'What we heard': A critical appraisal of the NHMRC's review of its Indigenous research excellence criteria

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In 2023, the National Health and Medical Research Council (NHMRC) undertook a national consultation process to review the Indigenous Health Research Excellence Criteria (IREC), which was significant given they have not been subject to review since their implementation in 1998. The IREC are four assessment criteria (these being: community building, benefit, sustainability, and building capability) against which research involving Indigenous peoples is assessed. Over the past 25 years, there have been substantial changes in the landscape of Indigenous health research, notably in the emergence of a critical mass of Aboriginal and/or Torres Strait Islander researchers who embody the excellence that the NHMRC has sought to define in its criteria.

The review process consisted of 13 workshops across Australia involving 192 participants, as well as 17 detailed written submissions.[1] However, no specificity was given as to where or who findings were drawn from, including whether findings were from Indigenous health researchers or non-Indigenous researchers. The report findings fail to privilege or even acknowledge when Indigenous knowledge was included or cited in the review process. As such, it is unsurprising that the review found that the criteria remained broadly suitable for assessing excellence in Indigenous health research. The NHMRC reduced a raft of participant suggestions such as "community-identified priorities (self-determination), be Indigenous-led, co-designed with communities, involve community-led governance (including data and intellectual property), respect Indigenous knowledges and research methods, value respectful relationships and result in research that is impactful and accountable with reciprocal benefits" ([1], p. 3) as mere additions for 'refreshing' the criteria. The NHMRC made no commitment to change; instead, they thanked the participants for their time and advised that they would "consider the findings" ([1], p. 3) ahead of future reviews.

The report claims that consultation feedback confirms that the IREC "are still needed" but that the language of the criteria needs "strengthening," ([1], p. 3) suggesting that all that is needed is to tinker with an existing framework. It is alarming that the NHMRC could conclude that the critical mass of Indigenous health research leaders over the past 25 years has not profoundly transformed the definition of Indigenous research excellence. The failure to realise how the suggestions provided to them are indicative of a need to radically reframe their approach might be a misreading and/or misunderstanding on the part of the NHMRC of the conceptualisation of self-determination and the strategies necessary to support it. Given the NHMRC insist they operate within "a framework that includes the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) ([2], p. 5)" we offer this commentary to assist them with better aligning their IREC to UNDRIP by drawing directly from it to frame our analysis.

Article 14 Indigenous peoples have the right to establish and control their educational systems and institutions…in a manner appropriate to their cultural methods of teaching and learning

The IREC are silent when it comes to Indigenous knowledges. This silence is reflective of the violence of Western knowledge production which has always presumed an Indigenous intellectual nullius.[3] This is evident in the NHRMC's IREC emphasis on Indigenous engagement and benefit, rather than Indigenous knowledges and control. The NHMRC, in its report, notes that a 'refresh' of the criteria is required to "reflect modern community expectations" ([1], p. 3) while refusing to recognise how it currently reflects racist retrograde imaginings of Indigenous Australian researchers and communities. For instance, the IREC emphasise "building capability," yet this only explicitly references the need to develop "relevant capabilities" of "Aboriginal and Torres Strait Islander peoples, community and researchers" ([1], p. 9). We are led to believe that these capabilities will be built via "partnership and participation in the project" ([1], p. 9). The non-Indigenous researcher is unnamed and erased as a racial category, yet visible as a site of benevolence for Black people. The track record of research on

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Aboriginal and Torres Strait Islander peoples does not support such a bold assumption.[4]

The consultation findings make note of the suggestion to "respect and value" ([1], p. 9). Indigenous knowledges but fails to articulate how. As our submission outlined, there is no actual weight given to the criteria of excellence in the NHMRC assessment process. It leaves us wondering how much value the NHMRC place on Indigenous research excellence given the criteria bears no material weight in the allocation of research funding. The IREC serves an accessorising function for the NHMRC rather than a transformative function for Indigenous peoples and communities.

Article 18: Indigenous peoples have the right to participate in decision-making…through representatives chosen by themselves

Rather than demonstrate excellence, the report findings of the consultation process embody the same mediocrity that the IREC currently reflect. The NHMRC review process effectively quantified a qualitative process via a word cloud and, in doing so, diluted the complexities of the feedback provided ([1], p. 9). Only 10 pages from the 38-page report related to consultation findings which is odd given almost 6 pages were afforded to the quantification of a qualitative review. If the NHMRC valued Indigenous knowledges, the contributions of Indigenous health researchers would not have been erased via their absorption into graphs, tables, and word clouds of non-Indigenous researchers and research office interests.

The NHMRC's analysis identifies "common themes" ([1], p. 5) that emerged, which appear as lists of concepts and terms (ie community engagement, building capacity, self- determination, Indigenous knowledges and knowledge translation) with no exploration of their meaning. Terms that could allude to divestment of power from non-Indigenous researchers to Indigenous communities are diluted by their consignment to floating signifiers without referent or context. Acknowledgement of these terms does not constitute meaningful engagement or action and works to erase Indigenous knowledges through their absurd emphasis on quantification.

Below is a table that illustrates how many comments from the consultation process were cited for each of the NHMRC four review questions. These comments are contrasted with the number of critical phrases that challenge the IREC cited for each question. The report disproportionately cites comments that are supportive of, or ambivalent towards, the IREC as they are currently defined. As the numbers below illustrate, it is hard to imagine that the NHMRC has objectively drawn from the feedback they have received, and it is unlikely that the comments they have cited reflect the analysis of Indigenous researchers that the NHMRC engaged in this review process. (See Table 1)

Table 1: Summary of thematic analysis findings "What we heard."

Question	Number of recorded comments	Number of critical phrases that challenge IREC
Question one	21 plus 10 broader comments relevant across categories	3
Question two	11	1
Question three	15	0
Question four	10	0

Article 21: Indigenous peoples have the right to the improvement of their economic and social conditions, including in the areas of health

It is our position that the standard of excellence in Indigenous health research must be those that have emerged directly from Indigenous communities' concerns and priorities, rather than the present situation where it is arrogantly assumed that external researchers are entitled to work 'with' and 'for' Indigenous communities through some sort of benevolent inclusion of Indigenous researchers.[5] In our submission,[6] we argued that current NHMRC Indigenous health research investments continue to be largely investigator-driven, and dangerously centre the intellectual curiosities of non-Indigenous researchers and research institutions.

Researchers should be required to demonstrate how Indigenous peoples and/or communities identify the need, conceptualise the study, and are actively involved in leading and governing the research process.[5] Evidence of research need must come directly from Indigenous peoples and/or communities, and not simply from literature about Indigenous peoples or the state's interest in studying and surveilling them, which represents a long and violent tradition upon the lives of Indigenous peoples.[7] Not only does the IREC currently fail to model this approach to Indigenous research excellence, but the NHMRC itself fails to model it in its own review process.

Article 23. Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development

Ironically, the NHMRC's report found that "two-way capability" ([1], p. 7) was essential to cultivating respectful relationships, and this was the responsibility of both institutions and the research team. This is hypocritical; if the NHMRC truly held this commitment then their report would have meaningfully engaged with the criticisms made of it rather than burying them beneath an obfuscating quantitative approach ([1], p. 3). The problem of Indigenous health research in failing to effect change is not the capability or capacity of Indigenous peoples, but rather the incapabilities of non-Indigenous researchers and research institutions to refrain from reproducing racialised knowledges about Indigenous peoples. How the NHMRC can be the arbiter of this is unclear, given the racialised framing of this criteria classified as 'excellence.'

The standard of excellence that must be set is one that insists upon transforming the unrelenting racialised knowledge production, if it is to truly to have a material dividend for Indigenous peoples. This requires a concerted engagement with the imbalance of power and the weight of existing structures. In so doing, it becomes difficult to use evidence deriving from current health 'excellence' criteria to confirm the status quo. For Indigenous health research, it "means research about Indigenous peoples being undertaken by Indigenous peoples whereby claims of Black lack—with this referring to "the absence of technical skills" ([6], p. 91)— can no longer deny Indigenous sovereignty.

Article 4. Indigenous peoples, in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs, as well as ways and means for financing their autonomous functions

Our submission was highly critical of the IREC, and yet, the NHMRC only quoted from our submission when we argued that research projects must deliver "a clear, immediate, and tangible benefit for Indigenous peoples and communities, commensurate with the financial investment made including appropriate remuneration for Indigenous Knowledges and Indigenous expertise."[5] This was one of our most self-evident critiques and, not only did the NHMRC make no commitment to realising this idea, but they also elided any acknowledgment of the more damning discrepancy between potential research and funding benefits derived from NHMRC investments which favour the careers of health researchers and the lack of benefits afforded to the cause of Indigenous health advancement. The NHMRC's review process does not address how it has demonstrably benefitted from its suppression of Indigenous knowledges and research excellence.

The NHMRC celebrates its success by claiming that in 2022, it exceeded its target funding for Indigenous health research. Still, the reporting framework does not address whether and how funding commitments reflect the health needs and priorities of Indigenous peoples and communities, as defined by Indigenous peoples and communities. The review fails to mention that (according to their latest report card in 2022) just 35% of the 208 active Indigenous health research grants are led by Aboriginal and/or Torres Strait Islander researchers. It is unclear what proportion of the almost $67M investment finds its way into the hands of Indigenous peoples or communities. How can the NHMRC be the arbiter of 'research benefit' as a signifier of excellence when it fails to model transparency and accountability in its own administration of health research funding?

The means by which the NHMRC currently assesses 'excellence' is via one reviewer, of which there is no guarantee that they will be an Indigenous researcher. This seems at odds with UNDRIP, and the claims of respecting and valuing Indigenous knowledges. The NHMRC appear to be largely interested in Indigenous knowledges that conform with and enforce their own criteria, foreclosing the possibility of engaging with dissonant Indigenous perspectives (enabled by expanded reviewer panels) that would positively challenge the limitations of the current IREC.

The current criteria of excellence relegate Indigenous peoples only ever as accessories to non-Indigenous knowing, and/or non-Indigenous way of knowing. To resist this racist enforced relegation, there must be a more critical interrogation of both research projects and the NHMRC's own research funding processes in such a way that centres Indigenous knowledges. The NHMRC should better appreciate that power works not only between 'the researcher' and 'the researched' but also within the processes of knowledge production, including research teams and seemingly benevolent review processes defined by research funding providers.[7]

The current IREC framing perpetuates a racist research paradigm that assigns Indigenous peoples and knowledges as intellectually inferior and is key to Aboriginal and Torres Strait Islander peoples and communities being denied meaningful control over Indigenous health research funding. Not only do these criteria, which purport to define Indigenous health research excellence, utterly fail to do so, but the NHMRC itself fails to model excellence in its own practices. We argue that its self-professed claims of 'excellence' works, not to benefit Indigenous peoples, but itself, and it is via the erasure of Indigenous knowledges that the NHMRC's power and control over Indigenous health research funding, and thus Indigenous peoples is sustained.

Tragically, the NHMRC has a long tradition of ignoring Indigenous calls for control over Indigenous health research funding, which extends beyond this review, and the establishment of the IREC in 1998. Humprey,[8] in her seminal paper "Dirty questions: Indigenous health and 'Western research'" critically challenged the rhetoric of reform that the NHMRC routinely performs. Centring Indigenous demands regarding Indigenous health research from the 1970s through to 2000, Humphrey points to the 1986 NHMRC conference in Alice Springs on 'Aboriginal health and social problems.' Here, Indigenous delegates were accused of 'taking over' the event in articulating their aspirations for Indigenous health research to be of benefit to Indigenous peoples. While this conference would be instrumental in the formation of the NHMRC's ethical guidelines in 1991, she notes, "Lost also, or rather ignored, was the more radical insistence on Aboriginal control of research funds" ([8], p. 200).

The lack of meaningful engagement with Indigenous knowledges, through this consultation process, as expressed in the available literature is not an oversight but reflects a mischievous appropriation of Indigenous excellence that serves to sustain white power. How the NHMRC can proudly boast of its adherence to the UNDRIP is beyond us, much like Indigenous sovereignty is beyond the NHMRC's imagining.

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