in remote communities [in to speak] …and that experience has always been really useful. But, it's not specifically around Aboriginal health – although I must admit, I do still want to get someone like Paul [Briggs in to speak].

This was particularly the case where staff are uncomfortable teaching Indigenous health, hence their choice to rely on guest lecturers.

So her first year teaching, it was last semester, and I know she specifically was asking for some Indigenous guest lecturers because again she didn't feel like she had the expertise.

The manual thematic analysis identified that, while guest lecturers are a valuable resource, they require support and background information about how their contributions fit within the structure of the course to increase their relevance and value.

From my perspective, not knowing much about the course, I struggled with the context, about where this was fitting in with things. I was trying to pursue that information to understand where we were supposed to be delivering – at what level, what was the background of the students, what they were going to be interested in? So that... was not clear.

There also needs to be a mechanism to formally acknowledge and recognise the contributions made by guest lecturers.

It’s how we value that. I think we need to value that somehow, in a better way than we do, rather than: ‘Thanks a lot!’

5.2.3.3. Internal teaching staff

Some subject coordinators choose to draw on their own expertise from their experience in the field of Indigenous health either in lieu of, or in addition to, the guest lecturers.

So in terms of formal lectures I get some academics to come in and give formal lectures and some of those will be on Indigenous topics in medical anthropology. Generally, in every classroom – because… we might be discussing some kind of theoretical concept – if it's an example that I'm using for my own work, it'll be an Indigenous example because that's the kind of work that I do.

Much of the Indigenous health teaching is routinely informed by research as this is the focus of the School, and thus the work in which staff are involved.

Within the School generally I suppose my feeling is that because we have a strong unit here, we've got Onemda and we've got the Shepparton students, I feel like we're doing okay in that whole area of Indigenous work. Because we've got people who actively research in partnership with Aboriginal communities, as Margaret [Kelaher] does, my sense is that... we draw on some of that research material in teaching.

Then last year, I think, we were invited to teach a subject which was Indigenous Health: From Data to Practice|... The work that we were doing within the Indigenous Eye Health Unit was a nice
But usually you find people who want to do that have certain character traits such as high achieving, curiosity, independence. I think they’re the main key drivers I would see with students that want to come… because it’s also working under a professor who sits on every board under the sun – if he’s not in Washington, he’s in Geneva, and he’s everywhere. So to be able to put that on a CV is also a privilege for that person.

I would then suggest paying guest lecturers who already have the experience to come in and at least give a bit of information and knowledge… But it’s [difficult if] the onus is put on people like myself and people in our team to volunteer our time to impart our knowledge. It’s twofold. It’s fantastic because we’ve got hands-on experience. But to fit it [in] takes commitment and that extra bit of drive to… get people ready.

Nevertheless, internal staff have expressed a level of commitment to contributing as guest lecturers to the Indigenous health content because they see it as important.

I also had a couple of the guest lecturers from last year actually ask to continue to be involved… this applies to internal staff rather than external community members. But a couple of the internal staff want to have an ongoing involvement in the Indigenous health subjects which is also, for me, another sign of support for what we’re doing.

It was noted that the content delivered in the courses is, therefore, often dependent on the areas of expertise of those coordinating or delivering the course, whether they are staff or guest speakers, and that this can change the content covered over time.

story that matched what was trying to be demonstrated in the teaching program.

The manual thematic analysis identified that this is one of the motivators for students to take the MPH program at the University of Melbourne.

Many of the University staff who seek assistance to teach Indigenous content rely on Onemda staff members to do so. This, creates challenges around balancing dependency on Onemda to provide the teaching, or assist with the development of subject material, and accessing staff in the unit who are already busy.

I think with Onemda, because you haven’t got time to put in that intense development, I feel like there’s opportunities when I’ve tried to do it, but it’s actually been very hard to actually pull off. I also teach some short courses and I’ve tried to [do] that there, but I haven’t got anywhere with getting people to come and talk to the wider [issues] which I think would be helpful at least… That’s hard to get unless you have the personal relationships in that area. I must admit a lot of my Indigenous health examples, frameworks are from me and if I didn’t have that experience I would be having to [ask] where do I go. You are conscious of going to somewhere like an Onemda all the time and you can’t just keep [doing so]… You feel like you’re really drawing on people too much as well.

It was also noted that Indigenous health teaching has historically been seen as the domain of Onemda. This has led to the question as to who should be responsible within the Melbourne School of Population and Global Health for teaching Indigenous health content in the MPH, and whether this responsibility should solely lie within Onemda or be the responsibility of all staff.

It’s interesting in terms of the Indigenous content in what we’re doing. Particularly [with] the Nossal [Institute] – we’ve actually shied away from it. In the sense of the existence of Onemda and the existence of [the Nossal] there’s a certain delicacy about whether we should be dealing with this or not.

The manual thematic analysis identified that the assumed responsibility for Indigenous health teaching lying with Onemda is an issue as it has resulted in a lack of awareness of what is taught in the Indigenous health specialisation. However, it was also noted that this is the case more broadly across many of the specialisations and that there needs to be more information sharing between course coordinators, especially now that the course has
been running in its current format for a few years. This kind of activity is currently being planned.

But I’d like to know more about what’s working well across the School… I am so busy just doing my subjects… I don’t feel that there’s the forum… I feel like I’m working in silence. A forum to get together so we can actually share and know what we’re doing [would be good], and it may be leaning that way because we’ve now got the Director of Teaching [and Learning].

I think our focus the last year and a half or so, has been getting this new degree up and running. Now I think we need to do more sharing of what we all teach. That is something we’re going to do in the next six months or so, actually really making sure what we teach is coordinated, finding out more about what people do. In Indigenous health, adding the Indigenous health subjects in there and making that a bit more of a priority I think would be good, because… a lot of people really don’t know what’s included in those. So that is something that we would plan to do.

There was one example highlighted in the interviews of an information-sharing mechanism happening at a Centre level, which did not seem to be occurring at the School level.

We have them each semester, a teaching jamboree where… people who are coordinating, for instance, come together and we talk about our teaching experiences in the semester – what we’ve done. We look at the student experience surveys and then we usually have an activity. So it might be about marking or it might be about… what we’re doing in the Centre but beyond that it’s very hard to know what’s going on.

5.2.4. Indigenous to year

This conceptual pathway linked a series of key words including ‘Indigenous’, ‘research’, ‘course’, ‘teaching’, ‘students’, ‘subjects’ and ‘year’. The key statements from the Leximancer discussion thread relate not only to how research informs the teaching, but also how the principles of research inform the ways in which the program is evaluated.

5.2.4.1. Newness of current MPH program

The newness of the current program structure, which reportedly stemmed from the discontinuance of the Victorian MPH consortium, was highlighted by interviewees.

I coordinate two core subjects in what we call the new Master of Public Health, so University of Melbourne’s own MPH… and it’s been running only two years.

However, it was noted that many of the new subjects within the program, while new in terms of name and structure, are underpinned by the research and values of the School, particularly in terms of the Indigenous health subjects.

I think it’s important to note that while some of the subjects are by name new, the suite of Indigenous health subjects at Melbourne is more than 10 years old and [has] been built on, if you like, a formal and informal context. We [re]named the units, which have principles around Indigenous leadership, community participation, community engagement; [but] those values have informed the development in our coursework over a decade.

The manual thematic analysis also identified that the newness of the program has inevitably created some challenges, as expectations and operational matters are negotiated.

But this year the unit was approached to help with some of the placements. I think the appeal was because of the Indigenous nature of the work that we’re doing. There was an attempt to have someone placed within the unit, and it didn’t work out for a range of reasons. I understand that’s new and we were trying to watch where it was going and what the purpose of it was, what was expected of us and how they were going to decide whether it was okay to do it, or not... But it was only starting so I understand that... But also, just working out what the expectation is on what students are going to achieve out of the experience, [and] what offering this placement contributes to the whole MPH learning experience as well? So it shouldn’t be too hard to have a framework in which everyone knows how they’re operating. But it would appear that it may have started without a number of those... things in place.

5.2.4.2. Evaluation of the program

Because the program is relatively new, staff recognised the need to review its effectiveness and whether or not the competencies and expectations were being met as intended.

I think we wrote all the MPH at the start and now we’re really coming back to a point where we need to review it. I think this should be part of our review, over the next six months, and seeing where we are [at] and comparing [it] to the competencies. We
[also] need to compare [it] to our graduate attributes and add Indigenous health competencies and things into that review. So I think that’s probably something we need to work on over the next six months or so with Rob [Moodie].

I don’t know if it needs a lot more in my two subjects but I guess what would be interesting is to know what other subjects are covering, and whether there is crossover or whether there is something missing and we don’t really do that … In this MPH one of the things we struggle with is how do we keep on top of what each other are doing and make sure that we’re covering everything. So that’s kind of any ongoing process.

We just decided to review it in August/September around methodologies, around content, around cohesion. So this might be a nice interlinking issue for work across subjects. I think we also will need to have an open discussion about whether we want [Indigenous health] to be really mainstream rather than specialised, …[and] if you need help [integrating the content], well come and get it or we’ll work out a way of supplying it. I want to do that with international global health issues as well because if you want to have an internationally respected program you’ve got to use more than local Melbourne, urban examples to teach it… But that means we have to support staff and skill them up.

The manual thematic analysis identified that one mechanism planned for the near future is to run student focus groups to seek feedback on the program generally and, more specifically, to determine why they chose to take (or not take) Indigenous health subjects.

I like to really find out from students – we’re doing some focus groups over the next six months or so – why they don’t choose the Indigenous health subjects, … and find out a little bit more [about why that is]. It’s often [that] the students either do the Indigenous health stream, and they tend to do all of it… or not do it. There’s only been a stream for a short period of time, so it probably does need a little bit of time. But I’d like to find out a bit more from students, I think, and get their input on that.

It was also noted that the Indigenous health specialisation subjects have been separately evaluated this year to ensure that student feedback is received, because the University central evaluation system is not used for subjects with low student enrolments.

We also this year – because the specialisation and two of the subjects are relatively new – conducted separate evaluations. We realised that because we had fairly low student numbers in some of the units due to the newness of them, we weren’t going to have the formal Student Experience Survey administered for those units because they don’t administer them for units below a certain enrolment level.

It was reported that the feedback on the Indigenous health subjects has been extremely positive.

So how do we know we’re doing a good job? In part student feedback and the part that has to be linked to student expectations of why they’re doing the course, so they’re self-selecting in one sense. We have very few drop outs, so it must be meeting expectations.

We actually conducted separate surveys of our students and overwhelmingly the feedback was incredibly positive. They all thought that it should even be a core part of the MPH, even though we have made a conscious decision not to do that and have instead also integrated Indigenous content in most of the core units.

This feedback has also been used to inform improvements in the subjects.

We thought that the field trip we did out to Healesville this year, we spent too much time out in the field and there was additional work we could have done with the students before we went out there that would have prepared them and enhanced that experience. Indigenous Health – From Data to Practice, as I alluded to before, we’ve changed that slightly to increase the length of the intensives and reduced the online self-directed learning component that we had previously.

5.2.5. Indigenous health content

The manual thematic analysis identified several additional areas of discussion not highlighted by the Leximancer analysis. The first of these was related to the content and resources used to teach Indigenous health.

5.2.5.1. Indigenous health specialisation subjects

The focus of the Indigenous health subjects is reportedly around the social aspects of health rather than the biomedical model of health.
So that subject is basically developed chronologically in the sense that we talk about history and health and the impact that it’s had on Aboriginal people. Particularly, mainly associated with social determinants of that… it’s not bio-medical influenced.

The teaching of these subjects is also undertaken using an experiential style of teaching that reflects an Indigenous model of teaching.

It’s a completely different model of teaching, where it’s literature based and we’re analysing articles and stuff like that, but then we throw in the human element of the truth. [We] challenge [students] to think a bit differently in the sense that people actually live these experiences. So that’s probably the gist of the content, particularly related to that subject.

This necessarily involves face-to-face teaching so that students are immersed in the experience – which they reportedly value.

One of the things that we do do well, because of the Melbourne Model and the fact that we do a lot of our teaching face to face, our students are being more immersed in it than they would be if they were doing it online. A lot of our students comment on the strength of the experiential learning that they actually have doing these courses. I think the feedback that we got around the [Indigenous Health –From] Data to Practice unit where they actually said, ‘Hang on we want less of the online stuff, we want more of that face to face immersion’, is indicative of that.

Students are also provided with the opportunity to complete their capstone projects in an Indigenous health setting as part of the specialisation.

So we provided an Indigenous health capstone experience in both the research project and the Professional Practice Unit that are offered at the end of the degree.

5.2.5.2. Indigenous content examples

Specific content examples throughout the whole MPH program were also discussed, including specific diseases and interventions.

They chose two subjects to focus on for the tutorials. One was obesity and then… they wanted an Australian example. So we developed material on trachoma, which is a specific… infectious disease [that] affects Indigenous people, particularly in Australia… But it looked at different aspects of trachoma health promotion and advocacy and translating research into policy and how to conduct health assessments.

One way in my electives that I try to build the Indigenous content is to set assignment topics in health program evaluation that actually reflect on an Indigenous issue. The last three years actually I’ve had… one topic [for] students. It’s early in the course, so they’re thinking about the notion of evaluation questions and the ethics of evaluation, [and] I set a question on the [NT] Intervention.

What I always try to do is to use Indigenous health data too [so] that they can either, in lectures or tutorials, use and calculate comparisons between non-Indigenous and Indigenous mortality rates or child mortality rates, [like] the one that we looked at in our last week. Or we look at an article where they’ve done research in Indigenous communities or remote communities. So I always try to include the content that way… We [also] do a critical appraisal [and] this year we did one [on] a randomised control trial of an asthma intervention in [a] remote community in Queensland… It was an assignment last year and this year it was a tutorial.

5.2.5.3. Teaching tools and resources

Those staff teaching Indigenous health also referred to various resources that were available.

I give them a number of good journal articles that have been written by people who are active in Indigenous health who talk about the particular care that evaluators have to take when working in Indigenous communities.

I get them to bring in newspaper articles that seem to be representing something theoretical. I bring lots of current news stories and say, ‘How could we interpret what’s happening here?’.

Staff are also developing a series of case studies to form the basis of content for tutorials in one of the core subjects, and these have the potential to be made available for other programs.

We’ve just applied to do two case studies… on the reduction of trachoma, which is a major health success and [part of] the work of the Indigenous Eye Health Unit as well. But [we] have them as impact case studies because I don’t know [of] that many case studies around and I think it’s something
that we should build up. In particular I’d love to do one on Indigenous tobacco... So that’s where I think there are lots of opportunities for teaching and making those resources available for every MPH program in Australia. They’ll also be available through the... Australia and New Zealand School of Government, through ANZSOG here, so they’ll have them in their library as well. We’re quite keen to get them overseas as well but in sort of Harvard Business School-type case studies...

Various student activities were also described. For the Health Policy unit, [in] the lecture that I gave we tried to finish up with an interactive activity, which was around... one of the things we did in our report. I got them to construct a heat map: [so] down on one side you had the recommendations that we make. Then across the top it was guiding principles for health care [in an] Indigenous context... So I think the students, as part of that, were given a bit of background [with] a few questions, and then they had to design a heat map around that.

I assign them... an individual from people who’ve lived at Cummeragunja. They’re thinking about leaders like Noel Pearson and [Marcia] Langton and [Ian] Anderson ... I get them to go back and think about William Cooper and others – William Barack, Uncle Doug Nichols and all those types of pioneers.

5.2.6. Student (dis)incentives
The thematic analysis also identified discussion about the incentives and disincentives to students undertaking studies in Indigenous health. The incentives were around career opportunities.

I think some students are becoming more aware that there’s opportunities in that field. They hopefully think they’re likely to get a job if they go into that area. So I think that’s an incentive which is growing. Other incentives that students have is that they think it’s an area of need and they feel that they would [be] of most use going into that area.

The disincentives were also related to job opportunities, as the perception is that the workforce need is largely in remote areas. It was also noted that in a methods-based course, it is difficult to identify and label career opportunities in Indigenous health.

I think the disincentives for students – students that come through us – are [that they’re] very focused on methods and skills. They want to say I’m a health economist, they want to say I’m a health program [evaluator]... they want to say I’m an epidemiologist. With Indigenous health they find it harder, I think, to put a label on that and therefore I think that is a disincentive. Some students don’t want to go into Indigenous health because they think they might end up working in a remote area and they don’t want to move into a remote location. I think that’s a disincentive for students.

In terms of the recruitment of Aboriginal and Torres Strait Islander students, incentives reported were the availability of Indigenous health subjects and Aboriginal and Torres Strait Islander staff at the university.

I think some of the incentives would be the subjects that we offer, and I think the staff we have here are very good. They would be the incentives.

The disincentives for Aboriginal and Torres Strait Islander students on the other hand included the lack of support for students from a disadvantaged background.

I guess Melbourne Uni has never had a great reputation for having students from disadvantaged backgrounds... So I think [the] Uni has probably got not a good reputation for those sorts of students and support.

5.2.7. Staff development
Staff development was also identified as a theme in the discussions. Interviewees outlined a need for more staff training across a range of aspects including teaching skills and the use of technology.

I guess the only other thing is training for us. I mean I’m not trained as a teacher [and] I think I could definitely benefit from education around teaching, but I’m also incredibly time-poor. So somehow for the University to build in some training that’s not really time-consuming and is targeted to what I need would be good.

So I could learn a lot about, using technology... Even just getting thrown into that class this semester with no real training, I kind of think I could benefit, and the students would benefit, if I had had a bit more training. You learn on the job and you learn through trial and error.
6. Findings, Commendations and Recommendations

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

6.1. Integration of the Indigenous competencies

As illustrated, throughout this report the University of Melbourne has demonstrated commitment to the integration of Indigenous health content within the MPH program. The data presented here suggests that the University has primarily adopted a vertical model of integration, providing a seamless, efficient and effective pathway of education. This is seen as a strength of the program and recognised as an important component of the curriculum for achieving positive learning outcomes, as discussed in Section 5.2.2.3.

While there is very strong content within the Indigenous health specialisation subjects of the MPH units, Indigenous health is not covered in all core units and only some other elective subjects. Those units that do have Indigenous health content in examples and case studies were often described as having informal content, and it was not reflected in the program documentation and unit outlines. This content should be documented within subject outlines, where possible, to ensure that the extent of the integration of Indigenous health content and the associated competencies are formally reflected and acknowledged in the program documentation.

Historically, the teaching of Indigenous health content has been seen as the domain of Onemda. There is no clear indication of who is responsible within the MSPGH for ensuring that the teaching of Indigenous health content in other subjects within the MPH occurs, or if in fact it is the sole responsibility of Onemda. The existing expectation on Onemda staff to be responsible for teaching this content, and/or assisting other staff to develop subject materials, places additional pressure on them when they already have significant workloads. Commitment to the integration of the Indigenous competencies needs formal support from the School if it is to be effective and sustained.

Funding was also raised as an issue, as the positions of the Onemda staff currently responsible for teaching Indigenous health are funded by external agencies for other project work. The investment in Indigenous content and teaching from the University of Melbourne was highlighted as an issue that clearly needs to be addressed.

While many staff interviewed showed a very high level of interest and commitment to the integration of the Indigenous competencies, there are several challenges currently hindering their integration. It was noted that staff were concerned about having the time to develop Indigenous health content as well as their ability to fit it within the existing curriculum. They were also concerned by the time required to supervise students involved in research and placement projects, and having access to appropriate resources and case studies to support the Indigenous health content development.

It was also raised that some staff did not feel competent to deliver Indigenous content, and therefore relied heavily on people with expertise in this area. In some cases the content was delivered by guest lecturers who are respected Aboriginal community members and/or people who are working in Indigenous health. However, it was noted there needs to be a formal process for recognising these contributions within the School.

Several staff also stated that they are unaware of what units actually make up the MPH Indigenous health specialisation, and that they have limited knowledge of who teaches what units and what the actual content is. However, it was noted that this issue is a part of a broader one and is not limited solely to the Indigenous health specialisation. This raises the need for a formal process of information sharing by course coordinators and more broadly across all staff who teach into the MPH. Although it was noted
that such a process is being planned, it needs to be on-going either through regular teaching and learning forums or a general meeting to discuss the MPH. It is also evident from the data that a review of the content and a mapping of the competencies across the curricula is needed to ensure that the program is meeting the aims it was designed to achieve, now that it has been running for two years.

6.2. Innovations to integrate the Indigenous competencies

The practice of face-to-face and team teaching, as well as the use of a wide range of guest lecturers, has several benefits. Firstly, it brings different perspectives and life experiences to the student learning that provide a rich, comprehensive and well-rounded experiential learning opportunity. Secondly, in teaching sensitive material, it helps to create a safe learning space for students by providing them with the opportunity to explore openly questions and concerns with the staff member within the team to whom they most relate.

The development and delivery of the suite of specialisation units in Indigenous health shows a level of commitment to ensuring that Indigenous content is comprehensively covered and not just treated as a tokenistic add-on. The range of subjects offered ensures that each Indigenous health competency area is explored in depth rather than covered only superficially.

One of the challenges the review has highlighted nationally is the lack of available and appropriate teaching resources to support staff trying to integrate Indigenous health into their curriculum. The University of Melbourne has gone some way to addressing this issue, as demonstrated during this review, by developing a series of case studies that have been integrated into one of the core units of the MPH thereby ensuring that all graduates have been exposed to this learning. These resources could potentially be used to start what could become a comprehensive resource library in the future.

As outlined in Section 5.2.2.2, the interaction between students in the mainstream MPH program and the Aboriginal cohort of students undertaking their Master of Health Social Sciences is also innovative. It enables the students to learn from each other through a peer-learning format that maximises the advantages of differing perspectives and world-views.

The use of web-based formats to enable this interaction also demonstrates the University of Melbourne's willingness to embrace new technologies to accommodate rural and remote student cohorts and enhance student learning in an area of national workforce development need.

6.3. Improving integration of the Indigenous competencies

The analysis undertaken by the review has highlighted the issue of subject sustainability in units with Indigenous health content. Low student numbers currently threaten the continuance of the Indigenous health subjects, due to subject quotas. While several reasons that can be easily overcome were identified for this situation – including timetabling clashes, levels of student interest and the perceived relevance of the subjects, particularly to international students – it is a concern. A comprehensive recruitment plan needs to be developed to attract students interested in Indigenous health to the University of Melbourne, a plan that should also include marketing to Aboriginal and Torres Strait Islander students. Enrolment processes also need to incorporate mechanisms for the recording and tracking of Aboriginal and Torres Strait Islander students.

The questions raised in the interviews that the MSPGH does not adequately value the Indigenous health subjects and their contribution to public health are of significant concern. Value should be placed on content areas identified as a national priority – rather than on student numbers. Given the poor state of health of our Indigenous population, this content area should be afforded the highest priority to address the issue.

Equally, the resourcing of teaching positions for the Indigenous health specialisation should be the responsibility of the University. It should not be reliant on external project funding to provide what should be core business for the School.

As already noted, additional teaching input from other internal staff and external guest lecturers also needs formal recognition. Similarly, guest lecturers need to be adequately informed about how their input fits within the context of curricula and what they are required to discuss to maximise the benefits gained from their contributions. They also need to be adequately resourced and assisted with their teaching preparation. While many guest lecturers provide their services as part of their work, many do it on a voluntary basis and should be compensated accordingly.

The debate as to whether one of the Indigenous health subjects should be a core unit also needs to be resolved. If Indigenous health does not become a core unit the integration of content and the application of the Indigenous health competencies clearly needs strengthening across the existing core units to ensure that all graduate are exposed to this important area of public health education.

A range of staff capacity development needs was also highlighted. Along with increasing the capacity and confidence of staff to teach Indigenous health, teaching and IT use were identified as priority areas.
This review has also highlighted the lack of evidence that shows Indigenous health education programs achieve the desired outcomes which are often articulated as improving Aboriginal health, or that the competencies and graduate attributes actually produce effective and competent workers in Aboriginal health, thereby meeting the health workforce need. Research into links between graduate attributes and community health outcomes is needed nationally, and while it is acknowledged that this may not be the responsibility of a single institution, information can nevertheless be gained from graduate tracking that should be considered by all in the tertiary sector.

6.4. Commendations

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

- Delivery of a comprehensive vertical model of Indigenous health education within the MPH program.
- The face-to-face and team teaching approaches for Indigenous health subjects, which provides a culturally safe and experiential learning environment for students.
- Use of a broad range of guest lecturers who provide different perspectives and real-life experience to enhance student learning.
- Development of the series of case studies that can be used by staff as a teaching resource.
- Innovative use of technologies to accommodate rural and remote students as well as peer learning.

6.5. Recommendations

The team also proposes the following recommendations to strengthen the integration of Indigenous health in the curriculum at the University of Melbourne.

- Indigenous health should either become a core unit or the integration of content and application of the Indigenous health competencies needs strengthening across the existing core units.
- Funding for teaching positions contributing to the Indigenous health subjects within the MPH should be supported by the School.
- Value should be placed on content areas of national workforce development priority rather than student numbers.
- Recruitment and marketing plans for Indigenous health subjects and specialisation be developed and implemented.
- Process for tracking enrolments of Aboriginal and Torres Strait Islander students should be implemented.
- Process for the formal recognition and compensation of guest lecturer contributions be developed and adopted by the School of Population and Global Health.
- Formal documentation of Indigenous health content should be compiled to reflect the actual level of integration of competencies throughout the curriculum.
- Regular formal process of information sharing by course coordinators, and more broadly across all staff who teach into the MPH, should be implemented.
- Regular review of the content and mapping of the competencies across the curriculum.
- Capacity development of staff for Indigenous health teaching and other identified areas of need.
- Graduate survey to ascertain application of learning in workforce.

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

- A library of teaching resources and case studies in Indigenous health be developed.
- A national workforce survey of MPH graduates to assess application of the competencies and graduate outcomes and their relevance to workforce need.
7. References

ANAPHI 2009, Foundational Competencies for MPH Graduates in Australia, Australian Network of Academic Public Health Institutions, Canberra.


# 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

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, University of Melbourne by phone on 03 8344 9375 or email at lcoombe@unimelb.edu.au.

8.6 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 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 +613 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: +613 8344 2073, or fax: +613 9347 6739.

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5 HREC #: 1034186.2, Version: 15 April, 2011
8.4. Consent Form

PROJECT TITLE:  *Review of the Integration of Indigenous Public Health Competencies within MPH Curricula*\(^7\)

Name of participant: 

Name of investigator(s): Prof. Wendy Brabham, Dr. Shaun Ewen, Ms. Wendy Anders, Ms. Janice Jessen, Ms. Melody Muscat.

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

**2.** I understand that my participation will involve (please check required box/s):

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

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<tr>
<th>Key incentives for Indigenous Australian students</th>
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<tr>
<th>Key dis-incentives for Indigenous Australian students</th>
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</table>
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>
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<tr>
<td>1. Analyse key comparative health indicators for Aboriginal and Torres Strait Islander people.</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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<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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<td>6. Demonstrate a reflexive public health practice for Aboriginal and Torres Strait Islander health contexts</td>
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</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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<tr>
<td>Lecture (face-to-face on campus)</td>
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<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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<td>Online Interactive Forum (synchronous)</td>
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<td>Online Interactive Forum (asynchronous)</td>
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<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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<td>Other (please list)</td>
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Other comments:

Thank you for your participation
Onemda VicHealth Koori Health Unit
Centre for Health and Society
Melbourne School of Population and Global Health
Level 4, 207 Bouverie Street
The University of Melbourne
Victoria, 3010 AUSTRALIA

T: +61 3 8344 0813
F: +61 3 8344 0824
W: www.onemda.unimelb.edu.au