

Educating for Indigenous public health competence – how do we stack up in Australia?

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In Australia, postgraduate Master of Public Health (MPH) programs have been run since 1987 to train an increasingly broad range of health and allied health professionals in public health academic theory and professional practice. Originally, MPH programs were supported through the Australian Government funded Public Health Education and Research Program (PHERP). This supported several initiatives besides education, including the development of a set of core public health competencies.¹ This imperative for students to develop public health competencies is not unique to Australia. In recent decades, there has been increasing attention given internationally to the foundational skills and competencies required to meet the needs of “a changing public health practice landscape and workforce”²

Graduates of MPH programs in Australia are now expected to achieve, as part of the foundations for their professional practice, a set of competencies based on six functional areas of practice, each of which includes a related Indigenous public health core competency, which will assist them to become ‘judgement safe practitioners’³ when working in the area of Indigenous health.¹ The need to train a culturally competent workforce to provide culturally safe services that meet the needs of Aboriginal and Torres Strait Islander peoples in order to address health inequalities and improve health outcomes, is now widely recognised.⁴⁻⁷ Specific to public health:

All Australian Public Health graduates need to be culturally attuned to not only Aboriginal and Torres Strait Islander health issues, their

Abstract

Objective: Internationally, work is underway to develop or revise public health graduate competencies, of which Indigenous public health competencies are a subset in Australia. This paper outlines the summative results from a review of Master of Public Health (MPH) programs undertaken to determine the level of coverage of Indigenous health in core content and to explore factors that influence the extent of integration.

Methods: Of the 22 Australian universities offering an MPH program at the commencement of this study, seven were eventually reviewed using a mixed methods approach.

Results: Results showed varying levels of relevant content in both core and elective subjects. Not all reviewed universities taught all the competencies in their core curriculum and some universities did not cover all the competencies in either the core or elective subjects.

Conclusion: These findings highlight the need for inclusion of the Indigenous public health competencies to be made obligatory in MPH programs.

Implications for public health: Significant gaps remain in public health curricula enabling students to develop competencies that enable them to become judgement safe practitioners when working with Indigenous peoples and communities. A revised curriculum framework document provides a range of useful strategies and resources to remedy these omissions.

Key words: Indigenous health, public health education, graduate competencies

*history and specific challenges, but also Indigenous agency in the development of successful population health strategies to improve Aboriginal and Torres Strait Islander health.*⁸

The core competencies were therefore designed so that an Indigenous health-related competency was included in each of the six areas of practice. In this way, graduates are not only expected to achieve cultural competency more broadly, but also to demonstrate application of culturally safe practice in each foundational area of public health.

Following the third review of PHERP,³ the Australian Government withdrew funding but continued support for the Public Health

Indigenous Leadership in Education (PHILE) Network project, a national coalition of leading academics in Indigenous public health. PHILE is part of a broader Indigenous Public Health Capacity Building Project, co-managed by the University of Melbourne and Deakin University. This project has been running since 2006, resulting in several waves of activity.

Commencing in 2012, members of PHILE reviewed MPH programs across Australia to examine the extent to which the Indigenous public health competencies have been integrated into their curricula. The method and research approach used was complex and innovative and has been described in detail elsewhere.⁹ The

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Submitted: April 2018; Revision Requested: August 2018; Accepted: December 2018

The authors have stated they have no conflict of interest.

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Aust NZ J Public Health. 2019; Online; doi: 10.1111/1753-6405.12872

models used by the universities reviewed to incorporate Indigenous health content into their programs have also been reported separately,¹⁰ adding to existing understanding of different approaches and methods of curriculum integration.

Background to the reviews

Over the past 15 years, the extent to which Indigenous public health content has been an integral part of public health education has been actively and formally addressed through three reviews. The first piece of work, of direct relevance to the findings from this review, was the National Indigenous Public Health Curriculum Audit.¹¹ The results of the audit showed that the universities teaching Indigenous health content in their curriculum were concentrated in Queensland and Northern Territory, and the Indigenous health courses/subjects/units (henceforth referred to as subjects) on offer tended to have broad generic content (e.g. burden of disease), or a focus on specific diseases (e.g. mental health) and risks (e.g. alcohol). The audit results identified an apparently minimal application of social science theory and cultural analysis, as well as a need to foster ethical and self-reflexive practice.

In 2008, a feasibility study into a national MPH program specialising in Indigenous health recommended Indigenous health topic areas that should be prioritised as core subjects in Australian MPH programs to avoid, among other things, the “risk of a separate program labelled ‘Indigenous’ encouraging indifference within the mainstream public health sector ...”¹²

Box 1: Indigenous public health core competencies¹

1. Analyse key comparative health indicators for Aboriginal and Torres Strait Islander peoples.
2. Analyse key comparative indicators regarding the social determinants of health for Aboriginal and Torres Strait Islander peoples.
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 of the allocation of resources relative to need.
6. Demonstrate a reflexive public health practice for Aboriginal and Torres Strait Islander health contexts.

The recommended core Indigenous health subjects included Indigenous Health and History, supplemented by additional subjects focusing on Indigenous Health Policy, Indigenous Health Promotion and Research in Indigenous Contexts. The study report included further recommendations for an expanded structure of elective subjects for universities to run for students who want to complete an Indigenous health specialisation stream as a part of their MPH program.

The other major area of work was a PHERP Delphi project, which incorporated a series of workshops during 2004–06 that led to the development of the Australian MPH graduate core competencies¹ (see Box 1), and an accompanying framework document.¹³ These two documents were intended to guide universities in the integration of Indigenous public health competencies within their curricula. Although the competencies and the framework content serve as a guide

for universities teaching Aboriginal and Torres Strait Islander health within the Australian context, they also acknowledge and incorporate content pertaining to the broader international context, particularly in relation to comparative health indicators, global human rights agendas and the need to decolonise research methodologies.

The objective of this paper is to outline the extent to which these competencies and recommended subjects have subsequently been integrated into the Australian MPH programs and to summarise the enabling factors and barriers found to influence the extent of integration of this content.

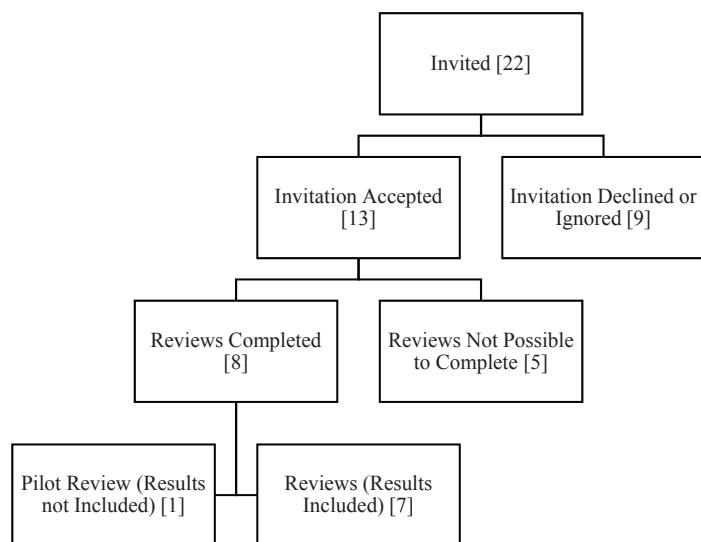
Methods

The overall project methods have been reported elsewhere in detail,⁹ in short, a mixed methods design was used (including questionnaires, interviews and focus groups, and analysis of curricula documents) as part of a cycle of participatory action research activities and curriculum enhancement. This involved members of PHILE, the teaching academics associated with the research and the institutions that were reviewed. This project was performed in accordance with the ethical standards of the University of Melbourne Human Research Ethics Committee (Approval #1034186.3)

As illustrated in Figure 1, invitations to have their program reviewed were circulated to all 22 Australian universities that offered an MPH in 2011. Thirteen expressed an interest in participating in the review of Indigenous health content within their MPH programs. However, it was not possible for logistical reasons to conduct reviews at five of these universities, due to unavailable staff or reviewers. One pilot review was conducted in 2011, the results of which were not included in the final analyses. Subsequent reviews occurred in 2012–13.

Two study questionnaires were designed to collect information, one from MPH degree program coordinators and the other from subject coordinators, to indicate where teaching of the Indigenous public health core competencies was incorporated into core curriculum, Indigenous health elective subjects and Indigenous health specialisation streams where available. Subject coordinators were also asked to provide their subject outlines, for the purposes of data triangulation, with learning outcomes and subject content examined by the research team for inclusion of relevant content.

Figure 1: University engagement with review project.



A detailed report of each individual review for the seven participating universities has been provided to each institution and published on the PHILE website (www.phile.net.au). A secondary thematic analysis of the summative results of the reviews, including location of relevant Indigenous health content in core and elective subjects, and an exploration of the common facilitators and barriers to teaching this content, have been consolidated in this paper.

Results

A total of 65 teaching staff members provided data for 73 subjects from the seven universities (some lecturers were responsible for more than one subject).

Levels of coverage

Each MPH program was individually structured, with different combinations of core and elective subjects. Table 1 indicates

the level of coverage found for each of the six Indigenous public health core competencies in the core subjects reviewed. In general, these competencies were covered in the core subjects, although not all of them were covered by every reviewed institution. Note that the quality of teaching of this content was not able to be assessed as part of this study, only the level of coverage of the competencies. Equally, the level of coverage was often difficult to quantify, as informal content described by teaching staff in the interviews and focus groups was often not matched in the formal curriculum documentation.

Most of the institutions studied offered limited numbers of dedicated Indigenous health subjects, with only three of these seven including an Indigenous health subject in their core curriculum. In summary, the key findings were that Indigenous health indicators, historical context, social determinants, public health policy and health

services and programs were reasonably well covered, while reflective practice was not strongly evident. Economic evaluation was highlighted as a deficiency.

For those MPH programs with dedicated Indigenous health subjects, the authors of this paper also mapped the content of reviewed subjects against the topic areas recommended in the results of the feasibility study,¹² as shown in Table 2. In summary, additional to the aforementioned three universities that had a dedicated core subject, two universities had dedicated elective subjects and one university had both a core and elective subjects dedicated to Indigenous health. Two universities did not have dedicated subjects. In recognition of the expertise of other universities, three of the institutions enabled or encouraged students to cross-institutionally enrol in Indigenous health elective subjects provided by other institutions to expand their studies in this area. When available, the subject areas

Table 1: Coverage of Indigenous public health competencies in core subjects.

Institution	University 1	University 2	University 3	University 4	University 5	University 6	University 7
Core subjects available							
Total number of core subjects	6	5	5	6	8	5	4
Core Indigenous health subjects reviewed	1	1	1	–	–	–	–
Other core subjects reviewed	2	2	4	5	6	5	4
Other core subjects not reviewed	3	2	–	1	2	–	–
Indigenous public health competencies integrated in core subjects							
– comparative health indicators	√	√	√	–	√	√	√
– social determinants	√	√	√	–	√	√	–
– historical context and impact of colonial processes	√	√	√	–	√	√	√
– public health policy or programs	√	√	√	–	√	√	–
– economic evaluation	√	–	–	–	√	√	–
– reflexive public health practice	√	√	√	–	√	–	–

Table 2: Coverage of recommended content areas in dedicated Indigenous health subjects.

Institution	University 1	University 2	University 3	University 4	University 5	University 6	University 7
Dedicated Indigenous health subjects available							
Core subjects	1	1	1	–	–	–	–
Elective subjects (*cross-institutional enrolment encouraged)	–	–	3	3*	–*	1*	–
Indigenous-health specialisation stream	–	–	√	√	–	–	–
– Public health practice (capstone)	–	–	–	√	–	–	–
– Research projects (capstone)	√	–	–	√	–	–	–
Coverage of recommended core subject areas							
– Indigenous health & history	√	√	–	√	–	√	–
– Indigenous health policy	–	–	√	–	–	–	–
– Indigenous health promotion	–	–	√	–	–	–	–
– Research in Indigenous contexts	–	–	√	√	–	–	–
Coverage of recommended elective subject areas							
– Indigenous social & emotional wellbeing	–	–	√	–	–	–	–
– Environmental health in Indigenous contexts	–	–	–	–	–	–	–
– Alcohol & drug issues in Indigenous health contexts	–	–	–	–	–	–	–
– Indigenous maternal & child health	–	–	–	–	–	–	–
– Other subject areas covered	–	–	1	2	–	–	–

covered tended to focus on the links between health and history, and research.

Influencing factors

A secondary analysis of the consolidated results was conducted to identify the factors that contributed to, or influenced, the levels of integration. The themes that emerged from this analysis can be divided into two main categories: external or internal related issues. A number of sub-categories were identified that apply across both areas, related to institutional issues, program focus, resources and content issues that hinder delivery of Indigenous health teaching.

The external context in which the institution was situated, both locally and globally, was shown to have an influence on the levels of integration in MPH programs. From a geographical perspective, universities located in regions with high proportions of Aboriginal and Torres Strait Islander peoples appear to be driven by a greater impetus to enable their graduates to be well equipped to work within this context.

The impact of globalisation and the increasing number of international students was another factor influencing the integration of Indigenous health, with several universities reporting increasing pressure to internationalise their programs for a range of reasons including: i) to attract students from overseas as an income generation measure; ii) to meet changing student expectations; or iii) to ensure their programs meet international standards. While this could potentially be a barrier to Indigenous health integration in the future, most institutions reported that they had chosen to retain and embed teaching of Indigenous health within an international context at the time of review.

This deliberate choice asserts that knowledge and skills needed to work in Indigenous health are also applicable to working with other disadvantaged or minority population groups in the broader global context. Providing opportunities for students from other countries, all of which have their own Indigenous populations,¹⁴ to contextualise Indigenous health issues globally also provides international students who wish to stay and work in Australia with adequate preparation to work in Indigenous health. Internal institutional issues were largely bound by institutional priorities, ranging from insistence on open access and multimodal teaching, student quotas required before

subjects were allowed to run, support (or rather a lack of) for cross-institutional enrolment and teaching, and the support of the institution for any kind of integration. Specific program factors included the overall orientation of the program. MPH programs differed considerably in length, ranging from the equivalent of one year (taking exemptions into account) to two years full-time, affecting the amount of content to which students were exposed.

The ways in which content was integrated depended on several structural factors, such as whether (or not) a core Indigenous health subject was a part of the program and whereabouts in the program such content was introduced. Some institutions had undertaken comprehensive curriculum mapping and quality improvement processes to monitor integration of content according to the competencies framework. At other institutions, some staff were consistently unaware of the Indigenous health competencies, and indeed questioned the relevance and currency of the existing broader public health competencies. Others cited a lack of access to appropriate teaching materials to support integration. Teaching staff also noted that content was delivered both formally and informally, with much of the informal content not acknowledged or identifiable within the curriculum documentation.

Students are not universally enthusiastic to learn about Indigenous health, often possessing pre-existing prejudice and perceived lack of relevance. The use of 'deficit' teaching materials was common, highlighting what is wrong, rather than what works to improve health and wellbeing, which risks reinforcement of negative perceptions of Indigenous health. We also encountered examples of subject teaching materials using research that has been developed without input from Aboriginal and Torres Strait Islander peoples, but found few examples of good practice in Indigenous health improvement using the agreed principles of appropriate research practice according to NHMRC guidelines.¹⁵

The capacity and experience (or lack thereof) of staff teaching Indigenous health content impacts their ability to constructively handle such challenges, affecting their willingness to integrate content. Unless Indigenous staff are employed in-house, non-Indigenous staff find it difficult to identify appropriate resources and teaching strategies, especially

those that promote self-determining approaches for integrating Indigenous health into teaching. Some institutions had no Indigenous teaching staff to provide personal authentic content to supplement and complement academic content. Those that did reported heavy workloads for them. The universities without Indigenous teaching staff in their schools noted this absence and that there is a lack of such staff nationally, at least partly because of a lack of candidates who are appropriately qualified. Four of the seven reviewed universities had dedicated Indigenous health units with staff who contributed to the teaching of the MPH programs reviewed.

All but one of the universities drew on Aboriginal community members, expert practitioners and research partners for guest lectures and curriculum advice. Around half of the participants noted that relationships with government departments could be beneficial for accessing input as a key employer; however, it was also noted that relationships with external stakeholders could fluctuate over time. One university specifically used a flipped classroom approach and field trips to supplement gaps in expertise.

Most universities recognised the financial constraints on their public health programs since the cessation of PHERP funding, with viability being further threatened by high fees; for Australian students without financial support a two-year course will cost at least \$35,000. One university response highlighted government support for rural health programs, suggesting that similar support is warranted for public health teaching programs. Several universities were aware that teaching is financially supported through mechanisms other than university-funded teaching positions; for example, through international student fees, external project grants, research grants and other university centres such as the Poche Indigenous Health Centres.¹⁶ Several of the interviewees noted that they did not have access to discretionary funds, making it difficult to appropriately remunerate community members for their contributions.

Several review participants made suggestions for improvement, such as including Indigenous staff on faculty to lead teaching and learning of Indigenous content, increasing the capacity of staff to teach this content, providing access to a pool of appropriate external teachers and guest lecturers, and using field visits to

Aboriginal communities and organisations. Several institutions noted at the time that the original competency documents were used to inform curriculum (re)design but that these documents were in need of updating to remain applicable and current. Lastly, and possibly most important, it was noted by interviewees that delivering Indigenous health content did not guarantee judgement safe practice.

Discussion

This paper shows that program reviews can provide teaching staff with evidence for the need for curriculum change. While it is likely that the universities participating in this review are the more proactive institutions in teaching this content, the findings presented here demonstrate that there are ongoing gaps in coverage of the Indigenous public health competencies in Australian MPH curricula that need to be overcome. This may be partly attributable to the finding that there is inconsistent recording of Indigenous health content in formal curricula documentation, a practice that needs to be changed if recognition is to be given to universities for the integration of the core competencies, and the importance of the content made explicit to students. Examples of best practice models of integration have been published elsewhere.¹⁰

However, there were several key challenges discussed that are likely to adversely affect less well-placed institutions, particularly if they are such significant barriers for the more proactive universities. Work to address the issues of access to appropriate content and teaching resources, and the question of currency and applicability of the existing competencies, has recently been undertaken as a result of this project. The national public health graduate competencies, which include the subset of Indigenous health competencies, have undergone a review and revision, with a second edition recently published.⁸ Similarly, the accompanying Indigenous health framework document has been republished with extensive expansion of the lists of teaching resources relevant to each competency.¹⁷ Nevertheless, effort is still required to ensure that all MPH program providers and their teaching staff are aware of, and familiar with, both of these documents given our results demonstrate that this has not uniformly been the case to date.

Although the shortage of appropriately qualified Indigenous academic staff to support teaching of this content is a national issue that only time will sufficiently rectify, recruitment and retention of staff with the expertise to contribute to this teaching must be prioritised. Furthermore, adequate support and professional development is clearly required to build capacity of teaching staff to deliver the required content in a way that is 'strengths-based' versus 'deficit-based' and to appropriately handle the noted negative preconceived student perceptions and prejudices.

Inter-university collaboration or cross-institutional student enrolment is another mechanism that was investigated in the early feasibility study,¹² which has seemingly had only limited uptake based on the findings of this study. Although there are several barriers to this occurring,¹⁸ particularly in the current higher education climate in Australia, opportunities for this to occur should continue to be explored as a solution to the limited Indigenous public health academic workforce.

These workforce-development needs highlight the noted impact of withdrawn funding support for these priorities by government, which calls for a review of national policy. Adequate resourcing of Indigenous health education is essential to fill the gaps in access to appropriate external expertise (including remuneration of community members) and the provision of innovative learning opportunities (such as field trips) for students.

Despite these challenges, this project has seen some improvements in this space. The original audit indicated that most of the Indigenous public health teaching was concentrated in the Northern Territory and Queensland,¹¹ which describes only one of the universities participating in this review. While a direct comparison of the findings from the two projects has not been conducted, results from this project imply that there has been an increase in the level of Indigenous health content in universities within other states, as several other institutions have demonstrated substantial coverage of the competencies and different content areas. This project has also raised the profile and visibility of the Indigenous public health competencies. Several of the institutions involved in the reviews have reported implementing curriculum change to

increase levels of coverage of the Indigenous public health competences.⁹

As already mentioned, the competencies document and associated curriculum framework documents have recently been revised and published, with the Council of Academic Public Health Institutions Australasia (CAPHIA) actively advocating for their adoption across its membership. The *National Aboriginal and Torres Strait Islander Public Health Curriculum Framework* document is designed to assist people to integrate Indigenous health into their curricula from a public health perspective. Furthermore, it can be adapted across disciplines that also incorporate the determinants of health into their practice. The PHILE document expands on the Indigenous public health core competencies by including suggestions for references, documents, journal articles and multi-media materials. A range of pedagogical strategies, including assessment outcomes, completes each competency. The use of Indigenous (alongside non-Indigenous) references is a notable step toward decolonising the curriculum, as it demonstrates Indigenous expertise in this space. Each competency begins with a section on underpinning knowledge, included to anchor the rationale for the need for each competence.

In the redesign of these competencies, we were mindful of people working with Indigenous peoples in other countries. We therefore hope that this document will be of use to our colleagues in countries other than Australia. Members of PHILE are also working with the World Federation of Public Health Associations to develop a Framework of Public Health Competencies, including Indigenous health, for global implementation.¹⁹

Limitations

Not all Australian MPH programs were reviewed, and it is likely that the institutions offering their programs for review are those with a commitment and active program of work to integrate the Indigenous public health competencies in their MPH curriculum. Although the number of core subjects to which all students are necessarily exposed varies considerably between institutions, we have shown that MPH students at these universities are potentially exposed to most or all of the required Indigenous public health competencies during their program.

However, institutions also vary in providing subject credits and exemptions, and this review has not included all core subjects within the reviewed programs. It is therefore possible that the findings presented here are not truly reflective of all Australian MPH programs. As previously noted, assessment of the quality of and methods for teaching Indigenous public health or decolonisation of the curriculum was not included in this study, and this is an area where future research is still needed, both locally and globally.

Conclusion

This national review of a sample of seemingly motivated institutions has highlighted that there are still significant gaps in our curricula that are required to assist students to develop these competencies. This situation is presumably worse in those institutions where there is a lack of Indigenous public health expertise among the teaching staff. Given that the six Indigenous public health competencies belong as a subset of nineteen overarching competency domains, this result is disappointing and requires immediate attention from public health educators and policy makers. Cultural competence is a concept that is hard to measure, and we acknowledge that it is sometimes difficult for teachers of future public health practitioners to find appropriate and non-stigmatising resources. Integrating 'strengths-based' examples of Indigenous health content across public health curricula is a necessary step to address the gap identified in the reviews because, at the end of the day, Indigenous health is everyone's business.

Public health implication

The need for MPH students to develop competencies that enable them to become judgement safe practitioners in many areas of public health practice of relevance to Indigenous communities all over Australia, such as policy making, research, education, health promotion and environmental health, is as important now as when the Australian public health graduate competencies were first developed.

The six Australian public health competency areas of practice⁸ were designed to enable public health curriculum development to ensure that all formally trained public health practitioners are competent to some extent in all important public health areas. The six

Indigenous public health competencies are included in the CAPHIA domains and are expanded upon in the second edition of the *National Aboriginal and Torres Strait Islander Public Health Curriculum Framework*. Furthermore, the Australian competencies documents are being used as a benchmark for the development of an international competency framework.

Notwithstanding these global developments, over and above cultural competence, it stands to reason that if MPH programs are designed using the Australian public health competencies, all students should be taught about Indigenous public health, even if the course designers have not encountered the framework documents. However, this project has shown that there are significant gaps in MPH curricula required to assist students to develop these competencies, and it is concerning that it is possible for a student to complete an MPH without encountering any content about Indigenous health, even in a sample of seemingly motivated institutions. This result is disappointing and requires immediate attention from public health educators and policy makers to ensure that readily available and appropriate content that has been approved by Indigenous public health leaders is included in all Australian MPH curricula. The revised PHILE curriculum framework provides a range of useful strategies and resources to remedy these omissions.

Acknowledgements

The authors gratefully acknowledge the contributions of members of the PHILE Network to the review process, and to staff from the universities who participated in the reviews.

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