

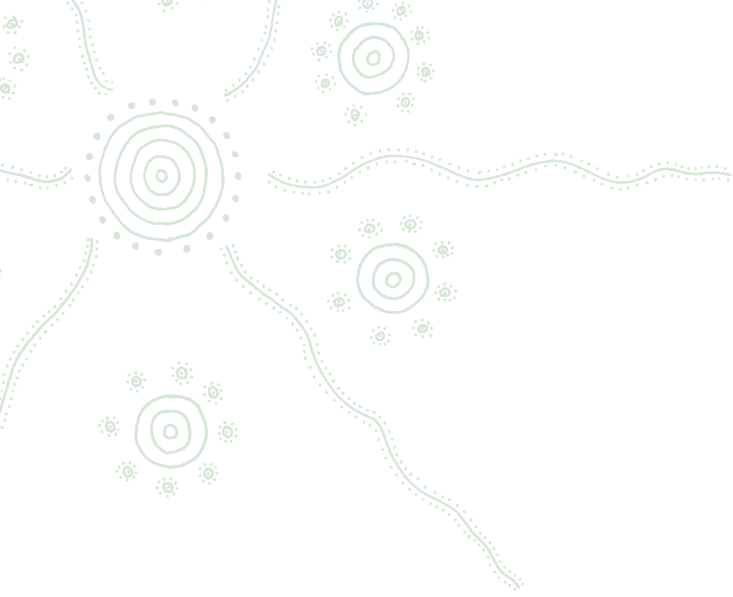


# **CDAMS** Indigenous Health Curriculum Framework

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On behalf of  
The Project Steering Committee  
Committee of Deans of Australian Medical Schools

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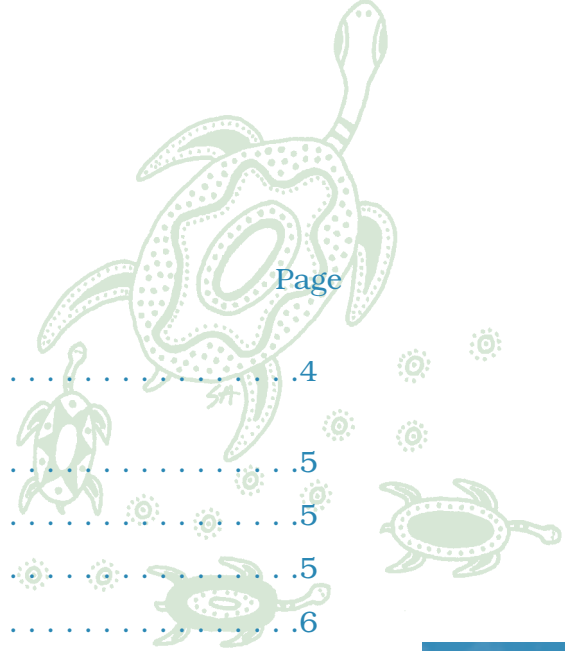
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# Contents

	Page
Foreword .....	4
Overview .....	5
Purpose .....	5
Rationale .....	5
Scope .....	6
Guiding Principles .....	7
Glossary .....	8
Suggested Subject Areas and Key Student Attributes and Outcomes .....	9
Pedagogical Principles and Approach .....	13
Delivery and Assessment .....	23
Suggested Process for Curriculum Development .....	24
Resources, Capacity and Workforce Development Issues .....	26
Acknowledgments .....	28
Endnotes .....	29



# Foreword

The Committee of Deans of Australian Medical Schools (CDAMS) is extremely pleased to present the *CDAMS Indigenous Health Curriculum Framework*.

CDAMS is excited and enthusiastic about the development of this curriculum framework, and we look forward to the challenges of working with our schools and other key stakeholders to facilitate its implementation.

We believe the guidelines for success contained in this document map clearly the task before us: how to ensure medical students nationwide receive the right information and skills development to enable them to become the best doctors we can produce for the improvement of Indigenous\* health outcomes.

With respect, we commend this framework to you in the hope that we may have a lasting positive impact on the health of the First Australians—Aboriginal and Torres Strait Islander Peoples—and, by extension, the well-being of the nation.



Professor S. Bruce Downton  
Chairperson of CDAMS



Professor James A. Angus  
Convenor, Steering Committee

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\* In this document, we use the term 'Indigenous' to refer to the Aboriginal and Torres Strait Islander Peoples of Australia. The terms 'Aboriginal and Torres Strait Islander Peoples', 'Indigenous', 'First Australian' and 'Indigenous Australian' are used interchangeably.

# Overview

In 2002, the Committee of Deans of Australasian Medical Schools (CDAMS) partnered with the Office of Aboriginal and Torres Strait Islander Health (OATSIH), within the Commonwealth Department of Health and Ageing, to establish and implement the CDAMS Indigenous Health Curriculum Development Project. The University of Melbourne, through the VicHealth Koori Health Research and Community Development Unit, kindly agreed to host the Project, which had four key objectives:

1. Audit existing Indigenous health content in core medical education.
2. Develop a nationally agreed curriculum framework for the inclusion of Indigenous health in core medical curricula.
3. Develop a network of Indigenous and non-Indigenous medical educators concerned with Indigenous health.
4. Seek accreditation of the curriculum framework by the Australian Medical Council (AMC).

The audit and consultation process has been completed, and plans for the development of a national network of medical educators are currently under way.

In addition to developing, endorsing and undertaking to implement the curriculum framework, CDAMS proposed to the Australian Medical Council (AMC) that this framework be included in their accreditation guidelines. The AMC have formally approved this proposal, meaning that all medical schools in Australia will be required to report on the implementation of these guidelines as part of their regular accreditation requirements.

This framework has been developed in consultation with medical educators, Indigenous health specialists, the Australian Indigenous Doctors' Association (AIDA), medical colleges, student bodies, and other organisations such as the Australian Rural Health Education Network.

## Purpose


The purpose of this curriculum framework is to provide medical schools with *a set of guidelines for success* in developing and delivering Indigenous health content in core medical education.

It is recognised that teaching Indigenous health in medicine is an emerging field and, as such, medical schools are at differing stages of curriculum development. This document seeks to enunciate the basic components of a functional curriculum for delivering Indigenous health effectively.

## Rationale

Aboriginal and Torres Strait Islander Peoples are the First Peoples of Australia, and deserve to be respected as such. Indigenous Australians have contributed much to the broader public good—in the mining and cattle industries, by showing ‘explorers’ how to find their way around the country, in politics, the arts, environmental movements, sports, cultural awareness and understandings of spirituality and place. Further, Indigenous Australians have shown incredible resilience by continuing to work in many ways to recover from the on-going impacts of colonisation.

One of the impacts of colonisation is the poor health outcomes of Indigenous Australians,<sup>1</sup> and it is our intention that this curriculum framework and overall project go some way to improving student outcomes and attributes in Indigenous health. This project responds to recommendations from numerous studies, inquiries, reports, policies and strategies emerging from the fields of Indigenous health, medical education and medical workforce development.<sup>2</sup> Over the past few decades, these documents have gradually, and then consistently, recommended the development and strengthening of training for medical professionals in both core and vocational education regarding the health and well-being of Aboriginal and Torres Strait Islander Australians.



The Project Steering Committee and stakeholders in this Project are passionate that a better informed medical education sector regarding Indigenous health issues will translate into better educational outcomes for medical students, which may, in turn, contribute to better health outcomes for Indigenous Australians.

This curriculum framework, then, becomes an investment in the future of not only the health and well-being of Aboriginal and Torres Strait Islander peoples and communities, but the training of a more competent medical workforce, and an improvement in the health status of all Australians. It is exciting and proper that medical schools are playing a critical role in this regard.

### **Scope**

This curriculum framework assumes the student has no prior awareness about Indigenous health, cultures or experiences. *It is suggested that the following subject areas are taught as part of core/compulsory medical education, rather than offered only as electives.*

6

The framework assumes some students will want to specialise in certain areas once these subject areas are delivered. It is suggested that schools may wish to develop elective options, through which students can gain a deeper experience and knowledge of Indigenous health, and we encourage the development of such specialisations or electives in accordance with the principles and approaches suggested in this framework.

# Guiding Principles

This section outlines some of the underlying philosophical principles and consensus statements that are likely to support the most effective development and delivery of Indigenous health in core medical curricula.

- Aboriginal and Torres Strait Islander Peoples have a diversity of cultures, experiences, histories and geographical locations. They are not a homogenous population, and this should be reflected in the design, delivery and evaluation of curricula.
- 'Indigenous health' in this context does not merely refer to the cultural, historical or socio-economic factors regarding Indigenous Australians that can be taught as a separate (and potentially stigmatised) part of the medical curriculum. Rather, we suggest Indigenous health is included in the broadest possible terms—where both specific subjects/areas and Problem Based Learning (PBL) cases about Indigenous people are taught and, further, where Indigenous examples in cardiology, for example, are also delivered.

- Indigenous views on health and well-being are both valid and critical to the delivery of culturally appropriate, and safe, medicine and health care. The first National Aboriginal Health Strategy defined health as:

*... not just the physical well-being of the individual, but the social, emotional and cultural well-being of the whole community. This is a whole of life view and it also includes the cycle of life-death-life.<sup>3</sup>*

- In addition, the *Ways Forward* report identifies concepts as diverse as harmonised relationships, spiritual well-being, care for land and self-determination as being central to the way Indigenous Australians understand health and well-being.<sup>4</sup>
- Indigenous views on, and knowledge of, health and well-being are beneficial for all Australians, not just Indigenous peoples. For example, the emphasis on community wellness and medicine in Indigenous societies could be further explored for the potential health benefits it may offer to all Australians.
- Indigenous professionals and community members need to be valued and recognised for their expertise not only in Indigenous health, but for their abilities and contributions to academic life and scholarship in general.
- The health outcomes of Aboriginal and Torres Strait Islander Peoples are governed more by the historical and social determinants of health, than with inherent Aboriginality.<sup>5</sup> Prior to colonisation, Indigenous Australians were healthy and maintained physical, emotional, mental and spiritual wellness. Thus, the prevalence of illness in today's society cannot easily be attributed only to genetic or even behavioural causes. Rather, as supported by evidence, the preferred view is that current health outcomes result from a range of interrelated historical, environmental, physiological, political and behavioural factors.<sup>6</sup>
- Aboriginal and Torres Strait Islander peoples require equity of access not only to mainstream services that are free of racism and other forms of discrimination, but also to services which are specific and culturally appropriate.
- In Canada, the USA and Aotearoa/New Zealand, a convincing case has been made that the health and well-being of Indigenous peoples is strengthened both by having their sovereignty recognised,<sup>7</sup> and having control over their own health care service delivery.<sup>8</sup>



## Glossary

### Cultural safety

Ensuring that those individuals and systems delivering health care are aware of the impact of their own culture and cultural values on the delivery of services, and that they have some knowledge of, respect for and sensitivity towards the cultural needs of others. There is much written about slightly different but related terms, such as 'cultural security', 'culturally appropriate', 'culturally aware', 'culturally valid', and 'culturally competent'.<sup>9</sup>

### NAIDOC

National Aborigines and Islanders Day Observance Committee—as in NAIDOC Week—usually celebrated nationally in the second week in July. Some regions celebrate NAIDOC at other times.

8

### Ownership

Refers to a process of ensuring Indigenous peoples are included in the design, delivery, implementation and review of health (or other) projects and services.

### Self-determination

Aboriginal and Torres Strait Islander peoples freely exercising their rights and responsibilities to make decisions regarding their lives, and for those rights, responsibilities and decisions to be respected and observed by non-Indigenous peoples and governments.



# Suggested Subject Areas and Key Student Attributes and Outcomes

This section suggests the key subject areas that make up learning about the health of Aboriginal and Torres Strait Islander Peoples, suggests how these subject areas might fit into the overall medical education domains or theme areas, and lists the types of attributes and outcomes students might be expected to achieve as a result of the delivery of this content.

The grouping and order of subject areas remains flexible so as to accommodate each school's needs; however, vertical and horizontal integration is the key to successfully meeting these outcomes (these issues are discussed in the sections on 'Pedagogical Principles' and 'Delivery and Assessment'). The relevant overall domains/theme areas listed here are approximations of the current domains/theme areas found in most Australian medical schools.

Suggested Subject Areas	Relevant Overall Domain/Theme	Key Student Attributes and Outcomes
1. History	<ul style="list-style-type: none"> <li>• Doctor &amp; Society (D&amp;S)</li> <li>• Personal &amp; Professional</li> <li>• Development (P&amp;PD)</li> </ul>	<ul style="list-style-type: none"> <li>• Describe an overview of Aboriginal and Torres Strait Islander history as a continuum from pre-contact to the present.</li> <li>• Identify, acknowledge and analyse one's own emotional reactions to this history, and offer opinions respectfully.</li> <li>• Explain the connection between history and present health outcomes, including the forms and impacts of racism.</li> </ul>
2. Culture, Self and Diversity	<ul style="list-style-type: none"> <li>• D&amp;S</li> <li>• P&amp;PD</li> <li>• Doctor &amp; Patient / Clinical Skills (DP/CS)</li> </ul>	<ul style="list-style-type: none"> <li>• Identify, acknowledge and analyse one's own cultural values and reflect on their implications for health care.</li> <li>• Describe and explore the influence of culture on perspectives, attitudes, assumptions, beliefs and behaviours.</li> <li>• Identify and analyse the epistemological construction of Western medical knowledge and how this might differ between cultures.</li> <li>• Acknowledge and analyse the limitations of one's own knowledge and perspectives, and incorporate new ways of seeing, valuing and understanding with regard to Indigenous health practice.</li> </ul>

Suggested Subject Areas	Relevant Overall Domain/Theme	Key Student Attributes and Outcomes
3. Indigenous Societies, Cultures and Medicines	<ul style="list-style-type: none"> <li>• D&amp;S</li> <li>• DP/CS</li> <li>• P&amp;PD</li> </ul>	<ul style="list-style-type: none"> <li>• Describe the key features of Indigenous Australian identity, languages, societies, cultures and spirituality.</li> <li>• Explain Indigenous conceptions of health and illness, including social and emotional well-being.</li> <li>• Outline the process of learning in Indigenous cultures.</li> <li>• Demonstrate ways of respectfully acquiring cultural information.</li> <li>• Identify the essential features of Indigenous medicine and outline the implications for doctor–patient interactions, including ways of respectfully working with Indigenous healing and spiritual practitioners.</li> <li>• Identify protocols and processes for referrals and for utilising support from Aboriginal Health Workers (AHWs), other Indigenous health professionals, and other support resources.</li> </ul>
4. Population Health	<ul style="list-style-type: none"> <li>• D&amp;S</li> <li>• DP/CS</li> <li>• Scientific Basis of Medicine (SBM)</li> </ul>	<ul style="list-style-type: none"> <li>• List key health indicators for Indigenous Australians, including characteristics of mortality and morbidity specific to Indigenous Australians, and population distributions and pyramids.</li> <li>• Demonstrate how concepts and ideas drawn from medicine and epidemiology were used to support the process of colonisation of Indigenous peoples.</li> <li>• Identify and demonstrate the impact of social determinants on Indigenous health, including specific health issues uncommon to the broader population.</li> <li>• Assess the strengths and limitations of available data used as key indicators of Indigenous health.</li> <li>• Explain the impact of culture on prevention, definition, diagnosis and treatment of illness.</li> <li>• Identify the key principles of successful health surveillance including partnership, ownership, consultation and action research.</li> </ul>

Suggested Subject Areas	Relevant Overall Domain/Theme	Key Student Attributes and Outcomes
5. Models of Health Service Delivery	<ul style="list-style-type: none"> <li>• D&amp;S</li> <li>• DP/CS</li> <li>• P&amp;PD</li> </ul>	<ul style="list-style-type: none"> <li>• Outline the concept of inequity of access and the factors which contribute to it.</li> <li>• Identify ways of redressing inequity (i.e., making clinics culturally safe, employing Indigenous staff, referrals to Indigenous services).</li> <li>• Describe the historical development of Aboriginal initiatives, including the community-controlled sector and AHWs, and reflect on lessons from these initiatives that can be applied in other health sectors.</li> <li>• Analyse the role and effect of comprehensive Indigenous primary health care, including self-determination, community control, collaboration, partnership and ownership.</li> <li>• Identify features of effective Indigenous health promotion and general practice programs.</li> <li>• Assess the features, strengths and limitations of community-controlled, private and government health service delivery.</li> <li>• Outline key Indigenous health policies and strategies.</li> </ul>
6. Clinical Presentations of Disease	<ul style="list-style-type: none"> <li>• SBM</li> <li>• DP/CS</li> </ul>	<ul style="list-style-type: none"> <li>• Diagnose and treat illnesses and cases of injury with both Indigenous and non-Indigenous patients.</li> <li>• Identify and analyse issues in diagnosing/treating/preventing diseases/illness/injury in Indigenous patients.</li> <li>• Describe the concept of social and emotional well-being and demonstrate culturally safe diagnosis, treatment and prevention of 'lifestyle diseases', such as mental distress or substance misuse.</li> <li>• Identify and analyse community-wide approaches to prevention.</li> <li>• Demonstrate understanding of age-related morbidity differences and their impact on client care.</li> </ul>

Suggested Subject Areas	Relevant Overall Domain/Theme	Key Student Attributes and Outcomes
7. Communication Skills	<ul style="list-style-type: none"> <li>• DP/CS</li> <li>• D&amp;S</li> <li>• P&amp;PD</li> </ul>	<ul style="list-style-type: none"> <li>• Demonstrate effective and culturally safe communication with Indigenous patients.</li> <li>• Identify features of overt, subtle and structural racism or discrimination in interactions between patients and health professionals and systems, identify ways to address such occurrences, and acquire skills to advocate for their resolution.</li> <li>• Demonstrate skills in effective consultation and collaboration with AHWs, and other professionals and support resources.</li> </ul>
8. Working With Indigenous Peoples—Ethics, Protocols and Research	<ul style="list-style-type: none"> <li>• D&amp;S</li> <li>• P&amp;PD</li> <li>• DP/CS</li> </ul>	<ul style="list-style-type: none"> <li>• Analyse the concepts of community development, ownership, consultation, empowerment, capacity-building, reciprocity and respect, and explain their roles in health care delivery and working/researching with Indigenous individuals and communities.</li> <li>• Identify key principles in developing collaborative and ethical relationships with Indigenous peoples.</li> <li>• Identify key community contacts, mentors and support structures in the provision of effective health care.</li> <li>• Describe the role of partnership, ownership and ethics in developing appropriate research methodology.</li> </ul>

# Pedagogical Principles and Approach

There are ten key pedagogical principles that are most likely to contribute to successful curriculum design and delivery in the area of Indigenous health. The principles are listed here, along with strategies, examples and cautions for teaching and implementation approaches.

**Principle 1**     **Educating medical students about the health of Aboriginal and Torres Strait Islanders is unique among teachings about the health of other Australians, and we can teach medicine in a way that enhances students' understanding of Indigenous experiences and world-views.**

**Rationale**     Indigenous Australians are the original Australians, with unique experiences and beliefs around wellness and illness. Further, Indigenous Australians are marginalised on most social, economic and political indicators. Broader society and, therefore, many medical students are exposed to, and conditioned by, a range of particular views, stereotypes and values regarding Indigenous Australians and their health. Thus, effective learning in this area requires us to enable students to engage critically with the realities faced by Indigenous Australians, and challenge any stereotypes that may exist.

**Strategies**     Both our experience and recent research<sup>10</sup> shows the best strategies in this area are ones that facilitate positive learning experiences and interactions with Aboriginal and Torres Strait Islander Australians based on real-world contexts, including:

- teaching that enables experiential processes and interactions;
- strategies that address the emotional reactions of students in a respectful and culturally safe manner; and
- allowing the student to move beyond awareness to a more critical analysis and understanding of their role in facilitating change.

**Examples**     • Cultural-based camps or community visits where students can be immersed in the realities of everyday life for Indigenous Australians, particularly in relation to their health care.

• Talking circles or lectures/tutorials where Indigenous Elders or community representatives are empowered to share their experience with students, and the students are supported to ask questions in respectful ways.

**Cautions**     • The 'real Aborigines' do not all live in the northern part of Australia (in fact, 60 per cent of Indigenous Australians live in large towns and cities). Thus, one should be wary not to reinforce a stereotype by only teaching this component in rural health week, for example.

• Approach teaching from a strengths-base perspective, rather than potentially reinforcing negative stereotypes by approaching all teaching from a deficit model.

• Given that Indigenous Australians are not a homogenous group, it is important to offer a range of views and examples of Indigenous experience both in terms of geographical location (e.g., urban, rural, remote) and historical and cultural experience (e.g., extended family, stolen generation, strong cultural ties, lost language).

## Principle 2 Indigenous health is an integral part of medical education.

**Rationale** Aboriginal and Torres Strait Islanders are Australian citizens and, therefore, entitled to equality in health outcomes. Indigenous Australian concepts of wellness and illness have enriched medical practice and health care. For example, concepts of community control, holistic health and whole-of-government approaches have influenced the development of primary health care in Australia more broadly.<sup>11</sup>

Further, in this context, the term 'Indigenous health' refers both to discrete topics concerning Indigenous issues, and to Indigenous peoples' experiences in other areas of medicine and while interacting with the health system. Finally, Indigenous health presents some complex medical issues that may inform teaching in other areas of the curriculum—Indigenous staff may be key in helping to identify and contextualise such cases.

**Strategies** In our experience, it is important to provide a foundation for Indigenous health by teaching discrete, compulsory subjects/lectures/PBLs about Indigenous history, cultures, societies, experiences and interactions with health systems and policies. This can be effectively complemented with Indigenous examples and content appropriately placed throughout the curriculum.

- Examples**
- The University of Newcastle teaches compulsory foundation Indigenous health content with the aid of a CD-ROM package called *Healing... Our Way*, and then supplements that learning with Indigenous and non-Indigenous examples of medical conditions such as gastroenteritis.
  - The University of Queensland teaches both Indigenous and non-Indigenous end-stage renal dialysis PBL cases as a way of contextualising Indigenous health, rather than seeing it as a discrete or stigmatised entity separate from medicine.
  - Indigenous academic staff could be offered teaching and research places in other areas of the curriculum/medical school to reduce stereotyping and any misunderstanding that Indigenous health is separate from medical education in general.
  - Complex examples from Indigenous health may be used to inform other areas of the curriculum—for example, an Indigenous diabetes patient in a remote setting presenting with a cardiac arrest brings issues of isolation, culture and service delivery into focus—and potentially could also inform rural health and chronic disease (diabetes and cardio-vascular) teaching.

- Cautions**
- Indigenous people should be included in the design, delivery and evaluation of curriculum content. If non-Indigenous people teach Indigenous health, they should collaborate with Indigenous people and organisations to effectively supplement their teaching.
  - Content should be locally accurate, as well as broadly translatable to a national context where appropriate. Local Indigenous people can help advise on this, and there are large numbers of Indigenous people in Sydney, Brisbane and Perth, for example, to assist in this process.
  - It is important to develop content and cases that are typical, but not stereotypical. For example, if only one Indigenous-specific case study is used, it need not necessarily be the alcohol and drug case. If such cases are used, it is important to contextualise and balance such examples with both non-Indigenous examples of alcohol and drugs and atypical disease in Indigenous communities.

**Principle 3 Teaching from a positive strengths-based model, rather than a deficit model, is more likely to encourage effective learning environments and attitudes.**

**Rationale** Indigenous Australian identities, while changed irreparably as a result of colonisation, are not forged by the process of colonisation alone. That is, Indigenous Australians existed before colonisation in healthy, functional societies, and continue to exert many strengths, unique talents and survival skills. Identifying and focusing on solutions is more likely to engender a sense within students that the situation is not entirely hopeless, and that there are some strengths to be built upon, even if the health issues are complex.

**Strategies** It is important to encourage conceptualisation of Indigenous Australians as living in functional, healthy societies before colonisation occurred, as well as to focus on successful health interventions thus far. Doing so contributes to a debunking of the myth that Indigenous societies were 'primitive' or 'less developed' in any way, and contributes to a sense that practitioners—with the right knowledge, skills, supports and attitudes—can contribute to better Indigenous health outcomes in partnership with Indigenous peoples.

- Examples**
- Always look for the positive example of successful programs in Indigenous Australia. These include: Indigenous health promotion campaigns such as 'condom-man', which were ground-breaking for the whole of Australia; Indigenous acknowledgment of post-traumatic stress syndrome in stolen generation survivors that has helped prompt non-Indigenous peoples taken away from their English parents to come forward and tell their story; Indigenous youth comic 'Deadly Vibe' that has helped redefine the way health departments sell their messages to young people Australia-wide.
  - Not all success stories will be written up in academic journals or government reports, but may present in more community-focused ways. This could actually help challenge students to redefine what is meant by success, and on whose terms.
  - Working with community Elders and representatives will enable students to get a dynamic, real, living account of the survival, talents and solutions Indigenous people regularly draw upon.

- Cautions**
- Make sure there is some Indigenous assessment of what is successful before using it as an example; even programs deemed successful in peer-reviewed evaluation articles in journals might not be considered useful by Indigenous community members. Looking for articles, resources or examples which have also been assessed by Indigenous people will be key. For example, if unsure about some teaching materials, ask Indigenous health staff or community representatives for their views on its suitability.
  - If working with Indigenous Elders/community representatives, do so in ways that are culturally safe and respectful; do not expect endless regurgitation of their personal stories, but do follow protocols for mutual benefit. That is, work with Elders and community to see what is appropriate on a case-by case basis, rather than 'slotting them into' formulaic or repetitive teaching and lecture plans.

**Principle 4 Planning vertical and horizontal integration is important.**

**Rationale**

As with any other area of medicine, overall co-ordination and planning will be necessary to ensure the most optimal learning outcomes.

**Strategies**

We suggest that to include Indigenous health most effectively in core/compulsory medical curricula, a range of measures can be taken to ensure that design, co-ordination and the quality of teaching is optimised.

**Examples**

- Statements of intent regarding Indigenous health in overall school strategic plans, in curriculum map objectives and in student attributes and outcomes are critical. These may assist in co-ordination, give schools self-set milestones to assess development, and signal commitment.
- Indigenous health content can be vertically integrated such that a 'staircase' approach is taken, in which foundation or basic learning in the earlier years is built upon to produce more advanced skills like communication, putting community partnerships into operation, and managing diabetes in Indigenous peoples, for example.
- Where possible, Indigenous health content can be most successfully delivered by horizontally integrating such content into broader curriculum teaching at any given point. For example, schools might teach Indigenous epidemiological profiles around the same time that population health basics are taught more generally.
- Horizontal integration might be supplemented with approaches taken by GP, nursing and Aboriginal health worker training, which have developed units that can be adapted to the needs of a medical curriculum.
- Quality of delivery can be maximised by involving Indigenous staff and communities in curriculum design and on-going evaluation, using Indigenous staff and communities in delivery, encouraging non-Indigenous staff to undertake professional development activities, and looking nationally and internationally to share examples both of good practice and of teaching and learning resources.

**Cautions**

- Collapsing as much Indigenous health content into one day of rural week, for example, does not allow a 'stair-cased', gradual learning approach. Spreading out Indigenous health content over the curriculum contributes to more stable, sustained learning, and avoids the potential stigmatisation of Indigenous health as only a rural issue.
- Teaching Indigenous health only as part of rural health can also potentially marginalise urban Indigenous experience. A significant proportion of Indigenous people live in urban areas. While the two separate disciplines may at times be appropriately taught together, it is important to balance rural teaching with urban Aboriginal Medical Service (AMS) placements, for example.



## **Principle 5 Indigenous staff are key curriculum developers and enhancers.**

**Rationale** Indigenous staff members are not only professionals in their own right, but also carry a wealth of historical, social, cultural and community expertise. Utilising this expertise will enhance students' overall learning experience.

**Strategies** It will be important to ensure Indigenous academic and general staff have key input into decision making around Indigenous health curriculum design, delivery and evaluation. In addition, Indigenous non-academic staff and communities may still have input into the curriculum based on their broader expertise. Indigenous academic and general staff will require recognition, adequate support and professional development opportunities, given that they will often carry multiple obligations beyond a regular staff role.

- Examples**
- Indigenous people (ideally academic staff) should have some senior decision-making capacity about the design, delivery and evaluation of Indigenous health content.
  - Input of this nature should be supplemented by specific Indigenous curriculum committees and/or community partnership groups.
  - Indigenous people (academic and general staff and community members) could be encouraged to teach in other areas of the curriculum based on their professional interests and capabilities.
  - Indigenous community input can be encouraged through campus-wide Indigenous education centres, or by establishing and utilising community partnership groups.
  - The medical school could run a seminar for Indigenous non-academic staff and community members to share ideas about medical education and curriculum development in general. Such a basic information-sharing exercise could build their capacity to contribute in meaningful ways.
  - Where non-Indigenous staff have no or limited expertise in Indigenous health, they should invite Indigenous staff to co-teach, thus ensuring cultural dimensions are covered, along with the specific medical case in question (e.g., teaching a PBL/case on burns for an Indigenous patient).

- Cautions**
- Indigenous people can be empowered to facilitate or lead this process, but they should not carry the whole weight of implementation; curriculum committees and the whole school will need to demonstrate support and commitment to the process.
  - While it is acknowledged that Indigenous academic staff are currently few in number, other Indigenous staff or community members can contribute cultural, sociological or community development expertise.
  - Indigenous non-academic staff should not be expected to go beyond their area of expertise or be 'thrown in at the deep end', but rather be invited to contribute where comfortable.
  - Curriculum development and Indigenous student support are two separate roles, and one Indigenous staff member should not be unrealistically burdened or expected to perform both roles. It will be important to build the capacity of the school to deliver both separate, but related, functions.
  - Student support for non-Indigenous students experiencing Indigenous health for the first time is a whole other area, and Indigenous staff alone should not be expected to perform this function. It may be necessary to ensure that non-Indigenous student support staff are trained in Indigenous health so that they are able provide support to non-Indigenous students.

**Principle 6** The attitudes of all teaching, clinical and administrative staff counts towards effective learning.

**Rationale** Role-modelling of positive attitudes and well-informed teaching in any learning environment is a powerful dynamic, particularly when student doctors place so much emphasis on teacher-clinicians as mentors.

**Strategies** Medical schools should ensure that staff who design, deliver, evaluate and administer curriculum are both confident and aware of some of the basic information they are dealing with, and passionate about improving Indigenous health outcomes. This may be planned as a school-wide endeavour, which will help to create a positive and respectful culture.

- Examples**
- It may be opportune to require all teaching staff in the first instance, and then all general staff, to attend a one-day seminar on Indigenous issues (preceded by preparatory reading and followed by a series of professional seminars and/or value-adding exercises). The program will be most successful if designed, delivered and evaluated in conjunction with Indigenous staff and community members.
  - Any professional development activities taken in this area, such as that listed above, may be rewarded with Continuing Medical Education points, for example.
  - Staff could be acknowledged for any particular expertise they develop in Indigenous health in conjunction with Indigenous communities.
  - Senior clinical teaching staff could be co-opted to such professional development by negotiating with hospital management on time and resources to allow their participation. Schools may consider offering teaching hospitals in-kind incentives in other areas.
  - Specific partnerships between medical schools, Aboriginal Medical Services and teaching hospitals may allow a powerful avenue/forum for support, advocacy and improved service delivery.

- Cautions**
- While it may be strategic to engage Indigenous staff to teach Indigenous health, this should not take precedence over the fostering of positive attitudes and learning for *all* staff about Indigenous health.
  - It cannot be presumed that one day, or even a semester, of seminars will equip staff with all the necessary knowledge, tools and confidence to deliver curriculum as effectively as possible. The focus, therefore, should be on opening up dialogue, facilitating on-going professional development and partnerships and encouraging peoples' commitment and passion to improving Indigenous health outcomes.
  - Schools may wish to set up processes which can adequately deal with any grievances or issues that adversely impact on the teaching of Indigenous health; for example, a process where particular grievances are heard by a committee of Indigenous and non-Indigenous staff and community representatives. If committee members feel the situation warrants particular attention or has broader implications for teaching in the school, they can be empowered to make recommendations to the Dean for resolution.

**Principle 7** In order to facilitate the most effective learning possible, partnerships with local Indigenous individuals, organisations, and communities will need to be developed.

**Rationale** Grounding Indigenous health in local contexts will enable the school to improve the quality of learning, facilitate specific strategies like community placements, and demonstrate its commitment to Indigenous health in real-world settings. Well-managed partnerships of this nature are likely to enrich learning.

**Strategies** Indigenous academic and support staff within the medical school (or university, in their absence) will be best placed to start making links with community groups. Such partnerships should be co-ordinated by one staff member charged with the responsibility to liaise and manage the relationship. Be mindful that partnerships of this nature will require time and resources to establish and maintain, and that staff and/or community representatives should be resourced adequately to undertake these functions.

- Examples**
- Establish links and develop a partnership with the local AMS or other organisation to facilitate collaboration, e.g., community placements.
  - Invite community representatives to be partners in forming an Indigenous reference committee, which may inform and assist in making decisions about curriculum design, delivery and evaluation.
  - Establish links with local traditional owners and formally recognise them in medical school functions, literature and lectures.
  - At the University of Melbourne, a lecture is given to medical students by an Elder/senior community representative, while several Indigenous community members from the Koorie Heritage Trust lead tutorial discussions in conjunction with regular university tutors. The lecturers and tutors all meet beforehand to discuss their strategies and to ensure cultural safety.

- Cautions**
- Many AMSs are happy to accommodate requests for partnership and community placements, yet schools should remain mindful that they need to compensate AMSs for the time and resources such placements require, as they would any general practice, for example.
  - It is critical that Indigenous Australians are both empowered and have some ownership and cultural safety in this process.
  - Partnerships of this nature may take more time than expected to develop. Trust and honesty of approach are important here, and Indigenous staff may be best to help initiate, broker and develop such relationships.
  - Given the nature of Indigenous community relations, it is imperative that the school be guided by Indigenous staff in cases where there are disagreements between community factions.



**Principle 8** It is important to teach Indigenous cultural safety/awareness separately to multicultural awareness.

**Rationale** Indigenous Australians are the First Australians, have unique experiences and cultures, and poor health outcomes. The Indigenous experience is quite distinct from the migrant experience, with different implications for health and well-being. Merging education about the health of Indigenous Australians with that of new Australians disrespects the former's place in Australia.

**Strategies** Awareness about Indigenous cultures and experiences can be taught most successfully by ensuring that:

- culture is taught in a reflexive way, in which *all* students get to identify and question their own cultural values and beliefs;
- Indigenous cultural safety/awareness is taught separately to multicultural awareness (given the specific issues Indigenous Australian health disparities encompass and the place of Aboriginal and Torres Strait Islanders as the First Australians); and
- *international* Indigenous experiences/examples are given, so that international students can reflect on Indigenous experiences in their own countries.

**Examples**

- Teaching personnel should be encouraged to start with cultural reflexivity and reflectiveness before moving into learning about 'the other'.
- Schools may wish to deliver specific Indigenous cultural safety/awareness on an on-going basis, while also including Indigenous components in any general units regarding culture and health in general.
- Local Indigenous staff and communities can be invited to have input into this part of the curriculum as guest lecturers, adjunct lecturers or cultural advisors on a casual or on-going basis.

**Cautions**

- It is important to allow Indigenous staff/communities/peoples to design and deliver this part of the curriculum with school support and in conjunction with school capacities and realities.
- Care should be taken to invite a range of Indigenous experiences to be portrayed, rather than concentrating on potentially romantic or stereotypical views of Indigenous cultures.
- Content in this area is always most effectively delivered if there are reflexive and non-voyeuristic techniques used (i.e., 'learning about self through the medium of the other' as opposed to 'learning about the other and not one's self').

**Principle 9** **Students can be important curriculum enhancers if effectively supported and encouraged, but they should not be expected or relied upon to perform this function.**

**Rationale** Peer learning, support and role-modelling will take on extra value in this context given the back-log of inappropriate information generally in the public domain regarding Aboriginal and Torres Strait Islander Peoples and their health.

**Strategies** While many students will initially question the relevance of Indigenous health to 'real medicine', schools may continue to encourage their support for Indigenous health, as it can be an enhancing phenomenon for the design and delivery of Indigenous health content.

- Examples**
- Where possible, two Indigenous students should be co-scheduled to take the same PBLs/cases at the same times. This is more likely to facilitate effective learning for them by virtue of enhancing their cultural safety, and increasing their potential ability to contribute to peer education and curriculum enhancement.
  - Encouraging students to research and design effective new interventions and treatments may decrease the negative sense that 'there's nothing we can do about the bad situation'. It is vital, however, that they have first understood and demonstrated respect for, and use, of protocols and consultations.
  - Monash University rural health student club organises a prestigious and successful annual lecture in memory of a deceased non-Indigenous student who was a passionate advocate for Indigenous health care improvement.
  - Where racism or discrimination may exist in the student body, or indeed the staff, it is important to name and identify it, encourage discussion, and make sure it is dealt with in a respectful and safe environment. This can be done in ways that empower victims, educate perpetrators and contribute to a sense of shared co-operation, resolution and learning.

- Cautions**
- Encouraging student initiative and creativity will require experienced staff guidance and supervision to ensure cultural safety and respect.
  - Indigenous students should not be expected to be experts on everything Indigenous, and are not likely to co-operate if publicly asked to produce sensitive information. More successful strategies might be to encourage their participation if they feel comfortable, but not to expect it.
  - In instances of racism and discrimination, it is our experience that if such instances are 'swept under the carpet', or alternatively 'blown out of proportion', then learning environments can be seriously compromised. A recognised strategy of dealing with such instances may assist in the process of shared learning and growth.



**Principle 10** Multi-disciplinary collaboration is likely to enhance learning outcomes.

**Rationale** There are regular audits and curriculum development initiatives in Indigenous health across a range of health sciences. It may be timely to link these developments and share with other disciplines, thereby saving resources and enhancing student understandings of the topics and cases at hand. Multi-disciplinary learning also obviously contributes to a more rounded practitioner and, in the case of Indigenous health, may contribute to the development of more holistic thinking and practice.

**Strategies** Literature reviews and curriculum development should take into account developments in other disciplines as a way of utilising the best available resources, thereby saving on the resources required to 'reinvent the wheel' every time.

- Examples**
- Case studies/PBLs/scenarios may draw upon and assess students' ability to communicate and collaborate with Aboriginal Health Workers and/or community representatives.
  - Indigenous week, or rural week, activities may see students go on rounds with community mental health nurses or social workers to gain a clearer understanding of psychosocial and psychosomatic health issues.
  - Students might be required to discreetly observe Indigenous patient–health professional interaction (perhaps with the hospital's Aboriginal Liaison Officer) in an accident and emergency ward, and note any differences or similarities in communication approaches to non-Indigenous patients.
  - The University of Newcastle teaches a core Aboriginal health subject to all health sciences students (covering societies, cultures, history), followed up by advanced discipline-specific cases/modules/subjects.

- Cautions**
- Obviously, developments and resources in other areas will need to be tailored or adapted to suit the specific requirements of teaching medicine.
  - Always encourage inter-disciplinary collaboration, rather than competition, especially given the often scant resources in contexts delivering health services to Indigenous patients.
  - Working with Indigenous health professionals and community members will require a whole period of relationship development, trust building and ownership in the process of specific module or broad curriculum design. Indigenous staff should be asked to assist in introductions and the following of protocols and cultural safety requirements.
  - Make sure teaching and learning resources are locally appropriate.
  - Be realistic about the time and resource constraints of guest tutors and lecturers and be prepared to compensate them for their contributions.

# Delivery and Assessment

In this section, recommendations are made about the delivery and assessment of curriculum across the suggested subject areas. These recommendations serve as guides only, and it will be up to each school to decide on the delivery format and assessment tools suited to their particular situation.

Subject Areas	Examples of Suitable Delivery Formats	Examples of Suitable Assessment Tools
1. History 4. Population Health 5. Models of Health Service Delivery	Lectures, tutorials, case studies, self-guided workbooks or multi-media tools	Assignments, exams, reading reviews.
2. Culture, Self and Diversity 3. Indigenous Societies, Cultures and Medicines 8. Working with Indigenous Peoples—Ethics, Protocols and Research	Introductory lectures and tutorials about protocol and respect, guest lectures, talking circles/reflective discussion, experiential learning (camps, field visits, community visits), case studies.	Assignments, exam questions, reflective journals, peer review, class dialogue participation and engagement, Elder assessment of willingness to learn, and ability to be open-minded and to accept limitations of one's own knowledge.
6. Clinical Presentation of Disease	PBLs/cases/scenarios, placements, community visits, simulated patient training.	Assignments, case studies, journals, skill exams, etc.
7. Communication Skills	Introductory lectures, interactional skills development, community visits, hospital or community clinical placements, simulated patient training.	Simulated testing stations, observed interactional skills.

# Suggested Process for Curriculum Development

The ultimate goal of this project is to ensure that Indigenous health is embedded as a sustainable, continuing and living part of every Australian medical school's curriculum. This means that this curriculum framework will require a broader commitment and process for its implementation than relying exclusively on the individual efforts of any particular staff member/s, student/s or community group/s.

To this end, encouragement is given to whole-of-school partnerships for implementing these guidelines, and to a gradual approach to growth and clarity of Indigenous health within the medical curriculum. While the process of embedding curriculum development in this area may take years, the establishment and/or continuation of developmental processes is strongly encouraged. It is acknowledged that each school may be at a different stage of curriculum development, and the following recommendations may prove useful for the growth or consolidation of Indigenous health in individual curricula.

## Whole-of-School Partnerships

### 1. *Encourage ownership and participation*

- Engage Indigenous staff and community members in the developmental process, encouraging their ownership and participation. If the school has no Indigenous staff members, invite staff in the campus Indigenous education centres to participate and identify other suitable Indigenous professionals and community representatives.
- Engage non-Indigenous staff across the school to work in collaboration with Indigenous colleagues, so that not only Indigenous people bear the responsibility for implementation, and so that they also feel ownership for the process.
- Encourage input and ownership from enthusiastic students and organisations.

### 2. *Embed the commitment and goals of the school in this area in strategic documents, curriculum maps and student outcome and attributes statements*

- Embedding growth and development in formal documentation and strategy will assist in co-ordination, focus and ensuring that the teaching of Indigenous health does not rely on individual champions.
- Including Indigenous health in student attributes and outcome statements will assist in maintaining the focus on Indigenous health, and help measure development for quality assurance and accreditation purposes.
- A school-wide planning workshop may assist in building support and strategically co-ordinating curriculum development.



## Developmental Processes over Time

### 3. Trial and review initiatives

- Review what has been tried before and trial new initiatives in PBL/case/scenario design, or in a staff development workshop, for example.
- Bring diverse groups together for curriculum development: a meeting of medical educators, senior clinicians, Indigenous health specialists, Indigenous community representatives and administrators may produce a number of different, sometimes competing, perspectives. This process of collaboration is exactly what may be required for schools and communities to own and to participate fully in developing successful and effective curricula.
- Work with other medical schools to share resources and learn about what has worked.

### 4. Celebrate Indigenous health as a part of regular curriculum

- Initiatives such as regular staff and student seminar series, an Indigenous health week or contributing to campus-wide NAIDOC Week activities may send positive messages that Indigenous health is an important and regular part of curriculum.
- Invite Indigenous community members to teach and participate in school activities. Indigenous staff can ensure cultural safety and protocols are followed for these activities and invitations.

### 5. Identify processes and methods for evaluation

- Community partnership groups and staff involved in designing and delivering Indigenous health can assist in developing evaluation tools and methodologies. It will be critical to ensure that Indigenous staff and community representatives, as well as non-Indigenous staff, have ownership and input into this stage, as with every other part of the process.
- Suggested evaluation tools include qualitative feedback from staff, students and community members, and participation statistics for subjects, camps and seminars.

### 6. Encourage vertical integration beyond core medical education

- When designing curriculum, bear in mind the need for vertical integration with Masters level and vocational training, and concentrate on establishing a solid platform in core training which can be built on later.
- Consider specialised certificates or streams in Indigenous health beyond the minimal suggested content and approach listed here. That is, schools may want to consider offering advanced studies for those students wishing to follow Indigenous health as a specialty within undergraduate and/or postgraduate medicine. For example, the University of Washington in Seattle, USA, offers a certificate in Indian health which specialising students have accredited as part of their studies (beyond basic training in Indigenous health that all students receive).

# Resources, Capacity and Workforce Development Issues

In this section, we outline the resources most likely to contribute to maximum success in this area, as well as suggestions for utilising available capacity and resources most effectively.

Area	Suggested Resources	Utilising Alternatives
Human Resources	<ul style="list-style-type: none"> <li>• Indigenous staff across the school, including dedicated roles in three separate areas: academia, Indigenous student support and retention, and administration.</li> <li>• Non-Indigenous academics trained in cultural awareness and/or co-teaching with Indigenous staff.</li> <li>• Indigenous external professionals and community members as guest/adjunct lecturers.</li> <li>• Train general student support staff in Indigenous health to work with non-Indigenous students, rather than expecting the Indigenous student officer to deal with all students' issues about Indigenous health.</li> </ul>	<ul style="list-style-type: none"> <li>• Utilise available Indigenous staff and non-Indigenous staff with experience in the area to co-ordinate staff training and community input into curriculum development.</li> <li>• Utilise the skills of external Indigenous academics on a casual basis.</li> <li>• Partner with Indigenous education centres and communities.</li> <li>• Invite external guest lecturers with experience in Indigenous health to contribute to teaching, e.g., The Royal Australian College of General Practitioners (RACGP) has an accredited Indigenous health module.</li> </ul>
Operations & Management	<ul style="list-style-type: none"> <li>• Establish an Indigenous health unit within the medical school, rather than relying only on Indigenous education centres. These Indigenous health units should be strategically placed such that they work across the school, rather than in any one department alone.</li> <li>• Ensure funding is sustainable and on-going, not project/<i>ad hoc</i> funding, and that it increases over time in line with growing workloads and curriculum development.</li> <li>• Develop clear guidelines between the Indigenous education centre and the Indigenous health unit on Indigenous medical student recruitment/retention.</li> </ul>	<ul style="list-style-type: none"> <li>• Utilise the Indigenous centre on campus for curriculum development and Indigenous student support (with clear guidelines).</li> <li>• Develop a sustainable funding model with Commonwealth and State governments and other potential funding partners where responsibility is shared.</li> </ul>
Curriculum Materials	<ul style="list-style-type: none"> <li>• Develop materials with local relevance and, if possible, national applicability.</li> <li>• Develop, implement and review materials in partnership with local Indigenous groups.</li> <li>• Design curriculum with vertical integration in mind.</li> </ul>	<ul style="list-style-type: none"> <li>• Consider sharing resources, or adapting resources developed in other schools.</li> <li>• Utilise Indigenous education centres or partnership groups as first point of reference for sourcing materials and assessing applicability.</li> </ul>



Area	Suggested Resources	Utilising Alternatives
Curriculum Support	<ul style="list-style-type: none"> <li>• Community partnerships group supported with incidental travel and catering expenses.</li> <li>• Consider how much and what should be given back to the Indigenous community financially in return for student placements.</li> <li>• On-going relationships with Indigenous community groups and traditional owners.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop ways of sharing in-kind medical school resources or expertise with community groups.</li> <li>• Work collaboratively with other medical schools to develop and share flexible, yet applicable, curriculum materials and strategies.</li> </ul>
Teaching & Learning Resources	<ul style="list-style-type: none"> <li>• Develop resources that are locally appropriate, yet broadly relatable. For example, for a medical school in Sydney, it may be appropriate to give an example of gastroenteritis in an Indigenous infant in Redfern, and discuss the particular social situations impacting on treatment. Give the example, and then draw out principles of cultural and social context for other locations, such as if the infant came from Wilcannia or Parramatta. Care should be taken to understand the differences and similarities between urban, rural and remote Indigenous communities, and not to over-represent one area or group of Indigenous people in the curriculum.</li> <li>• Compile a 'bank' of references and teaching materials, and make it available to all staff and faculty members, thereby encouraging interdisciplinary learning, and saving on costs. The Indigenous Theme Bank at the University of Tasmania is an excellent example of sharing resources across disciplines within a medical school. Local Indigenous groups can be included in developing and assessing the suitability of content and design.</li> </ul>	<ul style="list-style-type: none"> <li>• Share resources and initiatives across medical schools; e.g., developing a national staff development package may save dollars and assist in building a critical mass of medical educators, Indigenous health specialists, students and Indigenous community members.</li> <li>• PBLs/cases can be shared, along with formal and informal evaluations of their impact. Material would need to be adapted to local cultural and social realities, as well as a particular curriculum structure, philosophy and strategy.</li> <li>• The RACGP and others have developed a long list of resources for teaching Aboriginal health that may also be useful for undergraduate teaching.</li> </ul>

# Acknowledgments

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# Endnotes

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