

Evaluating Indigenous public health competencies in a Master of Public Health

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A highly ranked global school of public health, the Melbourne School of Population and Global Health (MSPGH) at The University of Melbourne offers postgraduate qualifications that enable a highly skilled public health workforce. Through the university's Master of Public Health (MPH) program, students are provided the opportunity to gain comprehensive skills and knowledge, with specialist fields that include biostatistics, gerontology, global health, health economics, health policy, Indigenous health, infectious disease epidemiology and sexual health. While Indigenous health is a specialist area that students can choose to study, this evaluation, led by Aboriginal and Torres Strait Islander academics, examined the degree to which Indigenous health-related competencies are embedded across the core, capstone and Indigenous Health specialisation units.

The review identified strong horizontal integration of teaching Indigenous public health competencies as topics across the core, capstone and Indigenous Health specialisation units. However, inclusion within capstone units was variable and often opportunistic, resulting in inconsistent student exposure to Indigenous public health learning. While it also identified a diversity of learning opportunities to engage with Indigenous knowledges, the evaluation highlighted ongoing gaps in systematic embedding of Indigenous leadership, governance and accountability within curriculum design. Overall, embedding a dedicated Indigenous public health unit as a core subject is recommended to ensure all MPH graduates develop deeper, critically informed competencies.

This evaluation hopes to assist educators and MPH course designers in ensuring that Indigenous health knowledges are effectively embedded into all units in the Master of Public Health. It is further recommended that a competency mapping and evaluation of Indigenous knowledges across the whole MPH should be undertaken in the future, including for the long-term benefit of all MPH degrees across Australia and internationally.

Keywords: Indigenous health, Indigenous knowledges, public health competencies

Introduction

Contemporary approaches to Indigenous education now extend beyond access and participation in Australian universities to addressing the structural changes of curriculum, the embedding of Indigenous knowledges and the creating of culturally safe learning environments (Gainsford & Attree, 2026). This contemporary shift recognises that meaningful transformation and the inclusion of Indigenous knowledges require structural change in what is taught, how it is taught and whose knowledge is

legitimised within the academy. Indigenising and re-centring Indigenous knowledge therefore requires an in-depth critical examination of dominant epistemologies to uncover deficit framing, and to lead to the integration of Indigenous perspectives as foundational rather than supplementary (Nakata, 2007).

Within this broader reform agenda, the success and experience of Indigenous knowledges in the curriculum therefore hinges on cultivating learning environments where students can safely engage with complex histories, challenge dominant assumptions, and develop reflexive, culturally safe public health practice (Murray & Campton, 2024). However, this is also dependent on a curriculum that is able to deliver learning opportunities that enable coherent, well-designed learning sequences which build cultural capability, deepen understanding of Indigenous worldviews and support students to apply this knowledge in authentic public health contexts.

In 2015–16 the World Federation of Public Health Associations (WFPHA) and the World Health Organization (WHO) co-developed the *Global Charter for the Public's Health* (The Charter) (Moore et al., 2016). The Charter was designed to provide a “framework to allow public health systems to communicate globally, compare capacity and improve performance through systematic action” (Lomazzi, 2016, p. 210). It outlined seven key elements for public health practice, namely: three core public health services (Protection, Promotion and Prevention) and four enabling functions (Information, Governance, Capacity, and Advocacy). Capacity building is one of the seven vital aspects of The Charter in terms of enabling health practice, and provides a guide for the effective design and execution of appropriate teaching and learning programs for the future public health workforce. Of note, The Charter also reflected the voices of First Peoples through its emphasis on health equity, cultural competence and community engagement, which align with Indigenous principles of self-determination and holistic health (Moore et al., 2016, pp. 3–4).

The WFPHA Professionals' Education and Training Working Group (PETWG) aimed to develop strategies to globally harmonise essential public health functions and competencies based on practice needs and performance standards (WFPHA, 2020). Recent research undertaken by this group involved mapping a range of public health education competency frameworks against the elements of The Charter. The results highlighted the importance of competencies related to culturally safe practice, particularly in relation to service provision for Indigenous populations, as a fundamental area of the Capacity building function (Coombe et al., 2020). The competency framework for graduates of public health programs in Australasia was showcased as one of the few frameworks analysed to include such competencies for culturally safe practice when working with Aboriginal and Torres Strait Islander peoples (Somerset et al., 2016). However, Aboriginal and Torres Strait Islander peoples' input is mainly seen in competencies related to cultural responsiveness and addressing health inequities with explicit recognition of Indigenous governance and traditional knowledge systems remaining limited (Parter et al., 2024).

This Australasian competency framework was originally developed as an initiative under the Australian Government-funded Public Health Education and Research Program (PHERP), by the Australian Network of Academic Public Health Institutions (ANAPHI) in 2009, for adoption into Master of Public Health (MPH) programs (Genat & Robinson, 2010). It was informed by a feasibility study that explored how Indigenous health should be taught in Australian MPH programs, which recommended that Indigenous health should be integrated into core content to avoid the “risk of a separate program labelled ‘Indigenous’ encouraging indifference within the mainstream public health sector” (PHERP, 2008, p. 1). This study also suggested that any core subjects should consist of Indigenous Health and History as foundational knowledge, complemented by additional coursework covering Indigenous Health Policy,

Indigenous Health Promotion and Research in Indigenous Contexts. Further elective study through a specialisation stream was also recommended.

The framework was updated in 2016 by the more contemporary Council of Academic Public Health Institutions Australasia (CAPIA); this was the framework that was analysed in the PETWG research. It clearly stated:

All Australian Public Health graduates need to be culturally attuned to not only Aboriginal and Torres Strait Islander health issues, their history and specific challenges, but also Indigenous agency in the development of successful population health strategies to improve Aboriginal and Torres Strait Islander health. (Somerset et al., 2016, p. 3)

During 2011–3, the Public Health Indigenous Leadership in Education (PHILE) Network also undertook a national review of the integration into MPH courses of the Indigenous public health competencies contained in the ANAPHI framework, which included reviewing the MPH program at the Melbourne School of Population and Global Health (MSPGH). Although they commended the MSPGH for the vertical integration of the competencies in an elective Indigenous Health specialisation, they also recommended that this specialisation be complimented and strengthened by adopting a horizontal model of integration within the program's core units (Lee et al., 2015), as also recommended in the earlier PHERP feasibility study. Following this, in 2015 the MSPGH responded by embedding the Indigenous public health competencies through a horizontal integration model into the core MPH subjects (Angus et al., 2016).

This project, therefore, looked to evaluate how the Indigenous public health content continues to be embedded into the core MPH curriculum seven years on, and to also identify existing gaps where future improvement is needed.

Background

In April 2023 a review of the current Indigenous health teaching and learning offered in the MPH was undertaken. Subsequently, a project to evaluate the delivery of Indigenous public health competencies focused on identifying units or subjects that embedded Indigenous public health in the MPH as offered by the MSPGH. During 2023, the MPH offered approximately 82 units distributed across 73 electives, 6 core and 3 capstone units. The suggested specialisations were Epidemiology and Biostatistics; Evaluation and Implementation Science; Gerontology; Global Health; Health, Gender and Society; Health Economics and Economic Evaluation; Health Policy, Systems and Practice; Indigenous Health; Infectious Disease Epidemiology; and Sexual Health.

While it would have been ideal for all subjects offered across the MPH to be included in the mapping project, limited resources and timeframes for project completion meant the core, capstone and units within the Indigenous Health specialisation were included (see Table 1). Furthermore, the suggested 2023 Indigenous Health specialisation units of Indigenous Health and History Insights (POPH90296) and Indigenous Policy Analysis (SOCI90018) were not included in the mapping project as they were rested or not an MSPGH subject.

From July 2022 to December 2022 the coordinators of the selected MPH units were contacted via email and invited to participate in a consultation process for this project.

Table 1: Master of Public Health core, capstone and Indigenous Health units 2023

Unit type	Unit code and name
Core	POPH90217 Foundations of Public Health
	POPH90013 Biostatistics
	POPH90014 Epidemiology 1
	POPH90231 Qualitative Research in Public Health
	POPH90218 Public Health Leadership and Management
	POPH90274 Prioritising and Planning in Public Health
Capstone Option 1	POPH90284 Research Project in Public Health Part 1
	POPH90285 Research Project in Public Health Part 2
	POPH90255 Research Project in Public Health - S
Capstone Option 2	POPH90286 Professional Practice - Part 1
	POPH90287 Professional Practice - Part 2
	POPH90239 Professional Practice - S
Capstone Option 3	POPH90227 Public Health in Practice
	Elective
Indigenous Health specialisation	POPH90200 Advanced Qualitative Health Research
	POPH90291 Indigenous Health in a Global Context
	POPH90201 Community Engagement for Health Impact
	POPH90244 Global Health and Human Rights
	POPH90205 Social Determinants of Health Inequality
	POPH90296 Indigenous Health and History Insights
	SOCI90018 Indigenous Policy Analysis

Method

In initiating this project, Indigenous and non-Indigenous people leading and working in public health across The University of Melbourne, Public Health Association of Australia (PHAA) and CAPHIA fields were consulted to identify appropriate frameworks, current best practice, and to seek advice and guidance based on learnings from previous work in this field. This evaluation drew on competency frameworks current at the time of data collection (2016–2023). Since then, the CAPHIA competencies, Australian Medical Council (AMC) accreditation standards, and the Royal Australasian College of Physicians (RACP) Public Health Medicine curriculum have undergone substantial revision; these updates occurred after analysis was completed and are not reflected in the mapping presented here (AMC, 2023; CAPHIA, 2025a; CAPHIA, 2025b; RACP, 2025). However, the findings of the evaluation remain relevant, as they reflect the ongoing gaps in the recognition of Indigenous public health education.

The four public health frameworks that emerged from this process were purposefully selected for their mention of Aboriginal and Torres Strait Islander populations and for their Indigenous public health themes applicable to public health in Australia. They are as follows:

1. *Foundation Competencies for Public Health Graduates in Australia* by CAPHIA (Somerset et al., 2016)
2. *Aboriginal and Torres Strait Islander Health Curriculum Framework (The Framework)* (Australian Government, 2014)

3. *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012* (AMC, 2012)
4. *Public Health Medicine Advanced Training Curriculum* by the Royal Australasian College of Physicians – current curriculum at the time of review, accessed 2023.

The Indigenous health competencies were then located in each of the four frameworks. Each framework had differing labels for the competencies which were aligned under the Domains heading listed as follows (see Table 2). The AMC and the RACP competencies were located within Domains, the CAPHIA within Area of Practice and The Framework within Capabilities.

Table 2: Competencies by framework

Framework	Domains *	Competencies*	Indigenous competencies	Uniform resource locator (URL)
CAPHIA Council of Academic Public Health Institutions Australasia	(Area of Practice) 6	(Elements) 102	7 (1.9, 1.10, 8.2, 9.3, 11.3, 12.5 & P5.3**)	caphia.com.au/competencies/
The Framework Aboriginal and Torres Strait Islander Health Curriculum Framework	(Capabilities) 5	(Key Descriptors) 13	13 (1.1, 1.2, 1.3, 1.4, 2.1, 2.2, 3.1, 3.2, 4.1, 4.2, 4.3, 5.1 & 5.2)	health.gov.au/resources/publications/aboriginal-and-torres-strait-islander-health-curriculum-framework
AMC Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012	4	(Graduate Attributes) 40	2 (3.4 & 3.8)	amc.org.au/wp-content/uploads/2019/10/Standards-for-Assessment-and-Accreditation-of-Primary-Medical-Programs-by-the-Australian-Medical-Council-2012.pdf
RACP Royal Australasian College of Physicians Public Health Medicine Advanced Training Curriculum	6	(Learning Objectives) 109	3 (2.3.1, 2.3.2 & 2.3.3)	racp.edu.au/trainees/curricula/professional-practice-framework

* Note frameworks have different labels relating to the domains and competencies and are listed in brackets.

** P5.3 is referencing the “Evidence-based Professional Population Health Practice” Area of Practice in which the unit of competency relates.

Ethics clearance was not sought for this project as it was deemed to be a quality assurance/evaluation activity expressly for the purpose of “maintaining standards or identifying areas for improvement in the environment from which the data was obtained” (National Health and Medical Research Council, 2014, p. 3). In essence, the purpose was to ensure that the current curriculum is delivering best practice as well as addressing the Indigenous public health competencies. While data may be linked to individuals (those being the subject coordinators), the unit content may or may not have been designed by the same persons;

it is a product of the MSPGH program in which they themselves will also be interested in the outcomes for quality assurance purposes.

Data collection

The collection of data focused on identifying the Indigenous public health content delivered and the formative and summative assessment tasks used in each unit. A pre-formed template was used to collate the data gained and discuss how each unit embedded Indigenous health in teaching and learning practices (see Table 3). The focus was to consult with unit coordinators to obtain unit structures such as lectures and assessment to discover how they were embedding and aligning with the Indigenous public health competencies. The team was able to independently map each of the competencies against the elements of the units. Indigenous public health content was identified primarily through explicit references to Aboriginal and Torres Strait Islander peoples, knowledges, histories, governance, or health outcomes within learning objectives, lecture content, assessment tasks, or prescribed readings. Implicit references (e.g., generic discussions of equity or marginalisation) were only mapped where unit coordinators clearly articulated their intentional alignment with Indigenous public health competencies during consultation.

Competency mapping was undertaken by members of the evaluation team using the template (Table 3). Each unit was initially reviewed by at least two team members, both Aboriginal and Torres Strait Islander academics, who independently identified explicitly stated Indigenous public health content within unit learning outcomes, teaching activities and assessment tasks. Following independent mapping, the team met collectively to review, discuss and moderate the identified competencies. Differences in interpretation were resolved through group discussion, with particular attention to Indigenous intent, depth and cultural integrity. Final mappings were agreed by consensus, with Aboriginal and Torres Strait Islander team members providing leadership in validating interpretations.

By identifying this information, comparison and analysis was able to take place to identify the Indigenous health competencies that are being met and which units are connecting to specific Indigenous public health competencies, and to identify any gaps that emerge which can then be used to address and enhance the teaching and learning in the MPH. Following the data collection process, reflective practice was then undertaken and the template was communicated to key staff members to ensure limited bias was present and the method remained robust.

Table 3: Template used for mapping competencies against the MPH subjects

Framework name			
Element of competency	MPH unit – Core	MPH unit – Capstone	MPH unit – Indigenous Health specialisation
	Details of how unit addresses element in the teaching and learning, including assessments.		

Results

Once the mapping of the competencies was completed, it was possible to identify and evaluate how much and where coverage was occurring across the MPH for Indigenous public health competencies in the selected units. It was identified that variation occurred in the number of competencies that were

addressed; however, it is important to note that not every unit is able to address every competency across the four frameworks, as their learning outcomes are specific to their unit.

Although levels of coverage varied by individual unit, all the Indigenous public health competencies across the frameworks were identified in some way across all the units selected. The competencies that were identified for each unit are listed in Table 4.

Table 4: Indigenous health competencies addressed by MPH subjects

	AMC	CAPHIA	RACP	The Framework
Core subjects				
POPH90217	3.4, 3.8	1.9, 1.10, 8.2, 9.3, P5.3	Out of scope	1.1, 1.2, 1.3, 1.4, 2.1, 2.2, 3.2, 4.1, 4.2, 4.3, 5.1
POPH90013	3.4	1.9, 1.10, P5.3	2.3.1	1.1, 1.2, 1.3, 1.4, 2.1, 2.2, 3.2, 4.1, 4.2, 4.3, 5.1, 5.2
POPH90014	3.4	1.9, 1.10, 8.2, 11.3, 12.5, P5.3	2.3.1, 2.3.2, 2.3.3	1.1, 1.2, 1.3, 1.4, 2.1, 2.2, 3.1, 3.2, 4.1, 4.2, 4.3, 5.1, 5.2
POPH90231	3.4	1.9, 1.10, 8.2, 9.3, 12.5, P5.3	2.3.1, 2.3.3	1.1, 1.2, 1.3, 1.4, 2.1, 2.2, 3.2, 4.1, 4.2, 4.3, 5.1, 5.2
POPH90218	3.4, 3.8	8.2, 9.3, P5.3	2.3.2, 2.3.3	1.1, 1.2, 1.3, 1.4, 2.1, 2.2, 3.2, 4.1, 4.2, 4.3, 5.2
POPH90274	3.4	1.9, 1.10, 8.2, 9.3, 11.3, 12.5, P5.3	2.3.1, 2.3.2, 2.3.3	1.1, 1.2, 1.3, 1.4, 2.1, 2.2, 3.2, 4.1, 4.2, 4.3, 5.1, 5.2
Capstone Option 1 – POPH90255 for semester capstone OR year-long (both POPH90284 (part 1) & POPH90285 (part 2))				
POPH90284 (part 1)	*	*	*	*
POPH90285 (part 2)	*	*	*	*
POPH90255	*	*	*	*
Capstone Option 2 – Professional Practice - year-long PPU (POPH90286 AND POPH90287) or a semester-long PPU (POPH90239)				
POPH90286	*	*	*	*
POPH90287	*	*	*	*
POPH90239	*	*	*	*
Capstone Option 3 – Public Health - capstone subject and must select an additional elective				
POPH90227	3.4, 3.8	1.9, 1.10, 8.2, 11.3, 12.5, P5.3	2.3.1, 2.3.2, 2.3.3	1.1, 1.2, 1.3, 1.4, 2.1, 2.2, 3.1, 3.2, 4.1, 5.1, 5.2
Indigenous Health specialisation electives				
POPH90200	out of scope	8.2	2.3.1, 2.3.3	1.1, 1.2, 1.3, 1.4, 2.1, 2.2, 3.2, 4.1, 4.2, 4.3, 5.1, 5.2
POPH90201	3.4	8.2, P5.3	2.3.1, 2.3.2, 2.3.3	1.1, 1.2, 1.3, 1.4, 2.1, 2.2, 3.2, 4.1, 4.2, 4.3, 5.1, 5.2
POPH90244	3.4	1.9, 1.10, 8.2, 11.3, 12.5, P5.3	2.3.1, 2.3.2, 2.3.3	1.1, 1.2, 1.3, 1.4, 2.1, 2.2, 3.2, 4.1, 4.2, 4.3, 5.1, 5.2
POPH90205	3.4	8.2	2.3.1, 2.3.3	1.1, 1.2, 1.3, 1.4, 2.1, 2.2, 3.2, 4.1, 4.2, 4.3, 5.2
POPH90291	3.4	1.9, 1.10, 8.2, 9.3, 11.3, 12.5, P5.3	2.3.1, 2.3.2, 2.3.3	1.1, 1.2, 1.3, 1.4, 2.1, 2.2, 3.1, 3.2, 4.1, 4.2, 4.3, 5.1, 5.2

* Represents no identifiable Indigenous public health competency. See below for explanation.

The capstone is required to be completed by all MPH students and aims to provide the student with a greater understanding of public health work across various contexts and offer work integrated learning (WIL) activities designed to assist students to gain exposure to and an understanding of public health in real-world application. The University of Melbourne's MPH has three options from which students choose to enrol in, option 1 and 2 include two semester-long units that can be taken concurrently (part 1 and part 2). Option 3 has a mandatory unit which students enrol in, but they must also enrol in an additional elective to complete the capstone requirements.

Two of the three capstone options did not contain structurally embedded Indigenous public health competencies within their stated learning outcomes or assessment requirements. In these capstone pathways, Indigenous public health competencies were only addressed where students independently selected a research project, professional placement or practice context focused on Indigenous health. As a result, engagement with Indigenous public health in these capstone options was not guaranteed for all students and depended on individual topic choice rather than curriculum design. In this sense, Indigenous public health competencies within these capstone units are best characterised as contingent or opportunistic, rather than systematically integrated. While the capstones provide potential space for Indigenous public health learning, the absence of mandated Indigenous learning outcomes limits consistent exposure across the student cohort.

Furthermore, some suggestions emerged from the yarns with unit coordinators for improving Indigenous health competency coverage across the MPH. In this project, yarns were used to support open dialogue about unit intent, perceived curriculum gaps and opportunities for strengthening Indigenous public health learning, rather than for formal data generation (Walker et al., 2014). These suggestions have been coded as the themes of leadership, global leadership, student outcomes, and the access to and use of Indigenous datasets as application tools and data.

Discussion

This project expanded on Angus et al. (2016) by examining how Indigenous public health competencies are currently embedded across The University of Melbourne's MPH and by identifying gaps that persist in the curriculum. It found strong horizontal integration of Indigenous public health topics across core and capstone offerings and within the Indigenous Health specialisation, yielding diverse opportunities for engagement. Students encountered focused Indigenous public health issues through case studies, guest lectures and assessment tasks; for example, Foundations of Public Health introduced the Ways of Knowing interprofessional program to unsettle default Eurocentric framings and invite multiple epistemologies into public health problem-solving (Bolton et al., 2011). In Epidemiology, a strength-based approach and infectious-disease cases were used to situate Indigenous public health within mainstream methodological training. These findings reaffirm that MSPGH is invested in representing Indigenous public health across the curriculum lifecycle from historical context to contemporary practice.

While horizontal coverage is a strength, rebalancing epistemological dominance requires more than additive inclusion of Indigenous content. It demands deliberate curricular architecture that re-centres Indigenous epistemologies, interrogates disciplinary assumptions and scaffolds learning vertically across the program, rather than relying on isolated subjects or elective choices. In this sense, current integration demonstrates exposure, but sustainable transformation requires coherence (program-level

learning outcomes, aligned assessments and capstone experiences that guarantee Indigenous public health capability development) and not merely tokenistic representation.

In this mapping, the focus was on addressing two main aims; firstly, to uncover where and how Indigenous public health competencies are currently being addressed in the available units and, secondly, to identify any gaps in Indigenous health competencies that currently exist within the curriculum.

The first aim identified that the MSPGH have embedded and maintained a strong horizontal integration of Indigenous public health teaching across the units of the MPH. To date, this has enabled a diversity of learning opportunities for students to engage in Indigenous public health curriculum, from specialisation subjects such as Indigenous Health in a Global Context to mainstream and capstone units that provide a focused Indigenous public health issue for learning. Furthermore, it found that the course is actively providing different learning opportunities in Indigenous public health, which includes individualised case studies and guest lecturers that are specific to the unit learning outcomes. It also highlighted how the MSPGH is deeply invested in ensuring that the curriculum is reflective of Indigenous public health as a lifecycle, from the historical context to how it impacts modern health. The capstone options provided the opportunity for students to choose an Indigenous health-focused research project, professional practice or public health subject.

The mapping also shows many instances where culturally relevant examples and guest lectures are used; however, cultural safety must be designed as an explicit curricular outcome, not an incidental by-product. This entails structured opportunities for reflexivity and positionality work, guided discussion protocols for engaging with difficult histories and racism, and assessment tasks that evidence growth in culturally safe reasoning and practice. Doing so would shift learning from awareness to accountable professional capability. When considered against CAPHIA, The Framework, AMC and RACP, the analysis clarified a very good breadth of coverage; but it also highlighted that the competency frameworks could easily become checklists that certify exposure rather than transformation. Several mapped elements (e.g., CAPHIA 8.2 and P5.3, Somerset et al., 2016, p. 15 and p. 22) were frequently addressed, but the depth of learning remained variable and contingent on unit design and staff expertise and/or dedication. To counter checklist drift, program assurance should pair competencies with capability-based evidence, for example, reflexive analyses, community-engaged project work or Indigenous data governance tasks assessed against clear standards of cultural safety and accountability.

Of the four public health competencies, CAPHIA and The Framework emerged as the strongest in terms of being embedded across the MPH. In particular, CAPHIA elements of competence 8.2 and P5.3 were both addressed in 10 out of the possible 18 units (acknowledging that the capstone units were unable to be mapped directly). The element of competence 8.2 focused on ensuring students understood the historical context of colonisation as well as build an ability to “analyse the impact of colonial processes on health outcomes” (Somerset et al., 2016, p. 15). This element of competence was addressed as a baseline through the Ways of Knowing module delivered in Foundations of Public Health POPH90217 and was then built upon with case studies such as rheumatic heart disease, guest lecturers and focused projects. The Evidence-based Professional Population Health Practice element of competence P5.3 was equally being addressed throughout the MPH and looked to “demonstrate a reflexive public health practice for Aboriginal and Torres Strait Islander health contexts” (Somerset et al., 2016, p. 22). As with the competency 8.2, it was also addressed in its baseline through the Ways of Knowing module and was again built upon by using reflexive practice in discussions, tutorials and assessment. The Framework was embedded across all its key descriptors, with the weaker competencies being that of 3.1 Clinical

Presentation, which has limited relevance for public health education, and 4.3 White Privilege, which was not expressly used as a term but often the unit coordinators felt it was a theme in most student discussions.

The second aim of this project looked to uncover the gaps that currently exist within the teaching and learning curriculum for the MPH. As identified above, the gap analysis identified four main themes emerging around Indigenous public health leadership, global Indigenous public health leadership, student outcomes for Indigenous public health learning and access to useable Indigenous datasets for teaching staff.

The first two themes emerged from discussions with unit coordinators within the core and capstone units and found a belief that there is a large gap in Indigenous health leadership (particularly where guidance and cultural oversight is needed in teaching) both nationally and globally, and an over-reliance on individual Indigenous academics. At the moment, limited support and resources are available in terms of cultural safety and supervision, particularly with Indigenous leaders. Indigenous leadership in teaching provides deeper understanding and learning for the issues of public health that impact Indigenous peoples, particularly that of racism and access to services (McKinley et al., 2011). However, leaning into Indigenous academics to provide this in each individual unit can mean that their capacity and availability is quickly exhausted. While Indigenous academic leadership strengthens curriculum quality and cultural integrity, reliance on a small number of Indigenous staff to deliver, oversee and legitimise Indigenous content risks reproducing colonial load within institutions. Sustainability therefore requires structural resourcing, workload recognition and governance arrangements that do not depend solely on individual Indigenous academics. One option would be to have prerequisite for a core subject in the MPH on Indigenous public health or Indigenous leadership. This would help to ensure that all students had sufficient exposure to an Indigenous public health curriculum and gain deeper understanding on issues of public health impacting Indigenous people both locally and globally.

The third theme emerged around student outcomes. Anecdotally, unit coordinators felt that international students can have difficulty understanding the experience and contextualisation of Indigenous public health issues, particularly that of the relationship between Indigenous people and non-Indigenous people in Australia. As such, it may also be beneficial to create more opportunities for the specialisation in Indigenous Health that cover both the national and global context.

Lastly, the fourth theme identified challenges for staff who want to teach practical examples in their lessons accessing useable datasets for teaching staff. Unit coordinators felt that it was difficult to both locate and identify Indigenous datasets that were available for practical analysis examples. This meant that embedding practical examples for students relied on old data sources or used case studies that lacked available and useable data. Access to Indigenous-governed data and knowledge resources was identified as a challenge for teaching staff. Importantly, Indigenous data are not neutral teaching tools but are embedded in Indigenous governance, lived experience and knowledge sovereignty. Addressing this gap, therefore, requires more than technical access; it necessitates Indigenous leadership, ethical governance and relationship-based approaches to teaching with Indigenous knowledges.

As already mentioned above, a core unit focusing on Indigenous public health could help to address most of the gap themes found in the mapping. Angus et al. (2016) initially recommended that there should be an Indigenous public health unit as a core standalone subject, which could support the development of Indigenous leadership in public health. The ability of a core unit would ensure exposure to all students enrolled in the MPH and would eliminate the chance of students undertaking their courses

without gaining a real understanding of Indigenous public health. Another option would be to strengthen the current offerings, acknowledging that the main basic underlying concepts of Indigenous health are being delivered well in Foundations of Public Health through the interprofessional Ways of Knowing module. Given that this module only meets the introductory basic level of understandings of the health issues for Aboriginal and Torres Strait Islander populations needed, it could be expanded to provide both a strength-based unit of learning that would enhance our public health training and provide better learning experiences for Indigenous public health. At the moment, opportunities can be missed in the way that content is delivered, meaning students can complete the MPH in its entirety and not gain a deep understanding of Indigenous public health, depending on the electives units that they choose.

At the program level, we also recommend introducing a core Indigenous public health unit (or a vertically scaffolded sequence across cores) to ensure every student attains depth, the establishment of Indigenous governance of the MPH curriculum with recognised workload and decision-making authority, the guaranteeing of capstone-level Indigenous learning outcomes regardless of project selection, and resourcing staff capability building (cultural safety, reflexive pedagogy, Indigenous data governance). At the institutional/sector level, ideally aligning internal assurance with external standards (e.g., CAPHIA competencies) should be complemented by measures that evidence cultural safety in practice, not only competency coverage. Embedding these changes would reduce reliance on individual Indigenous academics, strengthen curricular coherence and support graduate readiness for culturally safe public health practice.

The strongest enablers identified were existing Indigenous-led initiatives (e.g., Ways of Knowing), motivated coordinators who embed relevant case studies and emergent subjects that address structural capability gaps (e.g., the new POPH90308 Indigenous Data Governance in Health, introducing students to the principles, ethics and praxis of Indigenous data governance). Constraints included opportunistic capstone learning where Indigenous outcomes materialise only if students choose relevant projects or placements, variable staff confidence to teach Indigenous content and limited access to usable Indigenous datasets for practical work. Addressing these requires minimum Indigenous learning outcomes in all capstone pathways, structured staff professional development in cultural safety and Indigenous data governance, and centrally curated teaching datasets developed under Indigenous governance principles.

Lastly, through discussion with unit coordinators, this project enabled the identification of other subjects in the MPH that can be added to the specialisation of Indigenous Health due to the inherent nature of the Indigenous health competencies addressed. It also identified a project outcome that could help to address the issue of knowledge of and access to useable Indigenous datasets. In response to and as an outcome of the competency project, the subject POPH90308 Indigenous Data Governance in Health was developed and was available for enrolment in 2024. This unit provided students with practical understandings regarding the production and strategic dissemination of Indigenous health data central to governance, and of research in Indigenous public health with a jurisdictional lens. It is also recommended that unit coordinators are provided with professional development opportunities in understanding Indigenous data so that the content of their teaching and learning is reflective of the critical aspects of Indigenous data governance.

Conclusion

This project provided an evaluation of the Indigenous public health competencies as they were currently embedded into the core MPH curriculum in 2022–2023, seven years post the recommendations of Lee et

al. (2015) and the earlier PHERP feasibility study. Cultural authority within this project was provided through the leadership of Aboriginal and Torres Strait Islander academics with recognised expertise in Indigenous public health, curriculum design and health equity. The evaluation identified existing gaps where future investment can occur, particularly in Indigenous health leadership and knowledge of and access to Indigenous datasets. It also reinforced the recommendations of the earlier work of Lee et al. (2015) to strengthen Indigenous health learning by adopting both a horizontal and vertical model of integration.

The long-term and future embedding of an Indigenous Health unit as a core subject would ensure that all students are given exposure to in-depth, strength-based teaching and learning for Indigenous public health. Furthermore, as Indigenous public health is a fast-growing area for teaching and learning, to keep up with the pace of research in Indigenous public health, it is imperative that coordinators of courses and units also continue to develop their knowledge to ensure best practice in the intersection of teaching and learning of Indigenous health. Reinforcing the recommendation by Angus et al. (2016) to include a core unit for Indigenous Health, or to integrate the competencies both horizontally and vertically, provides the opportunity for a strength-based approach to the representation of Indigenous public health, in a more balanced and diverse methodology, to improve the education provided to the future public health workforce.

Overall, this evaluation highlighted areas of emerging best practice at the intersection of Indigenous public health content, competency-aligned curriculum design, culturally responsive pedagogy and Indigenous academic leadership. The findings demonstrated that, while Indigenous public health is meaningfully represented across multiple units, the depth, consistency and scaffolding of learning vary across the program. The current curriculum provides important foundational conditions for its development, including exposure to Indigenous knowledges, opportunities for reflexivity, and engagement with the impacts of colonisation, racism and governance on health. Strengthening these intersections through vertical curriculum scaffolding, Indigenous-led core learning and guaranteed capstone learning outcomes would further support graduates' readiness to work towards culturally safe public health practice with Aboriginal and Torres Strait Islander peoples.

It is also important to note that we mapped units against four frameworks: CAPHIA (Somerset et al., 2016), the *Aboriginal and Torres Strait Islander Health Curriculum Framework* (Australian Government, 2014), the Australian Medical Council standards (AMC, 2012) and the Royal Australasian College of Physicians (RACP) Public Health Medicine curriculum. Notably, the AMC released revised medical school standards in 2023 (effective 1 January 2024), superseding the 2012 framework, and RACP is rolling out new Advanced Training curricula between 2024 and 2027 (RACP, n.d.). CAPHIA (Somerset et al., 2016) remains current but is undergoing a competencies renewal project. Of note, the AMC 2023 standards, which superseded the 2012 standards used in this mapping, introduce a substantially strengthened focus on cultural safety, Indigenous governance and social accountability. While our mapping reflected the standards in use during the teaching period, the findings highlight the need for future alignment with the AMC 2023 requirements, particularly the expectation that cultural safety be embedded, taught and assessed across all levels of the curriculum. This further underscores the need for the MPH to move from horizontal exposure to vertically scaffolded and assessable Indigenous public health capabilities (AMC, n.d.; AMC, 2023; CAPHIA, 2025a; CAPHIA, 2025b; RACP, n.d.; RACP, 2025).

These recent revisions reflect accountability, and demonstrated capability with newer iterations emphasising cultural safety, anti-racism, reflexive practice, and Indigenous self-determination as core professional requirements, alongside explicit expectations for Indigenous-led design and

decision-making. They also move from exposure-based learning to assessable capabilities, including ethical community engagement and Indigenous data governance. These developments would further strengthen the vertical scaffolding and assurance of Indigenous public health learning identified as areas for improvement in this evaluation.

Overall, the learnings from this project will continue to inform the ways in which teaching and learning can continue to develop and embed Indigenous health competencies into course curricula. Strength-based and focused Indigenous Health units will not only deliver stronger grounding in public health, but will also inform future public health policy development to provide students culturally appropriate and safe ways to work with Aboriginal and Torres Strait Islander people. The project has enhanced knowledge and created awareness of the depth of education in Indigenous public health across the curriculum, including the outcome of changes in units on the listed Indigenous Health specialisation.

Finally, to uncover the full extent of the embedding of Indigenous public health competencies across the curriculum, a competency map of Indigenous knowledges across the whole MPH should be undertaken. A larger-scale mapping would uncover unexpected gaps in the curriculum, as well as identify potential areas of excellence, informing best practice for the future, including for other MPH programs worldwide.

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Abbreviations and symbols

Abbreviation	Meaning
AMC	Australian Medical Council
ANAPHI	Australian Network of Academic Public Health Institutions
MPH	Master of Public Health
MSPGH	Melbourne School of Population and Global Health
PETWG	[WFPHA] Professionals’ Education and Training Working Group
PHAA	Public Health Association of Australia
IPHERP	Public Health Education and Research Program
PHILE	Public Health Indigenous Leadership in Education
RACP	Royal Australasian College of Physicians
The Framework	Aboriginal and Torres Strait Islander Health Curriculum Framework
WFPHA	World Federation of Public Health Associations
WHO	World Health Organization

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