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OFFICE FOR ABORIGINAL & TORRES STRAIT ISLANDER HEALTH

CDAMS Indigenous Health Curriculum Development Project

National Audit & Consultations Report

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Committee of Deans of Australian Medical Schools

VicHealth Koori Health Research & Community Development Unit

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EXECUTIVE SUMMARY

The Committee of Deans of Australian Medical Schools (CDAMS) Indigenous Health Curriculum Development Project aims to produce a nationally agreed curriculum framework for the inclusion of Indigenous health in core medical curricula.

This project is a culmination of the efforts and experiences of many individuals and groups concerned with training a competent medical professional workforce. The intention is for the curriculum framework to help ensure that doctors have the necessary knowledge, skills and attitudes required for quality Indigenous health care, access and delivery.

This report documents existing Indigenous health curriculum content in Australian medical schools, and also discusses the key contextual issues and implications in delivering quality Indigenous health content.

The report has been written as background reading to inform the national curriculum workshop where the key components and issues implicit in a curriculum framework will be raised and discussed

The audit and consultations process has highlighted a number of issues that will need to be considered in the development of a curriculum framework, including:

- The principles, attitudes and conceptual understandings underpinning our approach.
- Definition, interpretation and pedagogical approach to Indigenous health.
- Structural and organisational arrangements required to support Indigenous health curriculum content development and delivery, including partnerships.
- Resource and teaching capacity issues.
- What makes good practice and how might we share and learn from it.
- The processes and commitment principles that are most likely to produce success.

This report represents the first exciting step in developing a curriculum framework that medical schools will find useful, realistic and achievable.

A. BACKGROUND

1. Overview of the Project

The Committee of Deans of Australian Medical Schools, the Office of Aboriginal and Torres Strait Islander Health (OATSIH) within the Commonwealth Department of Health and Ageing, and the University of Melbourne, through the VicHealth Koori Health Research and Community Development Unit have partnered to develop the CDAMS Indigenous Health Curriculum Development Project.

The project was established in response to recommendations by the Commonwealth's national 'Strategic Framework for the Inclusion of Indigenous Health in Core Medical Curricula and Recruitment, Retention and Support Strategies for Indigenous Australians In Medical Education'. While it is clear that Indigenous health curriculum development and Indigenous student recruitment and retention are intimately related, this project is concerned with curriculum development issues only. CDAMS has made a strategic decision to ensure that Indigenous health is included in core medical education for all medical students as a high priority.

The project aims to develop a nationally agreed curriculum framework for the inclusion of Indigenous health in core medical curricula. This aim is supported with four main objectives:

a. **audit and consult** with medical schools and other consultative groups regarding current Indigenous health content and contextual issues;

b. develop a **nationally agreed curriculum framework,** which is flexible enough to allow for the particularities of each school's curriculum approach and experience, while setting out guidelines for curriculum development that are most likely to produce success in the field;

c. develop a national **network** of medical educators and Indigenous health specialists to assist and support each other in implementation of the curriculum after the life of this project; and

d. seek **endorsement** for the curriculum framework from the full Committee of CDAMS and the Australian Medical Council for use in their **accreditation** processes.

Responsibility for implementing the curriculum framework rests with the individual medical schools throughout Australia. It is hoped the outcomes of this project, particularly the proposed network, will continue to support this process long after project completion.

It is envisaged that, in the future, CDAMS may work in partnership with the Australian Indigenous Doctors Association (AIDA) and OATSIH, to develop Indigenous student recruitment and retention strategies.

This report sets out the results of the audit and consultation process, provides a national picture of the current curriculum content and describes contextual issues that may arise in including Indigenous health in all twelve Australian medical schools. It has been written partly to inform the national curriculum development workshop, which is charged with drafting the national curriculum framework.

2. History of Developments in the Field

It is important to acknowledge that this project is due in large part to the hard work and dedication of many key individuals and organisations over the past ten to twenty years. These visionary individuals and agencies have strategised for the inclusion of Indigenous health in core medical curricula in a number of ways on many different occasions. The following represent some of these strategies:

- Early 1980s: The University of New South Wales attempts to encourage Indigenous students to study medicine, but with limited success.
- 1980s: Professor Rob Sansom-Fisher, Professor John Hamilton and others from Newcastle University work with Aboriginal community groups and health organisations to establish a specific program to recruit and support Indigenous students. This also includes introducing components of Indigenous health into the medical curricula. These initiatives were developed in partnerships with local Indigenous individuals, organisations and communities.
- Late 1980s: Submission from Ian Anderson and others recommends to a national inquiry into medical workforce issues that Indigenous health issues be included; this is the first time such issues are raised in the public arena.
- 1989: The National Aboriginal Health Strategy (NAHS) Working Party is instituted. In writing its visionary strategy, the NAHS working party makes a formal recommendation that Indigenous perspectives be included in health professional training.[1]
- Late 1980s and 1990 onwards: The first cohort of Indigenous medical students graduate and make seismic change in the way Indigenous peoples' professional abilities and roles are viewed.
- 1991 and onwards: many key reports such as the Royal Commission Into Aboriginal Deaths in Custody highlight the importance of the inclusion of Indigenous health in health professional training.[2]
- 1990s: More medical schools begin to make partnerships with Indigenous communities and employ pioneering Indigenous academic and support staff.
- 1997: Inaugural Aboriginal and Torres Strait Islander Graduate and Undergraduate Medical Conference (Salamander Bay) held.
- 1997 (July): Indigenous Medical Conference (Phase 2—Salamander Bay) held. Participants included Indigenous medical students and graduates, medical school staff and key stakeholders. Recommendations include the benefits of including Aboriginal health in medical curricula and the importance of active recruitment and support programs for Indigenous students.
- 1997 (August): Committee of Australasian Medical Deans Meeting (Perth) meets and Aboriginal and Torres Strait Islander medical students and academics invited to present recommendations to the meeting (see Appendix A). The Deans endorse the eight recommendations presented.
- 1998 (January): The report of the mid-term review of the General Practice Rural Incentives Program's rural undergraduate component actually states that medical schools should examine closely what they are currently doing with regard to Indigenous health curriculum. It also suggests the need to hold a national workshop on this topic (8.2.2.3).[3]
- 1998: The Australian Indigenous Doctors Association (AIDA) is formed and immediately plays a key role in drawing issues and strategies together.
- Mid to late 1990s: Key non-Indigenous academics begin advocating for changes to the medical curricula.
- 1998: The Yunggorendi Centre at Flinders University is funded by the Council for Aboriginal Reconciliation to produce an educational resource for Indigenous health in medical curricula•

- 1999/2000: The first national audit of Indigenous health curriculum in Australian medical schools is funded by the Rural Undergraduate Scholarship Scheme (RUSC) and undertaken by Dr Ngiare Brown and Ms Gail Garvey.
- Late 1999: CDAMS and others initiate a working group chaired by Associate Professor Ian Anderson to develop a strategic framework.
- 2000 (September): Integrated Indigenous Health in Core Medical Curriculum Workshop (Melbourne) held. Participants includes medical school staff, key stakeholders groups, OATSIH and others.
- 2000–01: CDAMS co-ordinates a series of meetings to draft the *Strategic Framework for the Inclusion of Indigenous Health in Core Medical Curricula and Recruitment, Retention and Support Strategies for Indigenous Australians in Medical Education.*
- 2003 (March): On behalf of CDAMS, the University of Melbourne signs a funding agreement with OATSIH, and this project commences.

Obviously, there are many individuals not explicitly named here whose contributions and dedication are critical. However, this project acknowledges and pays tribute to all those key individuals, organisations and agencies that have contributed such long hours and hard work to shaping developments in this field.

This history gives us a sense that we are part of something much bigger than any one individual or group. The CDAMS Indigenous Health Steering Committee considers it a privilege to carry on this work, and invites you to join us in ensuring that Aboriginal and Torres Strait Islander Peoples can enjoy adequate access to the best health professionals and health care possible.

3. Scope of this Report

This report is set out as follows:

- results of the audit of existing Indigenous health content—presented as tables based on each medical school's experience;
- results of the consultation visits to medical schools, including contextual issues in developing, delivering and evaluating Indigenous health content in medical curricula—presented as a summary that picks up on key components of the national experience;
- comments and contributions from other consultative groups;
- discussion of comparative data from international experience in this field; and
- discussion of the key questions, issues and implications for development.

The data has been presented and analysis given to inform the national curriculum development workshop.

4. Methodology

The audit and consultations process was conducted as follows:

1. Convenor of the steering committee (at the time, Professor Richard Larkins) wrote to all other deans informing them of the project and its intentions, and requested their co-operation with the project co-ordinator and audit and consultations process.

2. Audit and consultation tools were developed in conjunction with the steering committee (interview guides included as Appendix B).

3. Executive officers/faculty managers of each medical school were contacted by telephone, and meetings were arranged with the following people in each school:

    - the dean or equivalent;
    - senior staff members in medical education and curriculum development;
    - senior staff members in Indigenous health;
    - other staff members where appropriate; and
    - in some cases, groups of Indigenous and non-Indigenous students.

4. The project co-ordinator visited each medical school and conducted face-to-face, semi-structured interviews with the above participants (n = 33 individual and 6 group interviews). Two interviews were conducted by telephone. Participants were asked questions regarding:

    - principles and attitudes towards Indigenous health;
    - Indigenous health content in existing and new curriculum;
    - structural and organisational arrangements which supported this content;
    - teaching resources and infrastructure;
    - examples of good practice; and
    - broader environmental factors affecting this project as a whole.

5. The audit proforma was left with a key member of staff who was asked to complete and return the form.

6. Tables from a similar audit done in 1999 by Associate Professor Gail Garvey and Dr Ngiare Brown (sample included as Appendix C) were supplied to individual universities as a basis for them to complete the proforma with current details.

7. Interview notes were put into one-page summaries, and fed back to individual medical schools for their own confidential use, as well as accuracy checks and comment

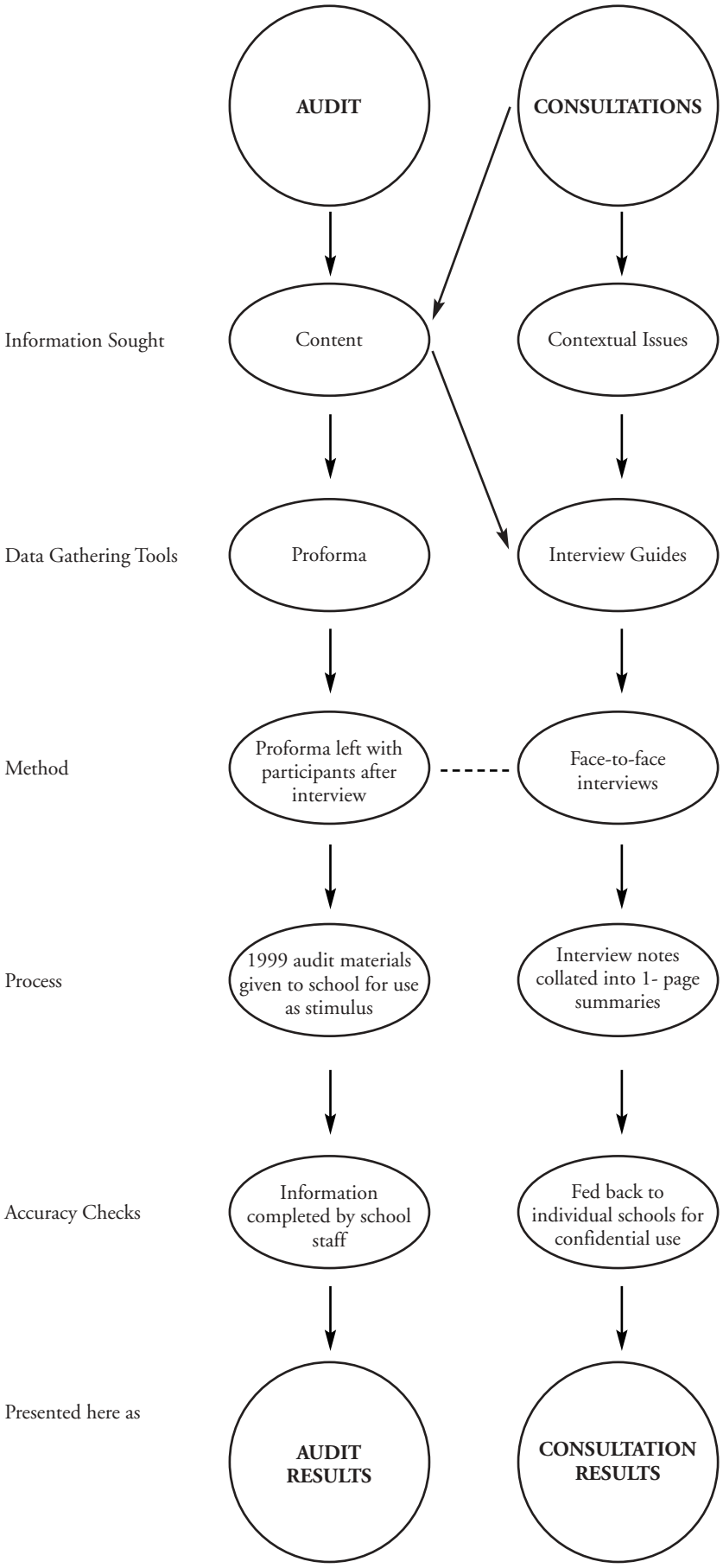
8. Medical schools were contacted by email and telephone both to remind them and obtain their completed audit proforma.

9. Materials were collated and organised as follows:

    - Completed proforma presented here as 'audit results' (Section B). This material covers Indigenous health content.
    - Interview notes and one-page summaries presented here as 'consultation results' (Section C). This material covers contextual and principle issues in developing and delivering Indigenous health curriculum content.

In addition, other consultative groups' comments and contributions have been presented in Section D as 'external contributions'.

Figure 1: Methodology Flowchart



B. AUDIT RESULTS: Indigenous Health Content in Existing Medical Curricula

5. Audit Results

The results are presented here as they were returned by staff from each of the following medical schools:

- Australian National University
- Flinders University
- James Cook University
- Monash University
- The University of Adelaide
- The University of Melbourne
- The University of Newcastle
- The University of New South Wales
- The University of Queensland
- The University of Sydney
- The University of Tasmania
- The University of Western Australia

Tables listing the Indigenous health content of each school's curricula can be found in Section F.

The information contained in the audit tables is current as of August 2003.

C. CONSULTATIONS: Contextual Issues in Developing Indigenous Health

6. Consultations Methodology

Thirty-three semi-structured interviews and six group interviews were conducted with deans, staff and students in medical schools. The broad object of these interviews was to draw out the contextual issues arising from the inclusion of Indigenous health into existing medical curricula. The project steering committee decided that this process would:

a) provide a chance to explain in person the objectives of the project, thereby encouraging general participation in it;

b) allay any concerns that individuals may have in regard to the objectives or process of the project;

c) assist in gaining an observed and related understanding of the realities and operational issues implicit in developing and delivering Indigenous health content, rather than merely a basic audit of content; and

d) assist in participant compliance with returning the audit proforma, particularly given the multitude of disciplines within medical education seeking to do the same.

A letter sent to all deans by the convenor of the steering committee assisted both in conveying the high regard in which the project was held, and in gaining their co-operation. All of the above strategies were important in ensuring this project did not become 'just another questionnaire'.

7. Consultations Results

The results of the interviews are presented here as a national summary.

Principles and Attitudes

- All medical schools displayed a general commitment towards the principles of Indigenous health, though the level of commitment and awareness of issues regarding Indigenous peoples in general and Indigenous health in particular varied greatly.
- Attitudes towards Indigenous health ranged from 'all doctors must have a core understanding of Indigenous health', to 'we're interested in positive solutions, not negative history'.
- Some medical school staff felt that 'many of our graduates will work in metropolitan areas, and therefore will not work with many Indigenous people'.
- While some schools enjoyed the advantage of university-wide policies for Indigenous education strategies and documents of reconciliation, for example, others did not have such strategies or were not aware if they existed.
- Some schools had strong stated principles, policies, strategies or curriculum maps for Indigenous health, but found it challenging to operationalise such strategies. Thus, it was often left to individuals to co-ordinate, decide or direct such developments, rather than being co-ordinated as a curriculum-wide priority.

- Some schools encouraged an Indigenous presence and profile from day one of teaching, including Indigenous traditional welcomes and partnerships with local communities.

Indigenous Health Content

Overview and Co-ordination

- The amount of Indigenous health content varied greatly across schools—from integrating it into all aspects and disciplines of the medical curriculum, to a one-hour lecture and minimal supplementary teaching over a six-year course.
- Some schools developed Indigenous health strategic plans, curriculum maps and domains/disciplines; others did not. Some schools were in the process of co-ordinating/refining/reviewing their Indigenous content, making them achievable and/or actually operationalising them.
- Co-ordination and continuity of content across the curriculum is an issue. For example, as schools developed more content and capacity to teach, it became necessary to ensure students did not receive merely different variations of cross-cultural awareness every time Indigenous health came up in the curriculum. In these cases, the goal was to start with 'the basics' and gradually build up to more advanced concepts.
- The quality of Indigenous health curriculum and teaching was seen as an issue of critical importance, and one that needed to be recognised and developed as content was written. Suggestions of benchmarking the quality of content and teaching was made by some staff.
- In most schools, the majority of Indigenous health content was included in non-compulsory or non-core training, or as a minor component of a core module (for example, one day of rural health week).
- Most schools reported that it was necessary to develop curriculum in this area in an organic, measured way, rather than implementing content without the necessary attitudinal shifts required to support such change.

Pedagogical Approach

- Most schools indicated a desire to integrate Indigenous health into other disciplines (for example, a PBL/scenario about renal disease that happens to have an Indigenous client), which is indicated as Approach A below. Some schools teach Indigenous health as a discrete subject area/discipline (Approach B). A limited number of schools teach Indigenous health both in an integrated and discrete fashion (Approach C).

Figure 2: Models of Including Indigenous Health in Medical Curricula

- Core Indigenous health training may include components in Indigenous history, culture, society and communications.

- Experiential learning and sharing with Indigenous people rated highly, both anecdotally and in student feedback evaluations. It has been cautioned though that:
  - staff and tutors must be prepared for this experiential interaction;
  - the interaction is contextualised and supported with prior basic historical, social and cultural education; and
  - key bridging personnel (usually an Indigenous academic/staff member) assist in translation between medical schools and Indigenous communities.
- Most schools were aware of the need to include content that was 'typical, not stereotypical'. All expressed some difficulty in finding the philosophical balance required between viewpoints while planning their curriculum, yet some also reported this process could be highly rewarding and enriching.

Placement and Timing of Indigenous Health Content

- Most schools teach Indigenous health more so in earlier training (basic PBL or lecture-based training), rather than in senior clinical years. However, all schools are interested in teaching and developing greater content in later training years.
- Most schools rely on rural weeks/camps/placements to include a significant amount of their Indigenous content or cross-cultural awareness
- There was a significant belief and attitude across all schools that Indigenous health should be taught within or alongside rural health content. While some schools understood the particularities of urban and remote Indigenous communities and circumstances, many appeared not to be aware of such differences.
- Some schools offered clinical placements in local Aboriginal Medical Services (AMS), but this depended on funding, infrastructure, student numbers, and whether partnerships with AMS were formalised or *ad hoc.*

Cross-Cultural Awareness

- There was great variability in schools' understanding of the principles of cross-cultural awareness, from basic 'outsider looking in' and 'the real Aborigines are in the Northern Territory' type models, to cultural relativism, where 'understanding of self as a means to understand others' was encouraged. Within some schools, intra-school differences on approach were apparent, and some expressed concern that this may be contributing to mixed messages for students.
- Great variability also existed across schools on the issue of teaching Indigenous health and cross-cultural awareness. Some taught Indigenous cross-cultural awareness:
  a) separately from general cross-cultural awareness (Approach A);
  b) as one part of general multicultural awareness (Approach B); or
  c) both separately and in an integrated approach (Approach C).

Figure 3: Models of Teaching Cross-Cultural Awareness in Medical Curricula

Student Attitudes

- Most schools' student feedback suggested that students wanted to concentrate on solutions and what they could do in their practice, rather than just on the causes and history of ill-health.
- Students reported that the majority of them regularly saw Indigenous health as an imposition, or as something other than 'real medicine' or 'hard science'. Many found it hard to understand why Indigenous health was important to them, as most of them saw themselves as working in metropolitan areas or in a specific discipline, and therefore would not have contact with Indigenous patients. There was difficulty in many schools in conveying to students why such attitudes were inherently flawed, why Indigenous health was an important area of medicine, or why Indigenous health was relevant to other areas of medicine.
- Some schools reported instances of overt racism against Indigenous students or staff, or that, more generally, students repeatedly asked loaded and highly controversial questions of staff, for example.
- Indigenous students felt that at times in PBLs they needed to be placed with other Indigenous students for support, but also reported a reticence to be seen to 'be getting too much support' for fear of being further alienated from their peers.
- Rural health student clubs frequently proved to be keen advocates of Indigenous health issues, and were sometimes relied upon to be 'hidden curriculum developers' in the absence of any co-ordinated faculty strategy.
- Some schools were receiving negative or concerned feedback from international, full fee-paying students that Indigenous health content had no relevance to them. A few wanted to internationalise Indigenous health in response, so that international students could begin to develop an understanding of Indigenous peoples and health in their own countries, and that 'understanding self as a means to understanding others' type approaches would validate their own cultural experiences and assist them in understanding why Indigenous Australian health was important to them.

Structural and Organisational Arrangements

Partnerships

- Some schools actively sought and formalised partnerships with local Indigenous communities and AMS, while others did not. Some found it difficult to know where to begin with establishing such a partnership.
- A limited number of schools had established an Indigenous health advisory committee made up of Indigenous community members and medical educators; most had not
- Half of the schools had established an Indigenous health unit separate to the general university Indigenous education and student support centre. Those who had established such units found it helpful to have a unit that was highly skilled in medical education (given the unique differences of medical pedagogical approaches to other disciplines).
- Most schools also had a partnership with the university-wide Indigenous education and student support centre, and this often proved fruitful. In some cases, there had been strained relations between Indigenous health/medicine units and general Indigenous education centres in the past; yet resolution of such differences had proved rewarding for all concerned.

Decision Making

- Some schools involved Indigenous staff or community members in curriculum decisions, writing and review; others did not. In those schools with Indigenous curriculum advisory committees, most found that striking a philosophical balance between standpoints was sometimes challenging but that it was always rewarding and exciting.

- Schools that had established an Indigenous health unit mostly had them as part of one school department—of rural health, population health or general practice, for example—but rarely with faculty-wide scope or responsibilities.
- Two schools employed a senior Indigenous academic (one at Associate Dean level) to co-ordinate Indigenous health curriculum, student recruitment and retention, and oversee faculty-wide partnerships, strategies and initiatives in the area.

Teaching Resources and Infrastructure

Personnel

- Some schools employed Indigenous health academics/personnel; others did not.
- Where Indigenous people were employed as academics or student support staff, they were often asked to perform both teaching and support functions, even though most felt these were two separate roles.
- Where Indigenous doctors were employed as academic staff, they most often did so part-time.
- Most schools reported that it was difficult to find suitably skilled Indigenous people for academic positions.

Teaching Capacity

- Some schools asked their Indigenous personnel to do teaching *and* Indigenous student support; others asked their staff to do one or the other.
- Where non-Indigenous teachers/tutors delivered Indigenous health content, most did so with little or no cross-cultural awareness.
- In some schools, where non-Indigenous staff taught Indigenous content, they had access to cross-cultural awareness first, and/or co-taught with Indigenous staff.
- Schools consistently saw staff development as an issue of major importance, and wanted guidance/suggestions on doing better. One student related that 'if they want to get students to respect Indigenous health, medical school staff have to respect it first'.
- Staff development for senior clinicians in teaching hospitals is seen as a particularly difficult group to deliver cross-cultural training to, but necessary nonetheless.

Funding and Resources

- Most schools see funding for staff, teaching, staff development and curriculum development as a major issue. Many are funding developments in this area on an *ad hoc* or project-by-project basis, and would like to see funds committed to assisting them in making developments sustainable and achievable.
- A limited number of schools see funding as a purely management/curriculum-based issue, and that Indigenous health curriculum content should be funded like other areas because it is core, and not peripheral or requiring 'special' treatment and/or funds.

Teaching and Learning Resources

- Most schools expressed a desire to have access to good quality teaching and learning resources. A limited number had developed specific educational resources, including:
  - CD–Roms for core Indigenous health training;
  - a video and education kit covering issues in Indigenous health and medical education; and

- a Web-based Indigenous health theme bank for use by all staff across the faculty.

- Most schools saw the advantage in sharing curriculum materials and staff development packages, and in cross-discipline sharing (e.g., nursing and allied health) of core/basic Indigenous health content on culture, society, history, etc.
- Where sharing of resources was advocated or implemented, it was generally acknowledged that the material would need to be adapted and/or flexible to take account of each local situation and experience.

Examples of Good Practice

Every school gave examples of good practice, and they are listed below.

School	Example/s
ANU	• Strong Indigenous advisory committee and partnerships.
Flinders University	• Cultural awareness early in Year 1. • PBLs and experiential learning seen as extremely advantageous and effective. • Opportunities for major part of training in the NT. • Indigenous people involved in writing and rewriting PBLs.
JCU	• Indigenous specific communication simulations – taped and assessed. • Cross-cultural awareness taught as cultural relativism (i.e., understanding self first). • structural/organisational/funding arrangements.
Monash University	• Experiential learning in camps. • Strong 'Indigenous Health Matters' co-ordinating and advocacy committee. • Student enthusiasm driving change.
The University of Adelaide	• Rural and GP training clinics. • Multicultural and Indigenous cross-cultural awareness taught together and separately.
The University of Melbourne	• Teaching informed by community development approach where possible. • Experiential tutorial delivered by Koorie Heritage Trust staff in Semester 1.
The University of Newcastle	• Core Aboriginal health units—multi-professional and compulsory. • Experiential learning critical—'looking at self first'. • Incorporating other disadvantaged groups in society and placing students in those environments.
The University of New South Wales	• Indigenous cultural immersion camps. • Aboriginal Medical Service placements.
The University of Queensland	• Indigenous renal PBL with guest lecturers and support from the Tiwi Islands.
The University of Sydney	• Students asking for more Aboriginal health option placements.
The University of Tasmania	• Indigenous Theme Bank—Web-based multi-professional teaching and learning resource.
The University of Western Australia	• Compulsory cultural awareness taught early in program. • Process for Indigenous obstetrics and gynaecology PBL being reviewed and improved drastically.

Broader Environmental Issues Affecting the Project

Process, Capacity and Implementation of Curriculum Framework

- 'Issues in this area are about *how* it's taught, and *how* to develop this area in the curriculum, rather than what is taught'; that is, schools are asking for practical suggestions around process, capacity, teaching, partnerships, staff development and funding.
- Schools endorse the need to keep the curriculum framework flexible, and are requesting support and practical guidelines for *how to* develop curriculum in this area, rather than being told what to do.
- All schools suggest the timing of this project is in some ways advantageous in terms of broader developments towards multi-disciplinary training and communication skills of medial practitioners.
- Just as rural health requires specific strategies for curriculum development, student recruitment and retention, and clinical placements, it was suggested that there is also a need to develop capacity to teach Indigenous health in similar ways with provision of the same opportunities.
- Schools made the suggestion that linking medical school curriculum development and University Departments of Rural Health (UDRHs) should be carried out in more co-ordinated ways.

Funding and Resources

- Most schools are keen to develop curriculum in this area, but are saying they will require some funding support to make ongoing development sustainable.
- Suggestions were made to fund an Indigenous academic in every medical school specifically to co-ordinate Indigenous health curriculum development.
- It was suggested that schools share educational resources, curriculum content and staff development packages, and deliver core/basic training in Indigenous history, societies and cultures in a multi-disciplinary way (i.e., similar/same units to all health sciences professions and then specialise in each discipline).
- Aboriginal Medical Services will require funding support to be able to cater for student placements—an issue affecting rural, urban and remote AMS. Schools will also need to consider their funding arrangements for supporting this training, as they would with any other placement.

Networking

- All schools are keen to be involved in a network of medical educators and Indigenous health specialists. Such a network is seen as a useful tool in the interests of mutual support, growth, and sharing of resources and energies. It was suggested that the Australian and New Zealand Association of Medical Educators (ANZAME) may be an appropriate body with which to form a link.
- Some universities are keen to see collaborations between Indigenous health academics internationally, particularly from Canada, USA and Aotearoa/New Zealand given that these countries have developed further in this area. It was also suggested that teaching international Indigenous health may highlight the issues as a global rather than merely as an Australian-specific phenomenon requiring 'special' treatment.

D. EXTERNAL CONTRIBUTIONS

8. Discussions with other Consultative Organisations

Groups other than medical schools have been consulted and involved in discussions regarding the project and its intentions. General feedback has been positive, and groups have expressed their approval of the project and support for its objectives. The following groups have been consulted:

- The Australian Indigenous Doctors Association;
- Indigenous Nurses Education Working Group;
- Australian Medical Students Association; and
- National Rural Health Network.

All groups acknowledged their appreciation that developments in this area have taken such positive steps, yet some expressed dismay that these developments have taken so long. All are happy that CDAMS has taken up the issues and are implementing this project. Participants were keen to see that implementation be monitored in some way, either by links to accreditation or by links between funding and outcomes. All participants saw the development of a network of medical educators and Indigenous health specialists as positive, and that it should be pursued and implemented.

The Australian Medical Council (AMC) and Accreditation

Officers of the Australian Medical Council, the accreditation body for medical schools, have also expressed support for the project and its objectives, and have outlined a process for the full council to consider a proposal from this project. The proposal would be to include the curriculum framework in the medical school accreditation guidelines. Officers stated that they have already begun asking medical schools about their inclusion of Indigenous health, even though it does not form a specific part of the existing accreditation guidelines. The AMC is also willing to take advice as to which Indigenous people may be willing to be a part of its Medical School Accreditation Committee (MSAC) visiting accreditation teams.

N.B. In late July 2004, the AMC formally accepted a proposal from CDAMS to include the curriculum framework in its accreditation guidelines for all medical schools in Australia.

In addition to the groups listed above, the following groups have also been consulted or notified of the project in a preliminary manner, and it is intended that more formal discussions will occur as an ongoing part of project development:

- National Aboriginal Community-Controlled Health Organisation;
- Congress of Aboriginal and Torres Strait Islander Nurses;
- Australian Rural Health Education Network;
- Australian Rural Health Alliance;
- Committee of Presidents of Medical Colleges;

- Royal Australian College of Physicians;
- Royal Australian College of General Practitioners;
- Australian College of Rural and Remote Medicine; and
- Australian and New Zealand Association of Medical Education.

9. International Developments and Comparative Data

A number of developments have taken place in Aotearoa/New Zealand, Canada, and the United States that are of particular interest to this project. However, from our review of the literature, it appears most of these developments are documented in the 'grey literature' only. Searches that used the key words 'Aboriginal', 'Indigenous', 'medical', 'health', 'curriculum' and 'education' in varying combinations were conducted on APAIS, ATSIHealth, Medline, Proquest Medical library, Meditext, the Web of Knowledge (including the Web of Science and Current Contents), Health Insite and Google.

However, it appears that the available documentation is extremely limited. Rourke[4] describes the development of a new medical school in Northern Ontario, Canada, and discusses the Aboriginal health curriculum context and content. Kaufman[5] provides a comparison of American Indian and Aboriginal Western Australian orientation sessions for medical students.

Australian literature focuses on curriculum developments at the University of Newcastle,[6] the implications of Indigenous doctors and training,[7] and the general need to include Indigenous health in medical curricula and workforce training delivery.[8] Max Kamien provides a rare Australian account of Indigenous health education in community medicine.[9]

We are in the process of making more formal links with medical schools and associations in Aotearoa/New Zealand, Canada, and the United States in an effort to gain a clearer understanding of developments. Having said that, a brief description of developments and some examples of international initiatives have been presented here.

Aotearoa/New Zealand

Maori health curriculum development is underpinned by the Treaty of Waitangi and issues of sovereignty. Further, Aoteaora/New Zealand is home to a larger proportion of non-Anglo peoples than Australia, with a higher proportion of Maori, Pacific Islander and Asian citizens than here in Australia. Medical schools at Auckland University and the University of Otago both consider Maori health to be integral components of medical education, and implement a number of curriculum development and student support and retention issues. Auckland University has instigated strong partnerships with Maori communities, and employs an Associate Dean of Maori Health, Executive Cultural Advisor to the Dean, a Professor of Maori Health, and other Maori academic and student support staff. The universities develop their training in conjunction with recommended best practice policies for hospitals, for example.[10]

Te Ora Maori Physicians Association provides professional support and a collegial atmosphere, while advocating for health policy and best practice developments.

Canada

In June 2003, a Canadian national audit of Aboriginal health in medical curricula was presented to a national meeting of 300 stakeholders in Aboriginal medical education. The audit was undertaken by students at MacMasters University in Ontario, and the stakeholder representatives are currently looking at the implications of the report. Associate Professor Gail Garvey from Newcastle University attended

the meeting, and claims that many of the issues arising from the report are very similar to the findings and issues we are dealing with here in Australia. We will continue to monitor this situation and report on developments as appropriate.

In addition, the National Aboriginal Health Organization (NAHO) in Ottawa is attempting to develop a national approach to cross-cultural awareness training for all medical and health professionals. Officers from NAHO have contacted this project seeking information sharing and awareness of developments in Australia.

Dr Barry Levallee, President of the Canadian Aboriginal Leaders in Medicine, is soon to visit Australia to work with the Australian Indigenous Doctors Association and other groups.

United States

In the United States, the inclusion of Indigenous health in medical curricula has taken place on a localised basis, with each university developing materials independently. This is due, in part, to the deregulated US tertiary sector and a minimalised capacity to co-ordinate or develop over-arching agreements or curriculum development.

The University of Washington School of Medicine Office of Multicultural Affairs delivers mentoring, enrichment and entry programs for Native American high school children, and programs for undergraduate students and medical students (including student support and curriculum development). One of the curriculum development measures was to implement an Indian Health Pathway course within the broader curriculum—on offer for all Native and non-Native students. The course aims to prepare students for careers in Indian health and encourage research, academic development and professional capacities for the student and graduate. Students receive a specialised certificate as part of their general accreditation.

The University of New Mexico offers a strong Pueblo and other Native student support program through the Office of Cultural and Ethnic Programs, which also contributes to teaching and academic development in the areas of '… cultural competence, exposure to underserved populations, and a deep understanding of the implications of a diverse population in the provision of health education, promotion and health care provision'.[11]

In addition, the University of Hawaii has developed a specific approach to Native Hawaiian and Alaskan medical education, which includes student support, curriculum development and Native Hawaiian approaches to medicine and healing.

The Association of American Indian Physicians advocates for student support and curriculum issues, as well as providing a professional collegial atmosphere.

E. IMPLICATIONS FOR DEVELOPMENT

10. Discussion: Key Questions, Issues and Implications

Given the audit and consultation results, this section attempts to draw out the key questions, issues and implications for developing Indigenous health curriculum content.

Principles and Attitudes

1. Why should Indigenous health be included in medical curriculum?

While it is clear that all schools accept the need to develop this area of curriculum, the rationale among staff and students for developing curriculum appears to differ. For example, some staff appear to see Indigenous health as separate to 'real medicine', and that we should develop this area of the curriculum as a 'special case', while others believe the rationale is more about Indigenous people as citizens having unequal access and spending on health care.

- Issue—medical schools are independent institutions, and each will take a different approach to gaining consensus or collective understanding on this question.
- Implication—each institution may need to spend time collectively developing their conceptual and philosophical rationale for inclusion of Indigenous health in core medical curricula. The curriculum framework should be kept flexible to allow for these differing approaches.

Indigenous Health Content

2. Who are we talking about in Indigenous health?

There are a range of perspectives on what we mean by 'Indigenous health', and what geographical areas are the most important to focus on. Some staff have the attitude that 'all the real Aborigines are out bush, or in the Northern Territory', and that graduates from those schools in metropolitan areas are unlikely to come into contact with Indigenous patients because they are more likely to base themselves in these areas. In fact, the largest concentrations of Indigenous people in the country reside in South East Queensland and Western Sydney. Further, some two-thirds of Indigenous Australia live in cities and rural towns.[12]

- Issue—if curriculum is to be relevant, it is important that it not just focus on one area or group of Indigenous people.
- Implication—training may need to be more localised *and* include the bigger picture from metropolitan to rural to remote situations.

- Issue—there is a tension in the extent to which all Indigenous health content is included as a part of rural health. While this is an appropriate teaching context for some geographical areas, it is important that other areas of Indigenous health are addressed as well.
- Implication—Indigenous health and rural health are two different specialisations, and Indigenous health will need to recognised uniquely in this regard. It is important that Indigenous health does not become collapsed entirely into the rural health domain.

3. What do we mean by the term 'Indigenous health'?

How we define Indigenous health has implications for what content we include and how we teach it. What are the domains of knowledge and learning that are encompassed by the idea of Indigenous health?

Is Indigenous health only about Indigenous culture, history and communication styles? Is it about those diseases and clinical presentations with high or particular prevalence/incidence? Is it about funding and health policy and paradigm shifts? Or is it about traditional Indigenous medicines and healing modalities? All of these may be valid.

- Issue—defining Indigenous health and the domains of knowledge and learning it encompasses.
- Implication—each medical school may develop their own working definition and approach in conjunction with their Indigenous community partnership groups. Another option may be to identify a nationally agreed definition and suggested model.

4. What do we mean by 'cross-cultural awareness'?

There are differing views on exactly *what* schools mean by cross-cultural awareness and the underlying assumptions and principles that inform this. Similarly, there are differing views on exactly *how* we teach Indigenous cross-cultural awareness as part of a broader cultural competence training (as referred to in Figure 3 above).

- Issue—the values, assumptions and conceptual approaches to teaching Indigenous cross-cultural awareness discretely, or in an integrated manner, or both discretely and in an integrated manner.
- Implication—schools may need to spend time considering and developing their conceptual approach to teaching cross-cultural awareness.

5. How do we ensure quality learning?

Commendably, most medical schools were aware of the need for further development in the co-ordination, streamlining and mapping of Indigenous health content in their curriculum. Many acknowledged that at present, such development was *ad hoc*, or not as easily achievable as they might like. Further, some staff suggested the benchmarking of skills and competencies of both student learning and staff teaching.

- Issue—funding, content quality review, staff development and curriculum partnerships are fundamental.
- Implication—in terms of quality, content matters. But the key issues in quality learning in Indigenous health will require greater focus on the *processes* of development and delivery within the school, particularly around who makes key decisions in curriculum content, and how is it delivered. Benchmarking of both staff and student skill is an option and could be investigated where appropriate.

6. What modes of delivery are useful?

While all schools acknowledge the need to teach in a variety of delivery modes, most report that experiential learning is their most valuable asset in terms of delivery. It is important that the domains of knowledge intersect with pedagogical approach and teaching strategy; documented and anecdotal student evaluations suggest experiential learning is the most valuable.

- Issue—experiential learning draws on another component of knowledge development that is about an individual's own sense of self and culture. Our curriculum approach should support this.
- Implication—developing learning opportunities for experiential engagement that is respectful, resourced and useful for both student and community.

7. How might we deal with student indifference, ignorance or racism?

Some schools found a generally indifferent attitude to Indigenous health across the general student body. Some asked 'why do we have to study Indigenous health?'; particularly some international fee-paying students. Others found an impatience among students who simply wanted 'the solution and what to do, rather than 'only learning how bad the problem might be.' Others again found rural student groups to be active Indigenous health curriculum advocates, and utilising this enthusiasm proved extremely productive.

- Issue—engendering understanding, empathy, patience and enthusiasm while dealing with some students' often highly emotional and complicated reactions. This includes the ability of staff to handle such situations, and the contextualisation of training to help counter such possibilities.
- Implications—it may be necessary to identify the enhancers and barriers to learning, and plan curriculum approaches by taking these into account. Rasmussen gives an easily understandable model in this regard.[13](See Appendix D) Further, learning broadsheets may be developed to list some 'what works solutions'.

Structural and Organisational Arrangements

8. How do we build partnerships and working relationships to support the development of Indigenous health content?

In the development and delivery of Indigenous health content, schools may require the skills and expertise of Indigenous Australians outside the faculty. Ongoing advice and input into the curriculum regarding the relevant historical, community and socio-cultural issues may be required as a part of a constituency-based approach. Further, some schools wish to acknowledge and work with local traditional owners as a marker of respect and mutual learning, and also with AMS in the interests of clinical placements, but are unsure how to develop such partnerships.

- Issue—schools will need an understanding of local cultural protocols, practices, processes, politics and family networks in order to develop such curriculum partnerships. One principle of working with Indigenous communities that is key here, is that it does not matter so much *what* you do in this area (although that is of course important), but *how* you do it.
- Implication—it may be necessary to articulate the principles of good practice in building relationships and partnerships at institutional and delivery levels.

9. Who makes the decisions about what Indigenous content should be included?

Developing, designing and delivering curriculum are important functions that may be beneficially shared with Indigenous staff, and/or local community partnership groups. While non-academic Indigenous staff and community members may in some cases lack medical knowledge, they will often be a wellspring of knowledge on cultural and holistic views of health and wellness—which in turn may inform your training in this area more appropriately.

- Issue—responsibility for decision making around curriculum content and delivery, and, developing the mechanisms for which such liaison and interaction can occur in a culturally safe and respectful manner.
- Implication—schools may wish to initiate partnerships and investigate ways in which local community perspectives can be included in the curriculum.

10. What roles do Indigenous health units play?

Indigenous health units with school-wide responsibility appear to assist both the co-ordination and delivery of Indigenous health content, and student support and retention, though it appears that these two roles are separate. Further, such units and staff seem to be utilised most beneficially by having responsibility across the curriculum/school, rather than by being located in and responsible to only one department or section of the school.

- Issue—resource and organisational capacity of whole medical school to deal with both curriculum and student support issues.
- Implication—schools may need to investigate their options for developing capacity, and may need to consider joint advocacy in this regard.

Teaching Resources and Infrastructure

11. Who should teach Indigenous health?

Where Indigenous academic staff are not available to teach in a particular discipline, some schools attempt to utilise other Indigenous staff members or community guest lecturers as co-teachers.

- Issues—staff development for non-Indigenous staff in terms of cross-cultural awareness; and sourcing Indigenous staff to co-teach from a limited pool of talent.
- Implication—options for staff development include sharing resources or modules between schools, and developing the capacity of Indigenous staff members to co-teach where necessary.

12. How can curriculum development be adequately funded?

At present, funding for staff and curriculum development may be sourced from central faculty funds, from special state, federal or private grants, or from reliance on project-by-project basis funding.

Just as the moves to improve access and quality of health care in rural areas has gone hand in hand with curriculum development, student support, teaching resource and infrastructure development, and recognition of rural health as a distinct discipline, so too may Indigenous health require similar macro and micro strategies.

- Issue—developing a joint understanding of the resource situation and developing funding models which are sustainable and achievable;
- Implication—schools may decide to develop localised, sustainable recurrent funding, and fund it as a regular part of curriculum development, or make a case for extra funds to support development in a sustainable manner.

13. What teaching and learning resources are available and how do we find them?

Though teaching and learning resources are scant in this area, some schools have developed their own resources with special funding, and some have developed lists of resources for use by staff and students. Other schools report a difficulty in locating adequate resources. Further, issues of relevance to local situations may change across the country.

- Issue—developing lists and banks of knowledge, information and resources.
- Implication—schools may wish to consider sharing resources (e.g., PBLs, educational resources), or develop staff development packages centrally and touring them nationally, for example. Cross-cultural awareness developed in other areas would require tailoring and relevance to local situations.

Examples of Good Practice

Commendably, every medical school has demonstrated striking examples of content and pedagogical approaches that work, and of processes, strategies and partnerships which are fully rewarding. Though there is much developmental work to be done, this is a solid foundation to work from.

Broader Environmental Factors Affecting the Project

Medical schools have requested practical guidelines and support on processes most likely to produce success in this area. It is suggested Indigenous staff, partnerships with Indigenous communities, and medical educators with a passion and interest in this area will be the greatest resources in this regard.

A school-wide strategy and approach to Indigenous health, linked to outcomes, will ensure content is not *ad hoc* and is of a high quality.

Linking UDRH staff into such developments will also be important, though all Indigenous health content should not be automatically linked or confused with rural health.

International networking is key, as the Canadian, US and Aotearoa/New Zealand models have shown that poor Indigenous health statistics can be turned around.

Accreditation of the curriculum framework by the Australian Medical Council as guidelines for success may be seen as a positive development in assisting schools to meet quality benchmarking.

Funding and resource limitations will mean sharing of resources between schools is key, as are innovative ways to utilise resources in cost effective measures. Sustainable funding models are clearly necessary.

11. Conclusions

In short, it is the networking of staff and communities, and the genuine commitment to the developmental processes necessary that will prove to be the factors most likely to produce success.

While such partnerships and processes may at times seem too hard and fraught with time, funding and resource limitations, the rewards are not only about having inclusion of Indigenous health in medical curricula, but for those involved to learn more about their own cultural and medical school values, approaches, knowledges and skills. In this reflexive process, they key issues are commitment, patience, openness and an ability and willingness to learn and share.

Again, it is not so much about what is done, or *what* content is included (although this is clearly important), as *how* it is included, what processes are followed, and for what reasons.

Perhaps learning about 'the boundaries' of medicine may in fact help us understand the core of it more clearly.

F. AUDIT RESULTS: TABLES

Australian National University

- Postgraduate four-year course.
- Teaching begins 2004.

Content	Mode of Delivery; Integrated or Discrete	Number of Hours/Units	Semester	Core or Elective	Delivered/Taught by
Socio-political background to Indigenous health		5 x PBL; 6–8 lectures	Yrs 1 & 2	Core	Self-directed plus invited lecturers and academic staff
Health indicators					
Social determinants of Indigenous health & health service structure	PBL and lecture series; integrated 3-day workshop planned				
Specific topics in Indigenous health: - communicable disease - chronic disease - 'lifestyle' diseases					
PBL and lecture series; integrated					

Flinders University

- Postgraduate four-year course; new curriculum beginning in 2004.
- Years 3 and 4 can be undertaken in Darwin leading to greater opportunity for student interactions with Indigenous peoples.

Content	Mode of Delivery; Integrated or Discrete	Number of Hours/Units	Semester	Core or Elective	Delivered/Taught by
Cultural Awareness Camp	Discrete unit consisting of lectures, scenarios, traditional dancing, a movie	1 day & 1 night	1 (Graduate Entry Medical Prog-GEMP 1)	Core	Indigenous academic
Rheumatic Heart Disease	Integrated PBL case	1 case = 2 x 3 hrs tutorials	2 (GEMP 1)	Core	Non-Indigenous case-writer/lecturer, PBLs
Chronic Renal Failure	Integrated PBL case + resource session consisting of literature review, clinical perspectives (screening), and personal perspectives	2 x 3 hr tutorials + 1 x 3 hrs resource session	2 (GEMP 1)	Core	Non-Indigenous case-writer/lecturer and PBL tutors + Indigenous lecturer, invited GP and transplant recipient
Aboriginal Health Issues and the Media	Discrete; interactive seminars and field visit	3 hrs / week	2 (GEMP 1)	Elective	Indigenous lecturer
Burns Management	Integrated PBL case	2 x 3 hrs tutorials	2 (GEMP 2)	Core	Indigenous case-writers + PBL tutors
Women's and Children's Health	Integrated; 2 x PBL cases—Gynaecology and Failure to Thrive	2 x 3 hrs tutorials each	GEMP 3	Core	Various (no Indigenous case-writers)
General Practice (chronic disease)	Integrated PBL case	2 x 3 hrs tutorials	GEMP 2	Core	Various (no Indigenous case-writers)
Streamed Studies: Lectures—Strongyloidiasis, Aboriginal Primary Health Care, and Research in Indigenous Communities	Discrete lectures	3 x 1 hr	All	Core	Indigenous lecturer
Endocrine and Reproductive Systems	Integrated PBL	2 x 3 hrs tutorials + 1 x 3 hrs resource session	1 (GEMP 2)	Core	Indigenous case-writer/ lecturer + PBL tutors

James Cook University

- Undergraduate six-year course.

Content	Mode of Delivery; Integrated or Discrete	Number of Hours/Units	Semester	Core or Elective	Delivered/Taught by
Med. 1 Health in Practice (culture, history, communication, self-determination, well-being, reconciliation)	Integrated, workshops, lectures	2 weeks	1	Core	All content taught by Indigenous lecturers, or non-Indigenous lecturers with Indigenous co-teachers
Health in Practice (acculturative stress—Indigenous populations)	Integrated; poster topics	1/2 week	1	Core	
Indigenous Community Placements	Placements	2 weeks	2	Core	
Med. 2 RRITH (Indigenous health services and management)	Integrated, Guided Learning Sessions (GLS)	1/2 week	3	Core	
Med. 2 CVM (Indigenous child and mental health)	Integrated, GLS, rotating workshops	1 week	4	Core	
Indigenous People and Ageing	Integrated, GLS	1 week	4	Core	
Med. 2 Renal	Integrated	2 weeks	5	Core	
Neoplasia, Tissue Injury, Cervical Cancer	Integrated, GLS	3 weeks	5	Core	
Infectious Diseases	Integrated, GLS	2 weeks	5	Core	
Med. 3 Preventative Medicine and Addiction Studies (cardiovascular, obesity, high-risk populations, suicide prevention)	Integrated, GLS, Synthesised Sessions (SS), rotating multi-stations	1 week	6	Core	
Med. 3 International Health (comparitive Indigenous health)	Integrated; lectures, GLS, SS	2 weeks	6	Core	

Monash University

- Undergraduate five-year course.
- New curriculum progressively introduced 2002 onwards.

Content	Mode of Delivery; Integrated or Discrete	Number of Hours/Units	Semester	Core or Elective	Delivered/Taught by
OSCE Danny	OSCE integrated assessment	2 x 8 mins	1 & 2	Core	Actors and examiners
Arthur Moffatt	Diabetes case	1 hr	1	Core	Tutors
PCL Mundawuy	PCL integrated (assessment)	3 hrs in 2 sessions	2	Core	Tutors use material prepared by Marlene Drysdale & case writer
Selective 1 2 x 20 students Cultural Awareness, Community Knowledge and Understanding	Field trips to Indigenous sites (assessment)	2 days	2	Elective	M. Drysdale and community elders
Selective 1 x 20	Field trip to cultural sites at Iga-warta in South Australia (assessment)	1 week	2	Elective	M. Drysdale and community elders
Rural Health Rotations	Day with local Indigenous communities/organisations	1 day	3 & 4	Core	Community elders
Urban Heath Rotations	Lecture—History of Indigenous people	3 hrs	3 & 4	Core	M. Drysdale or other staff
Indigenous Health	Lecture (assessment)	3 hrs	3	Core	M. Drysdale
6 yr curriculum: Indigenous Health Issues (General Practice)	Lecture/workshop (assessment)	4 hrs	Yr 4	Core	M. Drysdale/V. Jenvey
Indigenous Public Health	Lecture /workshop (assessment)	4 hrs	Yr 6	Core	M. Drysdale/J. Chesters + 8 tutors.

The University of Adelaide

- Undergraduate six-year course.
- Rollout of new curriculum currently in 4th year (began 2000).

Content	Mode of Delivery; Integrated or Discrete	Number of Hours/Units	Semester	Core or Elective	Delivered/Taught by
Course 'Beyond Me' (Professional & Personal Development Stream) - Sociological aspects of medicine and cross-cultural communication	Small group interaction student self-directed research Visitation program to Nunkawarrin Yunti (Aborginal medical centre)		Yrs 1, 2 & 3	Elective	Mostly non-Aboriginal, unless tutors facilitate this themselves — no way of mapping this.
Medical Education Unit (MEU) —Research Investigation Project (2500 word essay on Indigenous health)	Self-directed research for essay		Yr 1	Elective	MEU, Yaitya Purruna input to question, one lecture, and marking
Rural Week: Cultural Awareness Component Core	Workshops, presentations, Point Pearce community visit with the Aboriginal health team	6	Yr 1	Core	Aboriginal taught
PBL Case—Diabetes/Indigenous Health	Small group work, resource sessions		Yr 2	Core	Taught by non-Indigenous staff
Indigenous Health Elective - Dept of General Practice	Lectures, tutorial presentations, small group work, discussions	42 hrs over 2 terms	Yr 2	Elective	Delivered by Indigenous lecturer
Rural Week—Cultural Awareness elective option (2003 is first year of this option, chosen by 40 of 96 Australian students)	Fieldtrips—cultural education camp at the community	1 week	Yr 2	Elective	Yes—SGRHS and Iga Warta Community
PBL Case on Burns & Indigenous Health	Small group work, resource sessions		Yr 3	Core	Taught by MEU, with Indigenous guest speaker in resource session only
PBL Case on Acute Rheumatic Fever and Indigenous Health	Small group work, resource sessions		Yr 3	Core	
PBL Case on Stroke and Indigenous Health	Small group work, resource sessions		Yr 3	Core	
Dept of Public Health - Aboriginal Health Policy course	Lectures, tutorial presentations, small group work, discussions	1 week intensive	Yr 3; Sem. 2	Elective	Indigenous lecturer

The University of Adelaide cont...

Content	Mode of Delivery; Integrated or Discrete	Number of Hours/Units	Semester	Core or Elective	Delivered/Taught by
Dept of General Practice —Clinical Skills 3 - Cross-cultural Communication Module - Elective Clinical Placement at	Lecture and PBL case re: culture and and communication - Student clinical placement to Nunkunwarrin Yunti AMS		Yr 3	Module: core Placement: elective	Yes—Yaitya Purruna, and Nunkuwarrin Yunti
Dept of General Practice & SGRHS - Medical Science Attachment	Self-directed with appropriate supervisor		Yrs 4 & 5	Indigenous health option	Taught by non-Indigenous with Indigenous support
Department of General Practice - GP Attachments - NT Rural and Remote Health Workforce Agency	Community visits Hospital visits Aboriginal Health Service visits	7–10 days	Yrs 4 & 5	Elective Indigenous	Indigenous & non-Indigenous
Dept of General Practice Research Secretariat - Research Proposal	Self-directed with appropriate supervisor	144 hours	Yr 4	Indigenous elective	Indigenous & non-Indigenous
Research Secretariat	Self-directed with appropriate supervisor	21 days	Yr 4 or 5	Indigenous elective	"
SGRHS—Rural Cohort of Students Based in Country for 12 months	All core medical teaching in rural location	12 months	Yr 5	Indigenous elective	"
GP Attachments	Student placement	4–8 weeks	Yr 5	Indigenous elective	"
GP Attachments	Student placement	4–8 weeks		Indigenous elective	"
Specialist Community or Ambulatory Placements (SCAPS)	Student placement	4 weeks / 160 hours	Yr 6	Indigenous elective	MEU co-ord; possibly some ndigenous teaching
SCAPS	Student placement	8 weeks	Yr 6	Indigenous elective	

The University of Melbourne

- Undergraduate six-year course; postgraduate option (four years).

Content	Mode of Delivery; Integrated or Discrete	Number of Hours/Units	Semester	Core or Elective	Delivered/Taught by
Aboriginal Health and History—Health Transition	Lectures, tutorials	6 hrs	1	Core	Koori academics & community members
Community Nutrition	PBL & lecture; integrated	1 hrs	2	Core	Koori & non-Koori tutors and lecturers
Burden of Disease	Lecture; integrated	1hrs	3	Core	Koori & non-Koori tutors and lecturers
Population Health strategies to address Aboriginal health issues	Lecture; integrated	1hrs	3	Core	Koori & non-Koori tutors and lecturers
Gas Exchange	PBL	1hrs	3	Core	Koori & non-Koori tutors and lecturers
Race, Class, Gender	Lecture; integrated	2hrs	4	Core	Koori & non-Koori tutors and lecturers
Public Health / TB example	Lecture	1hrs	5	Core	Koori & non-Koori tutors and lecturers
Meningitis	PBl	2hrs	5	Core	Koori & non-Koori tutors and lecturers
Advanced Medical Science year	Research	2 sems	6, 7	Elective	Koori & non-Koori tutors and lecturers
Community Visits	Field visits	Several days	8, 9	Core	Koori & non-Koori tutors and lecturers
Indigenous Child Health	Symposium	1 hr	10	Core	Aboriginal Health workers
Indigenous Child Health	Research	4–10 hrs	10	Elective	Non-Aboriginal & Aboriginal lecturers
Koori Liaison Officer visits	Field visits	1 hr	1	Student selected	Aboriginal lecturers Koori Liaison Officer

The University of Newcastle

- Undergraduate six-year course.
- New changes implemented in 2004.

Content	Mode of Delivery; Integrated or Discrete	Number of Hours/Units	Semester	Core or Elective	Delivered/Taught by
Core Aboriginal Health (history, service provision and health promotion)	Lectures, Aboriginal community panels, SDL; integrated	16 hrs 1 of 4 topics	2	Core	Aboriginal academics & community members
Environments, Behaviour & Health	PBL; integrated	2 hrs	1	Core	Non-Aboriginal & Aboriginal tutors
Cultural Differences & Health Care Delivery	PBL & lecture; integrated	3 hrs	1	Core	"
Socio-Economic Inequality & Health	PBL & lecture; integrated	3 hrs	1	Core	"
Immunisation	PBL	2 hrs	1	Core	"
Youth Suicide	PBL & lecture; integrated	4 hrs	1	Core	Non-Aboriginal & Aboriginal tutors
Renal Failure	PBL	2 hrs	1	Core	Non-Aboriginal & Aboriginal tutors
Gastroenteritis	PBl	2 hrs	1	Core	Non-Aboriginal & Aboriginal tutors
Servicing the Needs of your Patients	Lecture	2 hrs	1	Core	Non-Aboriginal & Aboriginal Health workers
Pre-term Labour	Lecture	2 hrs	2	Core	Non-Aboriginal & Aboriginal Health workers
Health Equity Selectives	Field visits	4 weeks (9–5pm)	2	Elective	Aboriginal Health Organisations
Community Placements (Aboriginal organisations)	Field visits	12 hrs	2	Compulsory up to 10 students selected	Aboriginal Organisations
RUPP Electives	Field visits	8 weeks	2	Elective	Aboriginal Health Organisations
Elective Placements	Field visits	8 weeks	2	Elective	Aboriginal Health Organisations (Australia & International)

The University of New South Wales

- Undergraduate six-year course.
- New curriculum progressively introduced 2004–06, and will have integration across whole curriculum.

Content	Mode of Delivery; Integrated or Discrete	Number of Hours/Units	Semester	Core or Elective	Delivered/Taught by
Introductory Clinical and Behavioural Studies (ICBS): overview of Indigenous Health (IH) / inter-country comparisons / small group work on issues, barriers and strategies	Tutorials—discrete	3 hr tutorial x 4 (per group of 45 students)	Med. I (Sems 1 & 2)	Core	Senior lecturer, Indigenous Health
Human Behaviour: myths / contexts of Indigenous lives / becoming a culturally-competent practitioner / students also invited to submit questions which are then followed-up on the day and through web-posted answers	Lecture (but interactive, questions elicited)—discrete	1 hr	Med. II (Sem. 4)	Core	SL, IH
Population Health:					
• Introductory Lecture (joint): 'special treatment' versus a population health approach	Lecture (part general population health, part Indigenous focus)—integrated	1 hr	Med. IV	Core	SL, IH (joint lecture with non-Indigenous lecturer)
• Mid-year 'Common Campus' Indigenous Health (IH) and Multicultural Health (MCH) half-day: commonalities and unique aspects in approach between IH and MCH; cultural competence in clinical practice / case scenarios / panel including non-Indigenous GP, Indigenous graduate or student and Aboriginal Health Workers (AHWs)	Workshop—integrated	3 hrs	Med. IV	Core	SL, IH (with community, health worker, GP and multicultural health involvement)
• One-day workshop on IH for Greater Murray Clinical School: similar to above plus local elder and Aboriginal Medical service participation, extended small-group case scenarios with local AHW participation	1-day workshop—discrete	8 hrs	Med. IV	Elective (but core for Rural Clinical School students at Greater Murray)	Rural Clinical School staff (non-Indigenous, plus SL, IH, local elders, health workers from local AMS)

The University of New South Wales cont...

Content	Mode of Delivery; Integrated or Discrete	Number of Hours/Units	Semester	Core or Elective	Delivered/Taught by
Opportunistic Teaching: by range of lecturers raising Indigenous issues within topic-specific contexts (e.g., women's health term, alcohol and other drugs and chronic and complex care teaching)	Lectures & workshops—integrated	1 hr lectures & 3 hr hr workshops (portion only)	Med. I–VI	Core	Non-Indigenous lecturers
Rural Health Workshops: Prep. for rural placements—Indigenous component 60–90 minutes—with an emphasis on familiarity with Indigenous health issues and culturally appropriate methods of providing health care	Lecture (interactive)—integrated	1–1.5 hrs	Med. IV & V (Sems 7–8, or 9–10)	Elective (those students heading for rural placement)	SL, IH (with Sen. Lectr., Rural Health)

The University of Queensland

- Postgraduate four-year course.

Content	Mode of Delivery; Integrated or Discrete	Number of Hours/Units	Semester	Core or Elective	Delivered/Taught by
GENERAL ISSUES: Teaching of Indigenous health falls under all 4 domains of learning: BCS (Basic & Clinical Sciences); EPPD (Ethics, Personal and Professional Development); ICSCRP (Interpersonal & Clinical Skills, Clinical Reasoning and Practice) and PPH (Population & Preventive Health); with most issues falling under PPH domain. or disease, diabetes, TB)	Concepts introduced / raised throughout many **PBL cases, lectures, tutorials, clinical sessions** in an i**ntegrated** fashion. Many indigenous health issues are raised in topic-specific resource sessions (e.g., communications skills sessions chronic illness, health policy, risk factors	?	All 4 yrs	Core	Range of academic staff / health professionals, largely non-Indigenous
Indigenous health teaching is part of the INTEGRATED curriculum in UQ's MBBS program and as such, there is no discrete 'unit' devoted to it.	Also, a range of r**ecommended readings**– journal articles, etc.	?	All 4 yrs	Optional	N/A
SPECIFIC CONTENT AREAS MORE READILY IDENTIFIED: Year 1, Week 8 • Common causes of morbidity and mortality in Indigenous communities in remote Australia.	PBL case 8: 'Hidden in the crypts', 3-year old Aboriginal child with giardia	5 hrs	Yr 1	Core	PBL tutors; range of health scientists & clinicians
• Aboriginal concepts of health and disease and how they impact upon provision of health care.	Expert tutorial titled:'Mortality & morbidity patterns in ATSI'	1.5–2 hrs	Yr 1	Core	Indigenous lecturer
• Social and cultural factors influencing indigenous concepts of health.	Lecture : 'Issues in Indigenous Health'	1 hr	Yr 1	Core	Indigenous lecturer
• Historical, cultural and social factors influencing Indigenous healthcare delivery (kinship, parenting, women's business, concepts of time, acceptance)					
• The role of the Indigenous health worker					

The University of Queensland cont...

Content	Mode of Delivery; Integrated or Discrete	Number of Hours/Units	Semester	Core or Elective	Delivered/Taught by
Year 1 Community visits program	Students visit a community program. One such program is the Queensland Aboriginal and Islander Health Forum	2–3 hrs	Yr 1	Elective	Staff at the QAIHF
Year 2, Week 24 • Chronic renal disease (and its risk factors physical, socio-economic, lifestyle, etc) in indigenous and non-indigenous Australians.	PBL case dealing with chronic renal disease 'The Soon to Be Lost Generation'	3 hrs	Yr 2	Core	PBL tutors
• Addressing risk factors with cultural sensitivity.	Lecture on Indigenous health	1 hr	Yr 2	Core	Non-Indigenous lecturer
• Effects of chronic disease on patients and families. • Essential socio-cultural issues to consider in the design and conduct of a screening program / research study in an Indigenous population.	Hypothetical symposium	2 hrs	Yr 2	Core	Panel of epidemiologist, health economist, renal physician, medical ethicist, Indigenous patient with chronic renal disease, Indigenous health care worker.
• Ethical, cultural and practical issues which influence organ donation and its impact on donor families, recipients, medical and paramedical staff.	Symposium 'Aspects of brain death and organ donation'	1.5 hrs	Yr 2	Core	Non-Indigenous academic and clinical staff
Year 3 • Social, cultural and psychological factors affecting medical practice and access to medical practice in remote and urban areas of practice (e.g., birthing issues for Indigenous people. • Health professionals' need to develop a sophisticated critique of culture and cultural difference in order to practice effectively. • Awareness and identification of racism operating at different levels and forms, in health care delivery	PBL case on obstetric care of Indigenous women in remote Qld	2 hrs	Yr 3, Rural Rotation	Core	PBL tutors

The University of Queensland cont...

Content	Mode of Delivery; Integrated or Discrete	Number of Hours/Units	Semester	Core or Elective	Delivered/Taught by
Year 3 Rural Rotation Introduction to range of issues: Indigenous health; remote community health issues; cultural awareness issues	Actual formats vary at each of the two Rural Clinical Schools:	3-hr session	Yr 3 Rural Rotation	Core	
	Toowoomba - Lectures on Indigenous health - Visits to Indigenous health centres	3 x 1-hr	Toowoomba	Core	The Rural Health Training Unit, Indigenous member of staff
	Rockhampton - 3 x lectures	7 weeks	Rockhampton	Core	Dr from local ATSI Health clinic; Indigenous hospital
	Clinical placement in Indigenous community			Clinical placement is core, but optional for Indigenous community	
Year 4 Ethical issues relating to research methodology with particular focus on ATSI research	PBL case on research 'Decisions, Decisions'	2 hrs	Yr 4, O&G Rotation	Core	PBL tutors
ELECTIVES: Year 1 & Year 4 electives	Students in Years 1 and 4 undertake a 4-week elective in an area of medicine of their choice. Opportunities exist for students to consider Indigenous health issues in these electives	4 weeks	Yr 1 & Yr 4	Elective	Health practitioners – Indigenous and non-Indigenous.

The University of Sydney

- Postgraduate four-year course.
- New curriculum implemented 2004.

Content	Mode of Delivery; Integrated or Discrete	Number of Hours/Units	Semester	Core or Elective	Delivered/Taught by
Indigenous content in domains of Population Medicine & Clinical Sciences	Year 1: - 2 x PBL; 1 full week lectures			Core	Non-Indigenous & Indigenous lecturers
Topics covered include: historical overview, health trends, disease, resources, nutrition, domestic violence, poverty and health, renal, homelessness, prison health, resource allocation, Aboriginal health in urban/rural settings, GP term, mental health	- General option: placement in AMS Years 2–4: - Rural rotations - Community rotation - Yr 4 clinical rotation - Lecture with some Aboriginal health			Elective Indigenous options Indigenous options Indigenous options Core	" " " " "

The University of Tasmania

- Undergraduate six-year course.
- New curriculum fully implemented by 2006.

Content	Mode of Delivery; Integrated or Discrete	Number of Hours/Units	Semester	Core or Elective	Delivered/Taught by
Subject: Community Health & Medicine (some Indigenous content in 1 lecture)	Lecture	Less than 1	Yr 1	Core	Non-Indigenous staff
Subject: Community Health & Medicine ('Introduction to Rural & Aboriginal Health')	Lecture	1 hour	Yr 2	Core	Non-Indigenous staff
Clinical Specialties	Rural Health option has Indigenous -specific seminar series		Yrs 3 & 4	Elective	Non-Indigenous staff
Advanced Studies Program	Option to do clinical placements in Indigenous communities at Flinders Island or Northern Territory		Yr 4; Sem. 2	Elective	Non-Indigenous staff

The University of Western Australia

- Undergraduate six–year course.

Content	Mode of Delivery; Integrated or Discrete	Number of Hours/Units	Semester	Core or Elective	Delivered/Taught by
Foundations Clinical Practice	2 x PBLs; integrated		Yr 1	Core	Centre for Aboriginal Medical & Dental Health (CAMDH)
Rural Week	Some Indigenous content; integrated		Yr 1	Core	CAMDH & others
Aboriginal Health Option	Full subject (lectures, tutorials); discrete	Full semester	Yr 2	Elective	CAMDH
Foundations Clinical Practice	2 x PBLs; integrated	Full semester	Yr 2	Core	CAMDH & others
Aboriginal Health Option	Full subject (lectures, tutorials); discrete	Full semester	Yr 3	Elective	CAMDH
Aboriginal Community Organisation Placement	Placement; discrete		Yr 3	Elective	CAMDH
Foundations Clinical Practice	2 x PBLs; integrated	1 hr	Yr 3	Core	CAMDH & others
Core Clinical Methods	Lecture; discrete	8 weeks total	Yr 4	Core	CAMDH & others
Medicine Subject: - Indigenous Case Study - PBLs	Case Study (20% assessment) 2 x PBLs	Full semester	Yr 4	Core	CAMDH & others Others
Indigenous Research Project	Subject		Yr 4	Elective	CAMDH supervision
Medicine Subject	1 x PBL		Yr 5	Core	Others
Obstetrics & Gynaecology— Aboriginal Women's Health	2 x Tutorials		Yr 5	Core	CAMDH
Paediatrics subject	Some Indigenous content		Yr 5	Core	Others (+ CAMDH in future)
General Practice	Some Indigenous content		Yr 5	Core	Others
Aboriginal Health Options	3 options	Full semester	Yr 5	Elective	CAMDH & community organisations
Selectives / Electives / Rural Clinical School	Indigenous options / placements	Full semester	Yr 5	Elective	CAMDH (in future) & others
Rural General Practice Placement	Indigenous option	Full semester	Yr 6	Elective	CAMDH & others

Appendix A: Information Presented to the Australasian Medical Deans Meeting in Perth, 29 August 1997

Overall Principle to Implementation of Recommendations

It asks the meeting of Deans to make a commitment to increase the content and awareness of Indigenous issues within the medical curricula.

Fundamental to the development of policies and programs in Indigenous Australian health is significant and effective Indigenous Australian consultation and direction.

The conference expresses its concern in regard to the lack of Indigenous Australian health curriculum within the medical curricula.

In particular, emphasis should be given to developing communication skills to enhance cross-cultural awareness so that the needs of Indigenous people within Australian society can be better met.

The teaching of Indigenous health issues should be embedded as a theme throughout the whole medical curricula, recognising that Indigenous health is a specialist area requiring specialist knowledge. There is a need to incorporate within this teaching direct experience of Indigenous Australian issues.

Recognising the importance of Indigenous Australian issues in medical education, we assert that:

- ongoing consultation with, and participation of, Indigenous Australian communities and key national representative Indigenous bodies; and
- recognition of the important role of Indigenous Australian academics and teachers in both the content and process of the curricula. are essential elements in ensuing that the content and context of teaching on Indigenous Australian health issues to medical students is culturally appropriate.

Recommendation 1

Under these guiding principles, it is recommended that faculties and or universities implement/increase curricula that incorporate Indigenous Australian issues. Such curricula must be developed and delivered under Aboriginal and Torres Strait Islander control.

Entry and Support of Indigenous Australian Students

The following recommendations are designed to enable universities and faculties to increase the number of Indigenous Australian students entering medicine, and to improve the retention rates of these students.

Recommendation 2

Each university/faculty of medicine and/or health sciences has an active, affirmative, well-supported recruitment program for Indigenous Australian peoples in medicine and health sciences.

This program should involve a component that accesses Indigenous Australian students in secondary schools from at least Year 10 onwards.

Recommendation 3

Each university/faculty of medicine and or health sciences ensures that mechanisms are in place to provide functional access for entry into their faculties, recognising the special needs of Indigenous Australian students. Pre-entry programs for Indigenous Australian people wanting to study medicine and other health sciences are possible mechanisms to achieve this.

Recommendation 4

A pilot study of pre-entry programs be undertaken at selected sites over a period of three years, with integral process and outcome evaluation of the effectiveness of the proposed pre-entry programs in providing potential students with career path choices.

Support for Indigenous Australian students

Medical faculties are responsible for ensuring that ongoing support is provided for Indigenous Australian students.

Recommendation 5

Support needs to recognise and address the particular circumstances and obligations of each individual. Essential to this support is the employment of Aboriginal or Torres Strait Islander staff within the respective medical faculties.

Recommendation 6

To ensure that support for Indigenous Australian students is provided from a broad community base, it is recommended that faculties maintain and support active working relationships between themselves and Indigenous Australian organisations. These organisations should include the Indigenous Australian education centres within each university and other relevant organisations within or outside of the university.

Recommendation 7

Additionally, it is recommended that faculties provide facilities and resources to develop and sustain the activities of support networks between past, present and potential Indigenous Australian health science and medical students.

Recommendation 8

Indigenous Australian students generally have additional needs over and above both participation and academic support throughout the full duration of their course. Current financial support mechanisms are inadequate. The new Abstudy cuts will have significant impact on Indigenous Australian students' performance and enrolments.

We recommend that the Committee of Deans advocates for improved financial support of Indigenous Australian medical students. This support needs to include adequate living and travel allowance, access to childcare services and provision of scholarships.

Appendix B: Interview Guides

Interview Guide—Deans

Introductory Speaking Notes:

- Give general introduction to project including background, process and scope.
- What the project is and is not.
- Non-confrontational, consultative audit, seeking frankness, is going to be recorded, but not going to be about judgment or competitiveness.

A. Principles And Attitudes

1) What **principles** underpin your university's commitment to Indigenous health?

2) What about fostering positive values, **attitudes** and principles? How are these communicated to teaching staff?

B. Indigenous Health Content

3) Could you please describe the **structure** of your program and the key points for engaging Indigenous health and related issues, bearing in mind that I will be asking staff to fill out the detail of the content and a questionnaire?

4) What **aspirations** do you have in developing this area?

C. Structural/Organisational Issues

5) What **capacity** is required in terms of staffing? Do you have dedicated staff teaching Indigenous health? (prompts: staff development, cross-cultural awareness for staff)

6) What are your strengths and gaps? What do you **aspire** to?

7) Could you please describe **partnerships** between your faculty and local, State or national Indigenous communities or organisations with respect to teaching?

8) Do you have any particular examples of **good practice** or case studies you would like to see included in the audit?

D. Teaching Resources And Infrastructure

9) How is your teaching in Indigenous health **funded**?

10) What **other funding** support would you like to see?

11) What are the minimum requirements for a **viable** program at your university?

E. Broader Environment

12) We are trying to develop a national curriculum framework. Do you have any **suggestions** as to how we might proceed to ensure maximum value of this project's outcomes to your school?

13) We are looking to develop a **network** of medical educators and Indigenous health personnel to co-ordinate the on-going development of these issues. Do you have any suggestions for how such a network might be established and developed for maximum advantage?

F. Other Issues

14) Are there any there any other issues that impact on teaching Indigenous health in core medical curricula?

15) Do you have any other comments or suggestions?

Notes about Pro-Forma to follow:

- Please nominate a staff member who can lead in filling out pro-forma. The intention is to pass this on to two staff members:
  - one from medical education / curriculum development; and,
  - one from Indigenous health.
- Only one form need be completed (different sections by different staff if necessary).

Interview Guide—Staff

Introductory Speaking Notes:

- Give general introduction to project, including background, process and scope.
- What the project is and is not.
- Non-confrontational, consultative audit, seeking frankness, is going to be recorded, but not going to be about judgment or competitiveness.

B. Indigenous Health Content

1) Are you aware of any **existing audits** or maps of teaching Indigenous health in medical schools?

2) Could you please describe the **structure** of your program and the key points for engaging Indigenous health and related issues?

3) **What content** on Indigenous health is taught? How is this defined? (i.e., learning objectives, etc.)

4) **How** is this content taught and in what context?

5) **Who** teaches this content?

6) What are the **positives** and **negatives** of this approach?

7) Is the curriculum **documented**? Who can help provide a map of content?

8) What **aspirations** do you have in developing this area of the medical curriculum?

C. Structural/Organisational Issues

9) What **capacity** is required in terms of staffing? Do you have dedicated staff teaching Indigenous health? (prompts: staff development, cross-cultural awareness for staff)

10) Could you please describe **partnerships** between your faculty and local, State or national Indigenous communities or organisations with respect to teaching?

11) What are your strengths and gaps? What do you **aspire** to?

12) Do you have any particular examples of **good practice** or case studies you would like to see included in the audit?

E. Broader Environment

13) We are trying to develop a national curriculum framework. Do you have any **suggestions** as to how we might proceed to ensure maximum value of this project's outcomes to your school?

14) We are looking to develop a **network** of medical educators and Indigenous health personnel to co-ordinate the on-going development of these issues. Do you have any suggestions for how such a network might be established and developed for maximum advantage?

F. Other Issues

15) Are there any there any **other issues** that impact on teaching Indigenous health in core medical curricula?

16) Do you have any other comments or suggestions?

Notes about Pro-Forma to follow:

- Please nominate a staff member who can lead in filling out pro-forma? The intention is for two staff members to respond - one from medical education / curriculum development, and one from Indigenous health.
- Only one form need be completed (different sections by different staff if necessary).

Interview Guide—Students

1) Do you consider Indigenous health **important** and why? Is the study of Indigenous health important?

2) **How** is it being taught now? Do you consider that appropriate? Do you learn the sorts of content you think you will need as a practitioner?

3) **Who** was involved in teaching? Was that appropriate or useful? (prompts: personnel, support staff, guest lecturers, extra-curricula, etc.)

4) Are you aware of any Indigenous health **electives** in your course? What influences / would influence your decision to take Indigenous health electives? Should any of it be a part of **core** curriculum?

5) What **suggestions** do you have for teaching Indigenous health content?

6) What would make studying Indigenous health more **accessible** and **interesting**?

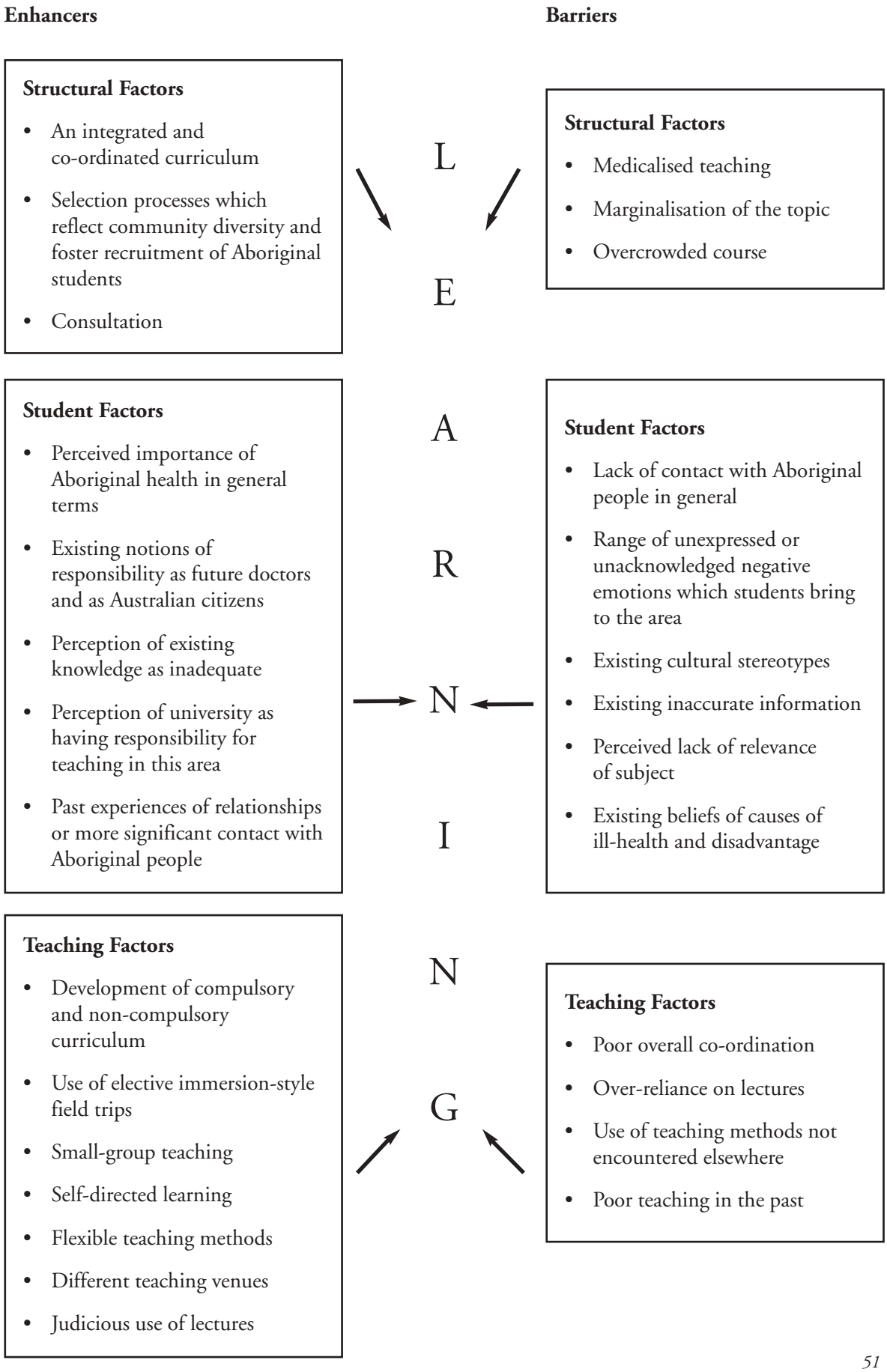
7) Do you have any **other comments** or suggestions?

Appendix C: Sample of 1999 Audit Tables[14]

Health Curricula									
Medical School	ATSI Input in Developing & Delivery	Core Hrs	Total Hours				Curriculum Presentation		
			Yr	Hrs	Domain/Subject	Components Covered	ATSI	Mode of Delivery	Resources
Flinders University	• Karpa Ngarrarendi—Aboriginal Health Unit, Flinders Medical Centre • Yunggorendi—First Nations Centre for Higher Education & Research • Nunkuwarri Yunti (ACCHS) • Department of Human Services—SA Govt • Rural & Remote Health—Alice Springs • RACGP Aboriginal Educator—Darwin • Aboriginal Health Council	-	1 3 	6–7 6–7 6–7 6–7 6–7	Renal Identity; Microbes; DefenseDefence Cardiovascular Women's & Children's Health Surgery	Renal Disease Tuberculosis Rheumatic Heart Disease Diarrhoea Appendicitis	No Yes No Yes	PBL—Tutorials Lectures / Workshops PBL—Tutorials Lectures / Workshops	-
The University of Melbourne	• Centre of Indigenous Education • Koorie Heritage • Hospital Liaison Officers • VACCHO • VACSL • VAIE • Country Cooperative groups • VAHS • Bramble Cultural Centre • VACCA		1	2 hrs	1999 curriculum Health & Society Intro. to Aboriginal Health	Different perspectives Key causes identified by Aboriginal people & tension with mainstream services Assumptions re: Aboriginality / perceptions of Aboriginal people / key influences—perception of poor health	Tutorials: 1 ATSI 1 non-ATSI (persons who have worked in Aboriginal Health)	Tutorials	Fairly reflective tutorial texts
			2	-	-	-	-	-	-
			3	-	-	-	-	-	-
			4	-	-	-	-	-	-
			5	3 1/2	General Practice Term	Aims: 4 cases for reflection (historical issues; S/E & culture of issues; views of health & well being; impact of racism; importance of having good epidemiological knowledge; communication issues)	-	2 lectures Small group work Question time in lectures Formal presentation Case studies Videos Discussions	Videos: *Bringing them Home; Beenie & Smoky Don't Mix; When Dreaming Paths Meet* (first 2 scenarios) Readings
			6	-	-	-	-	-	-

Source: G. Garvey & N. Brown 1999, Aboriginal Health: A priority for Australian medical schools project

Appendix D: Rasmussen's Barriers and Enhancers to Learning about Aboriginal Health Model [15]



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