The Australian Journal of Indigenous Education

cambridge.org/jie

Addressing the knowledge gap of Indigenous public health: reflections from an Indigenous public health graduate

Natasha Lee

School of Public Health, The University of Queensland, Brisbane, Queensland 4072, Australia

Research Article

Cite this article: Lee N (2020). Addressing the knowledge gap of Indigenous public health: reflections from an Indigenous public health graduate. *The Australian Journal of Indigenous Education* **49**, 110–118. https://doi.org/10.1017/jie.2020.15

Received: 28 February 2020
Revised: 26 June 2020
Accepted: 11 August 2020
First published online: 9 September 2020

Key words:
Cultural safety; racism and health system; Indigenous health; reflective practice; transformative learning

Author for correspondence:
Natasha Lee, E-mail: natasha.lee@uq.net.au

Abstract

The current agenda in public health training in higher education works to produce well-trained public health professionals. Operating within a western pedagogical framework it aims to build a cohort of critical and analytical thinkers, skilful problem solvers and extraordinary communicators across key disciplines in health. Many graduates possess interdisciplinary specialities, skills and knowledge transferable within health and other sectors. Core competencies in the curricula, which notably does not currently include Indigenous health, are considered the foundational platform of theory and practical understandings of public health and the health system. Despite a framework that aims to produce health professionals capable of improving the health of the population as a whole; the lack of engagement with an Indigenous health criticality maintains a longstanding Australian public health tradition of failure when it comes to addressing the health disparities experienced by Indigenous people. As a recent Indigenous public health graduate with practical training and experience working in the public health system, I consider possibilities for decolonising the curricula through an Indigenist approach to health, including theories of transformative learning which could strengthen public health practice and in turn facilitate the changes necessary to improving Indigenous health outcomes.

Introduction

I am a Mualgal, Yidinji, Dunghutti and Kullili woman, living in Meeanjin in South East Queensland. I completed my Master of Public Health (MPH) within the Faculty of Medicine at the University of Queensland (UQ) in 2019. I am a trained public health professional with an interdisciplinary background in anthropology, sociology, ethics, human rights and political science. I have over 21 years of experience working in Indigenous affairs, including in tertiary education, health research and within the public service, both state and Commonwealth. For the purposes of this paper, Indigenous will be used interchangeably with Aboriginal and Torres Strait Islander throughout this reflective article. My career in health began in 1995 when I was employed as a Receptionist and Executive Assistant to the Chief Executive Officer at our local Aboriginal and Torres Strait Islander Community Health Service (formally known as AICHS) in Woolloongabba. During this time, I was surrounded by Indigenous leaders who sought to improve health outcomes for our people. Their strength and guidance influenced my decision to return to undertake further studies in health. These experiences provided a foundational understanding of the importance of community engagement and empowerment and their centrality to Indigenous health. It was not until I had undertaken a medical anthropology course in my undergraduate degree, that I gained valuable insight into the cultural interpretations of health, and the importance of drawing upon social, cultural, biological and linguistic anthropology to better understand factors that influence health and wellbeing. Throughout the course, I became interested in exploring and interrogating how the Australian public health system relies upon specific cultural understandings of health and draws upon global, historical and political forces that shape population health and health outcomes; particularly for Indigenous Australians. This interest was a driving force for enrolling in the MPH program. I also wanted to further explore the structure, function and social nature of the public health system, its claims to be concerned with eliminating Indigenous health inequality, and how Indigenous worldviews and knowledges of health and wellbeing are centred within the system, health practice and research given the predominance of the biomedical model. More broadly, I wanted to interrogate how westernised conceptualisations of Indigeneity are framed, and how it informs the treatment and ultimately health outcomes for Indigenous people.

As an MPH student, I encountered significant challenges during my studies, after graduation and re-entry into the health sector. This paper reflects upon not only these challenges, but also recent research experience that examined the most extreme and obvious failures of the

CAMBRIDGE UNIVERSITY PRESS

Master of Public Health - Standard Course structure					
Part A – Core units (14 Units)	▪ Health Systems ▪ Social Perspectives ▪ Environmental Health		▪ Health Promotion ▪ Epidemiology ▪ Biostatistics ▪ Public Health Research Methods		
Part B – Capstone units (2 Units)	▪ Public Health Practice		▪ Project (4 units)		
Part C – Electives	Up to eight units from postgraduate courses offered by the School of Public Health (student eligibility), including up to four units from other postgraduate courses approved by the Program Director				
Master of Public Health – Specialisation Includes Part A & B					
Part C - Electives from general specialisation (4 Units)	Alcohol, Tobacco and other drugs	Global Health	Health Promotion and Disease Prevention	Indigenous Health	Nutrition
Part D – Electives	Up to four units from postgraduate courses offered by the School of Public Health for which the student is eligible.				

Figure 1. Master of Public Health Program – Course Structure, UQ 2018.

health system for Indigenous people and the methodological approach in terms of reflexivity, self-care and foregrounding of care for Indigenous people through transformative learning. I should note, this was in contrast to how public health trained me to understand Indigenous health, or rather ill-health. I also draw upon my experience of three interrelated conflicts in the oppression of Indigenous voices to reveal how Indigenous ways of knowing are undervalued within the public health sector demonstrating the need to foreground a decolonising approach to Indigenous public health training drawing upon Rigney's (1999) Indigenist research framework. Rigney's Indigenist research framework (1999) centres the survival of Indigenous peoples and our sovereignty. Further, it is through my being, as a sovereign Mualgal, Yidinji, Dunghutti and Kullili woman, that I draw upon Moreton-Robinson's Indigenous Women's Standpoint Theory, in order to centre the power of my voice and experiences in knowledge production (Moreton-Robinson, 2013).

In writing about my experiences, I was guided by three factors; the critical shortage of Indigenous health scholars within the School of Public Health at UQ, the lack of involvement and leadership in the structure and design of Indigenous public health course content, despite the number of Indigenous scholars in the field of public health and other disciplines located at the university, including the valued intellectual, scholarly and cultural knowledge of Indigenous elders in the community and finally, because of a failed health system that neglects to centre Indigenous knowledges of health and well-being, the ways systems of oppression are maintained within Indigenous communities, including premature death and disease. Using Rigney's Indigenist research framework (1999) that privileges Indigenous survival and as an Aboriginal and Torres Strait Islander woman and public health professional, it is a commitment I wish to hold my discipline to, so that we may be beneficiaries of the claims it makes.

Locating Indigenous knowledges in the public health program

The MPH program is an internationally recognised and interdisciplinary post-graduate qualification for individuals interested in a career within public health. The structure of the program includes 24 units, six of which are core (14 units) competency-based education and learning standards in epidemiology, biostatistics, public health practice, research methods, social perspectives of health, environmental health and health systems (figure 1). These standardised learning outcomes are designed to equip students to apply foundational knowledge in an area of specialisation. Students are also required to undertake up to four electives from postgraduate courses offered by the school of public health, and up to two electives following specialisations in Indigenous health, health promotion, nutrition, global health, alcohol, tobacco and other drugs. Each course within the program integrates a component of Indigenous health into the curriculum. The existing approach to Indigenous knowledge in public health from my experience appeared to rely on a deficit-based approach. This logic thus frames graduate thinking in how to approach Indigenous health. Rather than centre Indigenous people, community elders and scholars as knowers of the determinants of health and wellbeing or examine how public health operated as part of the colonial project in its commitment to the racial theories of a 'dying race', the curriculum appeared to sustain the power and positional superiority of western knowledges. The location of

Indigenous health-focused content at the end of term rather than at the beginning was a cause of concern among Indigenous public health peers. The refusal to foreground Indigenous health within the semester by senior teaching staff was a further indication of the prioritisation, or lack thereof, of Indigenous health within Australian public health training. The failure to attend to the concerns raised, or an offer of explanation, tells of the ongoing indifference to Indigenous health that persists in public health more broadly.

The lack of response to Indigenous students' concerns about the importance of foregrounding Indigenous health and knowledges in the program was my first encounter with the apparent disjuncture between public health claims of commitment to Indigenous health with the practicalities of public health training. It is when I first realised that I needed to armour myself intellectually and emotionally in order to navigate the program, and more specifically to protect myself against a dominant structure that did not necessarily value the contribution of Indigenous knowledges or share in my aspirations for a transformative public health agenda that was accountable to Indigenous peoples.

During my studies, it did not take long for me to become aware that the representations of Indigeneity and Indigenous health as expressed within non-Indigenous academic's teaching methods and materials was very different to my own understandings and lived experience. Non-Indigenous academics appeared to draw primarily from a western understanding of health rather than Indigenous understandings of health, as well as a pedagogical approach that refused to foreground Indigenous ways of knowing, being and doing.

Teaching methods in class occasionally open dialogue so that Indigenous students can provide insights that might address Indigenous health disparities. Whilst Indigenous students, particularly in undergraduate courses, experience cultural tensions when non-Indigenous teaching staff assume that Indigenous students are experts on Indigenous culture (Barney, 2016), as a mature-aged Masters student, the consequence of attempts by non-Indigenous educators to be 'culturally-respectful' is a silencing of our knowledges and experiences. In failing to appropriately recognise the rich knowledges and experiences of Indigenous students, notions of Indigenous deficit are upheld. This speaks to the importance of non-Indigenous educators reflecting on their problematic positioning as 'knower' in the class on Indigenous health where Indigenous knowledges and experience in the room may be silenced. I quickly learnt that evidence-based public health practice is fundamental to the development, implementation and evaluation of effective policies and programs in public health, yet the discounting of Indigenous evidence as offered by Indigenous peoples remains a key oversight in public health practice and training. This privileging of a particular kind of evidence-base constrains critical contributions to Indigenous health, as someone who brings to the classroom and discipline a lived experience and embodied knowledges. While my disciplinary training has taught me to value an evidence-based approach, I cannot accept an approach that excludes Indigenous knowledges as a legitimate form of evidence.

Absence of Indigenous knowledges

Within my MPH cohort, a majority of students were international students returning to study, as well as a few non-Indigenous Australian medical students who elected to undertake an MPH within their Doctor of Medicine program. The bulk of our training involved the development of specialised knowledge and skills about the prevention, promotion and protection of health within the western pedagogical framework (Angus *et al.*, 2016). It is the same framework that often situates Indigenous health as a subset of Australian public health and uses western knowledge as a means to come to know Indigenous peoples (Harvey and Russell-Mundine, 2019; Morrison *et al.*, 2019). The western pedagogical framework also serves as a resource for faculties and academics to *enhance excellence and education accountability* of public health teaching and learning within the school (Calhoun *et al.*, 2008; Genat and Robinson, 2010). As an Indigenous woman, I encountered difficulties in deciding how I would articulate my own unease with academics about the positioning and approach to Indigenous health and content, as any questions I raised seemed to be acknowledged but too easily dismissed. Frustratingly, I felt constrained and restricted in speaking my truth.

From discussions with my peers, there was a common theme that Indigenous health topics within numerous courses of the MPH program discussed policies of oppression and reinforced the strength of Indigenous peoples. Yet, the lack of engagement with systemic racism and the ongoing violence of colonialism seemed to cater to the need of the school to maintain the colonial power relationship through knowledge production. This denied students the opportunity to interrogate how racism has been legitimised through public health, including health systems and policies. It became clear that academics were reluctant to engage in critical discussions about these issues including interrogating individual and systemic racism within the health system and its effect on Indigenous health outcomes. Instead, in both core and elective Indigenous health subjects, historical context was often considered, but rather than examine the role of race and racism, these courses were concerned with the societal barriers that were assumed to contribute to health inequities.

The problem of Indigenous health was characterised as a societal issue about social disparities and not a political or systemic one. Despite literature highlighting the association between social disparities and the health system as a result of power, racism and oppressive policies, such analysis remains largely absent in public health discourse in higher education (Henry *et al.*, 2004; Bond, 2005). There is increasing evidence of the health effects of racism and oppressive policies that can be measured through the institutional, structural policies and social effects (Paradies *et al.*, 2008). It seemed that equipping students with valuable knowledge of systems of oppression was, and will always be, an ongoing site of resistance due to the structural forces that continue to define Indigenous health as being *less important* (Harvey and Russell-Mundine, 2019). Although a key strategy in higher education is to ensure that the provision of training and learning outcomes enhance employability among graduates (Nakata *et al.*, 2017), students lacked the fundamental skills to critically analyse how these systems of oppression work in public health and in the production of Indigenous health inequality.

Throughout my MPH, I became a student and mentor to my fellow peers and would often question the types of teaching practices and discourse that were considered standardised learning outcomes because of the limitations in teaching materials and methods. Teaching and learning outcomes appeared to be designed to equip students with the ability to apply training and foundational knowledge, skills and values in their area of specialisation, including Indigenous health. Yet this led me to question whether I was being disciplined to think a certain way and changing the very essence of my own understandings of my identity.

Starting the postgraduate program, I had a keen interest in thinking deeply and critically about Indigenous health but I quickly felt constrained and, as a result, I fell silent. I was isolated as there were no Indigenous academics within the school to reflect, yarn and to whom I could express my concerns. I had thought undertaking an Indigenous public health course within my program would give strength to my embodied knowledge and provide a safe space to interrogate racialised inequities. However, I quickly realised the course was not structured nor designed by Indigenous health scholars within the university. As an Indigenous woman, I questioned the values, beliefs and knowledge of academic staff delivering the course, whether the course would provide a culturally safe space, and whether the safety of my cultural needs would be met if I contested the theories and the actions of staff (Wepa, 2003; Gerlach, 2012). As I felt I was being disciplined to develop a western public health framework, I questioned how non-Indigenous academics so readily dismissed my concerns in contesting knowledge and engaging in critical discussions.

Seeking support, I spoke with Indigenous peers who had undertaken the course previously. In essence, they affirmed that the course was dominated by western ways of knowing and positioned Indigenous health issues as too complex to address and discuss with students (Harvey and Russell-Mundine, 2019). The structure of the course provided theoretical and practical understandings of contemporary health systems (Genat *et al.*, 2015); rather than incorporate a strengths-based Indigenist practice through meaningful transformational learning in centring the importance of reconfiguring power relationships that privilege Indigenous ways of knowing about our health. Transformative learning approaches in the form of critical self-reflective practice and cultural reflexivity are an important element of competency for students (Public Health Indigenous Leadership in Education Network, 2016; Somerset *et al.*, 2016). However, there remains an absence of critical analysis that resists positivist and post-positivist teaching and methodologies that tend to validate colonising knowledge about Indigenous people (Saunders *et al.*, 2010). The inherent need to dismantle the system is the work of decolonised practice that speaks against the deficit discourse and centres Indigenous strengths-based practice (Henry *et al.*, 2004; Askew *et al.*, 2020). Yet, I still questioned whether my training equipped me with the skills and knowledge necessary to work within public health and feel confident to challenge the health system that focused attention on disparity rather than the strength and success of Indigenous-led health programs. I felt as though the absence of an Indigenous criticality in terms of content and method was a glaring omission, not only because of my embodied experience as an Indigenous woman, but one that fails to equip prospective public health professionals with the ability to facilitate better outcomes for Indigenous people.

Location of Indigenous people in public health

I can recall two specific incidents which illuminated for me, the need to interrogate the theoretical underpinnings of Indigenous health within higher education and specifically, my training. These incidents revealed the location of Indigenous people as sites of public health interventions and benevolence rather than as key leaders capable of offering solutions. One experience involved an academic who labelled me 'a problem' for questioning the content that reproduced racialised logics about Indigenous people, our health and Indigenous public health practice. Not only were the stories expressed within the course about 'the problems' within Indigenous health, the academic staff member attempted to oppress my voice, embodied knowledge and understanding. It made me question the claims public health makes about improving Indigenous health, having experienced the kind of epistemic violence which Spivak (1988) speaks to on the subject of marginalising voices and inflicting harm within a western discourse (Spivak, 1988). I experienced violence in the silencing of Indigenous voices and experiences both in the content, and in my raising concerns. This experience reaffirmed to me the centrality of race, power and privilege in improving the circumstances of Indigenous peoples, including those of us seeking to both understand and undermine them.

The other experience occurred at an annual national public health prevention conference. As an organising conference committee member, I arranged for a prominent Aboriginal female academic to present as a keynote speaker in the closing ceremony. Ten minutes before the keynote speakers arrived, I noticed her academic title was not included, nor was there a prefix title. Despite raising my concerns with the conference staff to address the problem, nothing was done. As the academic gave her keynote speech, I witnessed first-hand the violence of my discipline upon the senior academic Aboriginal women. Further, the Chief Executive Officer of the association appeared more interested in attending to their mobile device, than respecting the keynote speakers' critique of the public health system. This left me visibly upset and angry that I could not protect her from the sheer ignorance and dismissal of her voice, her intellect and presence, but it took me back to my experience as an Indigenous student whose knowledge and experience too had been routinely dismissed. The question of how to protect myself from the violence of public health continued to circulate in my mind and in particular the varying ways it seemed to police Indigenous thought and emotion.

These encounters also provided a deeper insight into the systematic and structural violence including the violence upon Indigenous bodies that insist Indigenous people are an inherent problem and thus incapable of providing solutions (Askew *et al.*, 2020). It also provoked reflection around the complex nature of politics in health and the underlying need to restructure Indigenous health education to dismantle an inequitable system. Furthermore, it reaffirmed the need to restructure the program so that it challenges students to extend themselves beyond the constraints of western epistemological frameworks; and for non-Indigenous students to critically reflect on their complicity with ongoing practices of colonialism (Nakata *et al.*, 2012). I realised transforming Indigenous health outcomes requires more than acquiring core knowledge and skills through a western epistemological framework through higher education. It also requires more than educating about Indigenous strengths instead of deficits; it demands attending to race as an oppressive structure which produces the racialised health outcomes Indigenous peoples experience alongside a more meaningful engagement with Indigenous knowledges. It requires incorporating an Indigenist approach to transformative learning to shift the power of paternalistic coursework content and the delivery of lecture styles that reproduce Indigenous health as well as Indigenous being as a deficit (Nakata *et al.*, 2012; Askew *et al.*, 2020).

National Indigenous Public Health Framework

The National Indigenous Public Health Framework Curriculum (NIPHFC) was first developed in 2008 as part of the Indigenous

Public Health Capacity Development Project of the Public Health Education and Research Program (Genat, 2008). It was endorsed by the Australian Network of Academic Public Health Institutions (ANAPHI) that provided advice on the development of the curriculum framework; and incorporated six core Indigenous health competencies across the MPH program and standardised learning outcomes (Genat and Robinson, 2010). It involves core competencies in analysing key comparative health indicators regarding social determinants of health for Indigenous peoples and describing Indigenous health in the historical context through analysing the impact of colonial processes on health outcomes (Genat, 2008).

A revised NIPHFC framework was released in 2017 focusing on Indigenous capacity development across the health spectrum with a specific emphasis on building cultural capabilities (Lee *et al.*, 2017). The framework emphasised the need to address institutional racism in the health system in order to achieve health equality (Lee *et al.*, 2017). This was also outlined in the ANAPHI—Foundation Competencies for Public Health Graduates in Australia that described the comprehensive spectrum of competencies to benchmark curriculum development in the MPH program (Somerset *et al.*, 2016). However, the need to address institutional racism was only included in the context of public health policy and program course content. The revised framework outlined the core competencies to apply additional understandings necessary to evaluate Indigenous health, which included colonisation and health and the local experiences of racism and its institutional manifestations and effects (Lee *et al.*, 2017). Despite the incredible value the framework brings to Indigenous public health, it appeared that racism in the health system was seen as only relevant to health policy and programs—and not across the spectrum of public health education. It also became apparent that the development of framework included editors from UQ; however, the university did not participate in the curriculum review of Indigenous public health. In essence, this reaffirmed my personal experience of the lack of Indigenous presence and capacity within the school to integrate critical evaluations and interrogations into the nature and ubiquity of race as not only operating within the health system, but within public health education.

In 2009, ANAPHI endorsed the *foundation competencies for MPH graduates in Australia* that guide the development of standardised learning outcomes using a set of key public health functions (Genat and Robinson, 2010). The guide emphasised the underlying assumptions that;

> 'all Australian MPH 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' (Genat *et al.*, 2009).

A revised Australian Public Health Competency guide was developed in 2015, under the auspices of the Council of Academic Public Health Institutions Australia (CAPHIA) that involved more than 20 Australian universities offering the MPH program, of which included UQ (Genat *et al.*, 2015). Again, both guides referred to the fundamental importance of Indigenous health within health policy and health promotion. The guides emphasised competency in health promotion as being able to 'describe Indigenous health in historical context and analyse the impact of colonial processes on health' (Genat *et al.*, 2009, 2015). My experience within the program made it clear that the criticality of that rationale was only demonstrated in the most superficial way. Possibly, due to two reasons – limited understanding and critical analysis of the context, or lack of willingness to accept ongoing colonial practices and process that continues to operate in the current health system and within health research.

Competency standards in the revised guide were considered useful for students, and 'critical to maintaining the standard of Master of Public Health courses in the current (and changing) health policy context' (Genat and Robinson, 2010). But useful in what way? Whilst the conceptual and theoretical framework centred on the assessment, analysis and communication of population health trends, reflecting on my experience, it appeared that little had changed (Paradies *et al.*, 2008; Harvey and Russell-Mundine, 2019). Topics on the lack of cultural safety at both individual and institutional levels, ethical decisions within public health, oppressive health practices, dehumanisation of Indigenous people and the lack of culturally sensitive and appropriate communicative practises within health institutions are a part of the cultural dimensions within Indigenous health that must be implemented as a core component within the program. Without this integral knowledge, I believe the next cohort of MPH students will not be prepared nor adequately trained to critically evaluate significant contributions to ill-health for Indigenous peoples; including understanding how to address these challenges that are embedded within institutions and the health system. Throughout my studies, it was evident that critical analysis of the Australian public health system and its contributions to health disparities continues to remain hidden, reinforcing that the health system is 'built on the cultural stance of the population it serves' (Henry *et al.*, 2004; Bourke *et al.*, 2019). If public health training at national institutional levels was committed to *quality, training and accountability*, then incorporating an Indigenist approach through transformative learning centres the knowledge of Indigenous public health leaders in academia. It is also an opportunity to decolonise the curricula and transition Indigenous health as a core competency.

The benefits and limitations of reflective practice in the MPH framework

As a social scientist, I have been trained to draw upon my life experience through reflective practice to guide and define analysis. This reflective practice is essential for investigating the connections between practice and theory. It is a skill that is incredibly valuable to any public health professional; particularly around the design, evaluation and assessment of models and practices of care (Mann *et al.*, 2009; Fragkos, 2016). It also benefits ethical decision-making within public health and research as it involves careful reflection and intentional decision-making to fulfil public health obligations (Jennings, 2020). Whilst it is a tool that can be used to improve a professional's ability to render visible and assess their own values, belief systems and approaches to public health practice, it also challenges students to contest assumptions that inform their knowing through dialogue with peers and patients in order to better address health outcomes (Joyce-McCoach and Smith, 2016).

To some degree, critical reflective practice was embedded in a few core subjects. This involved reflective journal writing and the development of qualitative approaches to thematic analysis. However, critical reflective practice was not expanded into all areas of the public health program nor the public health sector.

I would often encounter situations with other health professionals (in a working environment) who were in a position of power but lacked the ability to recognise the systemic challenges Indigenous peoples encounter. This lack reinforced to me the limitations of public health practitioners who do not have an understanding of how power works, including within their disciplinary practice. Reflexivity is useful in critically evaluating public health policy or programs as it considers how power operates during access, treatment and discharge (Ewen *et al.*, 2012). Yet, working alongside public health professionals highlighted the differences in its application that seemed to benefit unfavourable collaborations that were not culturally appropriate. These collaborations did not value Indigenous contributions within decision-making to improve practices and achieve health goals within Indigenous communities despite there being known Indigenous leaders within health advancement. Measuring the impact of health promotion within the health system lacked Indigenous knowledges within a health-workforce, and effective leadership and governance to prevent institutionalised racism (Bourke *et al.*, 2019). The concept and practice of institutional racism operates in such a way that discriminates, controls and oppresses Indigenous populations in the form of funding inequities, lack of culturally appropriate treatment procedures and access to services (Henry *et al.*, 2004; Paradies, 2016).

I witnessed the failure of colleagues to apply reflective practice that became more prominent in team-work activities. The capacity of team members to engage in reflective practice to expose power and privilege was not apparent. An example of this was an incident involving a team member's statement that my analysis of a research area was not necessary as they considered their work sufficient; despite my contribution providing a critical and otherwise ignored Indigenist lens to health research and practice. Whilst I believed this approach would afford team members the ability to recognise the value of an Indigenist lens to health practice and research, it became apparent the team member lacked the ability to understand a framework of position of privilege and power; and without the ability to critically reflect on this, had a direct consequence of the negative effect of these contested views and my contact and communication with them (Jongen *et al.*, 2018). This approach would assume western knowledge as fundamental or superior and the only rational ideas to hold (Tuhiwai Smith, 2012). It also further marginalises and excludes Indigenous knowledge holders and advisors and questions whether the research is ethical, respectful, reflexive, critical and culturally appropriate. Within my representative positions, it became apparent the more knowledge and skills I acquired and the confidence I displayed in vocalising this, a deeper problem persisted in colleagues not acknowledging my contributions within health practice and research. These attempts at silencing exemplify the privileging of western knowledge and as such remains an ongoing challenge in addressing health disparities and dismantling systems of oppression.

This challenge became more apparent in my position as a member of an advisory group at a local hospital. It became a constrained setting to work in due to limited ability of team members to apply critical reflections of their own unconscious bias, position of privilege and understanding power imbalance in decision-making. An example is a discussion relating to the role and responsibility of a patient entering a healthcare institution. Members of the committee protested that a patient must act responsibly when accessing the health service, despite the more fundamental concern that the health workforce has a responsibility to treat patients accessing the service respectfully and in a culturally appropriate manner. It struck me how swiftly patient concerns could be silenced particularly given my training had taught me of the importance of *effective communication styles* as one means by which we could undermine the continued oppression of Indigenous peoples within the health system (Henry *et al.*, 2004). Examining these relationships made me realise the need to drive transformative learning within public health that is conducive to *meaningful* critical reflections within learning environments; to ensure services are culturally safe and meet the direct needs of Indigenous Australians (Bullen and Roberts, 2018).

The ability to apply reflective practice *must* become a habitual action considering it is a core component within public health. Embedding this component in all facets of the program equips students with the ability to critically analyse the dynamics of power, privilege and individual bias associated with professional status (Jongen *et al.*, 2018). Reflective practice can strengthen health professional's cultural knowledge, engagement and enhance personal development by leading to self-awareness and better health service delivery for Indigenous people (Ewen *et al.*, 2012; Jayatilleke and Mackie, 2012; McKay and Dunn, 2014).

The Poche Centre Winter Research Program

The UQ Poche Centre Winter Research Scholarship provides Indigenous students with an opportunity to gain research experience and work alongside the university's leading academics and researchers. It is offered mid-year for a period of approximately 4 weeks. The research project I applied to join involved investigating and critically analysing coronial cases of preventable Indigenous deaths within the Australian health system. It included a textual analysis of coronial inquiries and investigating how race and racism works through coronial findings. Participating in this program was the catalyst for me realising the limitations of my training that failed to adequately prepare me to think critically about the Australian health system's models of care, the indirect and direct effects of systemic racism and the inequities of the health system. The research scholarship allowed me to interrogate my own unconscious bias, to reflect on the importance of self-care/personal healing as well as core competencies in prevention, promotion and protection of health. Despite my training, I needed to armour myself every day to prepare for the psychological battle and challenges of engaging in a textual discourse analysis of coronial findings.

But this discomfort and unease was different to that which I experienced in my MPH training because it allowed me to think deeply and critically about the ways in which the health system fails Indigenous peoples, and to identify systematic silences. While it remains incredibly difficult and upsetting trying to describe this violence by giving an account of the evidence, through this research, I was encouraged to recognise the power of Indigenous voices in the coronial cases, their untold truths and strength. This approach was contrastingly different from the classroom tutorials I experienced in the MPH. In sitting with these accounts, I felt a deep inherent fear that I, or my own family, could be subjected to such violence within the health system that would ultimately cause a preventable death, in the course of seeking help within a health system that claims to be patient-centred.

My experience during this research became a driving force for critically evaluating and exploring how models of care claim to be designed to optimise the health system to improve Indigenous

health outcomes; but fails Indigenous peoples in the most fundamental ways and with the most-dire consequences. More importantly, it became a personal commitment to change and contest the barriers and structures that oppress Indigenous people in the health system. This experience allowed me to apply an Indigenist lens in research without constraints or the requirement to work *within scope*. It allowed me to become increasingly aware of the lack of engagement in critical discussions with academic staff through the remainder of my postgraduate degree that was often stagnant due to the inability to actively engage and encourage critical discussions on systematic factors contributing to health disparities. The failure to incorporate these critical discussions legitimises the power relationships that underpin racism (Stanley *et al.*, 2019).

The nature and efficacy of communication and information in the health system and the degree to which risk is communicated is critical to the process of culturally safe health care delivery. It was confronting to comprehend the process by which coronial findings make determinations about Indigenous deaths in the health system while there is an absence of recommendations or reform in public health policymaking, and prevention strategies associated with so many Indigenous deaths in health. The coronial system continues to fail to address racism within the health system and hold health professionals accountable for preventable Indigenous deaths. Working as a collective with my direct supervisors and fellow research team members, I discovered the detrimental limitations of my public health training and limited ability to apply an Indigenist lens within a majority of core components of the MPH.

An Indigenist framework in public health education

The dominant western public health framework reproduces racialised social structures and power inequities between privileged and oppressed populations (Durey and Thompson, 2012). Despite the overwhelming evidence that health inequalities, including those experienced by Indigenous peoples are socially determined, there remains limited engagement with the social sciences and for that matter the social world of Indigenous peoples. Not only are there significant gaps in the framework; the situation is worse in institutions with a shortage of Indigenous public health expertise, knowledges and perspectives among teaching staff and within primary programs in the school (Coombe *et al.*, 2019). Primary components for both Indigenous and non-Indigenous students in preparation for work in the field of public health and future engagement with Indigenous peoples is more than understanding and applying core competencies; it demands an understanding of Indigenous knowledges, cultures, historical contexts and the contemporary concerns and matters that directly impact communities (Harvey and Russell-Mundine, 2019).

Each competency within public health begins with an introduction of the underpinning knowledge around public health history and the rationale of appropriate study designs and research methods (Coombe *et al.*, 2019). Yet, without embedding Indigenous historical and current social conditions that continue to further sustain inequitable power dynamics and legitimise a violent health system, it is all but meaningless (Durey and Thompson, 2012). Few courses within the MPH highlighted the history of privilege begins with how health is conceptualised, and whose ways of thinking about health is embedded within the health system; from the types of services and the delivery of these services, to health policies and public health interventions. Public health needs to equip graduates with a criticality about it as a discipline which includes an understanding that 'Indigenous health' as conceived through public health has failed Indigenous peoples, thus enabling 'less leeway for systemic or interpersonal bias in public health and clinical decision-making' (Paradies *et al.*, 2008). The limited capacity of non-Indigenous academics teaching Indigenous health to engage in this disciplinary criticality impacts their ability to constructively comprehend and address challenges of systematic failures, thus subsequently affecting their willingness and ability to integrate Indigenous content (Coombe *et al.*, 2019). Consequently, future public health professionals will not be well-equipped to critically evaluate and reflect on how the values, norms and practices of contemporary structures and institutions consider one group superior to others (Bastos *et al.*, 2018).

Embedding an Indigenist approach through transformative learning shifts a more empowering and self-determining outcome and reconfigures public health training. It also contributes to the fundamental need of a decolonised rationale and pedagogical reform that aligns with social justice framework in Indigenous health (Nakata *et al.*, 2012; Askew *et al.*, 2020). Increasing the presence of Indigenous public health academics, community elders involvement in the school, and centring Indigenous collective memory and shared experience as a valuable resource to public health also works towards a meaningful engagement in cultural safety philosophically and practically. It also recognises Indigenous public health must no longer remain a subset of public health core competencies.

The failure to embed cultural respect and safety within the curriculum, both as content and pedagogy, the school will continue to increase the risk of culturally unsafe experiences for Indigenous peoples across the health system. The provision of culturally safe practice and culturally competent health professionals requires a sustained focus of Indigenous ways of knowing and teaching. Integrating an Indigenist strengths-based training approach across public health competencies within the program is fundamental to addressing the identified gap in Indigenous health (Coombe *et al.*, 2019). A challenge is the lack of willingness to embed a decolonised approach of Indigenous health knowledge as well as address how racism works within public health education.

Conclusion

The MPH program has not been an easy path and not because I could not thrive academically, but because I succeeded academically in spite of being in a culturally unsafe environment—such demands take a toll upon the Black body which cannot be revealed in grade point averages or teaching evaluations. It has been difficult navigating public health training and practice due to the constrained conceptual framework of my learning and work environments which exacts a particular kind of violence upon those of us working within them. I struggled with even telling this story for fear of repercussions for sharing my experiences and insights. I had to censor and keep vague some of my experiences in order to protect myself and others.

My experience in public health as an Indigenous woman was one in which I felt the layers of my identity being stripped away, seeking to change the very essence of who I was; moulding me into what was deemed *adequate*. My training and practice taught me to rely on the authority of a public health research literature about Indigenous peoples by non-Indigenous peoples,

rather than the authority of my own voice and experience to advocate for meaningful reform. Barriers are still present that limit possibilities for change that might improve Indigenous health outcomes, even in an era committed to embedding Indigenous knowledges and addressing inequalities in higher education.

There is a need for pedagogical reform in public health higher education. Such reform must not only include Indigenous knowledges, but must privilege Indigenous knowledges in health education in order to improve health outcomes for Indigenous peoples. Despite current attempts to incorporate and embed Indigenous knowledges within the public health curricula, the decision to utilise this opportunity to initiate greater reform lies at a national public health level. Considering the reluctance and failure to recognise Indigenous sovereignty, engage with Indigenous public health scholars, identify racism as a public health crisis and reconfigure power relationships between Indigenous and non-Indigenous people—I question the capacity of the national public health agenda/plan and health research, and its investment in Indigenous excellence as leaders in health advancement within Indigenous health.

Acknowledgements. I would like to acknowledge the Turrbal and Jagera peoples, whose ancestral lands the University of Queensland now stands. I pay my respects to their Elders past, present and emerging including my ancestors who have paved the way for me to continue my cultural growth and cultural knowledge. This paper has benefited greatly from the comments and critiques made by Helena Kajlich, Janet Stajic, Associate Professor Chelsea Bond, Eylania Naawi, Dr Bryan Mukandi, Dr David Singh, Dr Alissa Macoun, Ali Drummond and Associate Professor Lisa Whop. I extend my deepest appreciation and gratitude to you all. Special thanks to Helena Kajlich and Associate Professor Chelsea Bond for guiding me and believing in me, and for the opportunity to contribute to this special issue.

Conflict of interest. The author declares no potential conflicts of interest with respect to the research, authorship and/or publication of this paper.

References

Angus L, Ewen S and Coombe L (2016) Aboriginal and Torres Strait Islander public health: online and integrated into core Master of Public Health subjects. *Journal of Public Health Research* **5**, 32–35.

Askew D, Brady K, Mukandi B, Singh D, Sinha T, Brough M and Bond C (2020) Closing the gap between rhetoric and practice in strengths-based approaches to Indigenous public health: a qualitative study. *Australian and New Zealand Journal of Public Health* **44**, 102–105.

Barney K (2016) Listening to and learning from the experiences of Aboriginal and Torres Strait Islander students to facilitate success. *Student Success* **7**, 1–11.

Bastos J, Harnois C and Paradies Y (2018) Health care barriers, racism, and intersectionality in Australia. *Social Science and Medicine* **199**, 209–218.

Bond C (2005) A culture of ill health: public health or Aboriginality? *Medical Journal of Australia* **183**, 39–41.

Bourke C, Marrie H and Marrie A (2019) Transforming institutional racism at an Australian hospital. *Australian Health Review* **43**, 611–618.

Bullen J and Roberts L (2018) 'I wouldn't have been culturally safe': health science students' experiences of transformative learning within Indigenous studies. *Journal of Higher Education Research & Development* **38**, 688–702.

Calhoun J, Ramiah K, McGean Weist E and Shortell S (2008) Development of a core competency model for the master of public health degree. *American Journal of Public Health* **98**, 1598–1607.

Coombe L, Lee V and Robinson P (2019) Educating for Indigenous public health competence – how do we stack up in Australia? *Australian and New Zealand Journal of Public Health* **43**, 143–148.

Durey A and Thompson S (2012) Reducing the health disparities of Indigenous Australians: time to change focus. *BMC Health Services Research* **12**, 1–11.

Ewen S, Hill S and Paul D (2012) Revealing the (in)competency of 'cultural competency' in medical education. *AlterNative: An International Journal of Indigenous Peoples* **8**, 318–328.

Fragkos K (2016) Reflective practice in healthcare education: an umbrella review. *Education Science* **6**, 1–16. doi: 10.3390/edusci6030027.

Genat B (2008) *National Indigenous Public Health Framework*. Retrieved from http://www.phile.net.au/files/site/docs/PHERPFramework.pdf.

Genat B and Robinson P (2010) New competencies for public health graduates: a useful tool for course design. *Australian and New Zealand Journal of Public Health* **34**, 513–516. doi: 10.1111/j.1753-6405.2010.00599.x.

Genat B, Robinson P and Parker E (2009) *Foundation competencies for Master of Public Health graduates in Australia*. Retrieved from http://caphia.com.au/documents/Competencies-MPH-Graduates-Australia-ANAPHI-2009.pdf.

Genat B, Robinson P and Parker E (2015) *Foundation competencies for Public Health graduates in Australia*. Retrieved from http://caphia.com.au/testsite/wp-content/uploads/2016/07/CAPHIA_document_DIGITAL_nov_22.pdf.

Gerlach A (2012) A critical reflection on the concept of cultural safety. *Canadian Journal of Occupational Therapy* **79**, 151–158.

Harvey A and Russell-Mundine G (2019) Decolonising the curriculum: using graduate qualities to embed Indigenous knowledges at the academic cultural interface. *Teaching in Higher Education* **24**, 789–808.

Henry B, Houston S and Mooney G (2004) Institutional racism in Australian healthcare: a plea for decency. *Medical Journal of Australia* **180**, 517–520.

Jayatilleke N and Mackie A (2012) Reflection as part of continuous professional development for public health professionals: a literature review. *Journal of Public Health* **35**, 308–312.

Jennings B (2020) Ethics codes and reflective practice in public health. *Journal of Public Health* **42**(1), 188–193.

Jongen C, McCalman J and Bainbridge R (2018) Health workforce cultural competency interventions: a systematic scoping review. *BMC Public Health* **18**, 1–15.

Joyce-McCoach J and Smith K (2016) A teaching model for health professionals learning reflective practice. *Social and Behavioral Sciences* **228**, 265–271.

Lee V, Allen C, Robinson P, Jessen J, Angus L, McLachlan E, Coombe L, Genat B (2017) National Aboriginal and Torres Strait Islander Public Health Curriculum Framework. Retrieved from http://caphia.com.au/testsite/wp-content/uploads/2016/07/Curriculum-Framework-2nd-Edition.pdf.

Mann K, Gordon J and MacLeod A (2009) Reflection and reflective practice in health professions education: a systematic review. *Advances in Health Sciences Education* **14**, 595–621.

McKay F and Dunn M (2014) Student reflections in a first year public health and health promotion unit. *Reflective Practice – International and Multidisciplinary Perspectives* **16**, 242–253.

Moreton-Robinson A (2013) Towards an Australian Indigenous Women's standpoint theory: a methodological tool. *Australian Feminist Studies* **28**, 331–347.

Morrison A, Irabinna-Rigney L, Hattam R and Diplock A (2019) *Toward an Australian culturally responsive pedagogy: a narrative review of the literature*. Retrieved from University of South Australia.

Nakata M, Nakata V, Keech S and Bolt R (2012) Decolonial goals and pedagogies for Indigenous studies. *Decolonization: Indigeneity, Education and Society* **1**, 120–140.

Nakata M, Nakata V, Day A and Peachey M (2017) Closing gaps in Indigenous undergraduate higher education outcomes: repositioning the role of student support services to improve retention and completion rates. *The Australian Journal of Indigenous Education* **48**, 1–11.

Paradies Y (2016) Colonisation, racism and Indigenous health. *Journal of Population Research* **33**, 83–96.

Paradies Y, Harris R and Anderson I (2008) *The impact of racism on Indigenous health in Australia and Aotearoa: towards a research agenda*. Retrieved from Darwin: http://dro.deakin.edu.au/eserv/DU:30058493/paradies-impactofracism-2008.pdf.

Public Health Indigenous Leadership in Education Network (2016) *National Aboriginal and Torres Strait Islander Public Health Curriculum Framework*. Retrieved from Canberra.

Rigney L-I (1999) Internationalization of an Indigenous anticolonial cultural critique of research methodologies: a guide to Indigenist research methodology and its principles. *Wicazo Sa Review* **14**, 109–121.

Saunders V, West R and Usher K (2010) Applying Indigenist research methodologies in health research: experiences in the borderlands. *The Australian Journal of Indigenous Education* **39**, 1–7.

Somerset S, Robinson P and Kelsall H (2016) *Foundation competencies for Public Health graduates in Australia*. Retrieved from http://caphia.com.au/test-site/wp-content/uploads/2016/07/CAPHIA_document_DIGITAL_nov_22.pdf.

Spivak G (1988) *Can the Subaltern Speak?* Urbana and Chicago: University of Illinois Press.

Stanley J, Harris R, Cormack D, Waa A and Edwards R (2019) The impact of racism on the future health of adults: protocol for a prospective cohort study. *BMC Public Health* **19**, 1–10.

Tuhiwai Smith L (2012) *Decolonizing Methodologies – Research and Indigenous Peoples*, 2nd Edn. London, UK: Zed Books.

Wepa D (2003) An exploration of the experiences of cultural safety educators in New Zealand: an action research approach. *Journal of Transcultural Nursing* **14**, 339–348.

Natasha Lee is a Mualgal (Moa Island, Torres Strait), Yidinji, Kullili and Dunghutti woman who holds a Bachelor of Arts Degree in Anthropology and Sociology, and a Master of Public Health Degree from the University of Queensland.