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… but what about the Aboriginal and/or Torres Strait Islander Health Worker academic? Transcending the role of 'unknowing assistant' in health care and research through higher education: a personal journey

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Research Article

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Abstract

The Aboriginal and Torres Strait Islander Health Worker/Practitioner (A&TSIHW) workforce provides not only clinical skills but also responds to specific social and cultural needs of the communities they serve bringing knowledge derived from lived and embodied knowledges. The A&TSIHW is a recognised health professional within the Australian health system; however, this workforce continues to be under-supported, under-recognised and under-utilised. A common discourse in literature written *about* A&TSIHWs focused on the need to empower and enhance the A&TSIHW capabilities, or rendered the A&TSIHW as part of the problem in improving the health of Indigenous peoples. In contrast, articles written *by* A&TSIHWs, published in the *Aboriginal and Islander Health Worker Journal*, tell a different story, one about the limitations of the health system in its ability to care for Indigenous peoples, recognising A&TSIHW leadership. This paper deals with two interrelated tensions—the undervaluing of the A&TSIHW as a clinician and the undervaluing of the A&TSIHW as an academic—both of which the author has had to navigate. It explores the specific challenges of the A&TSIHW academic who too seeks recognition beyond that of 'assistant' within the research enterprise, drawing upon personal experiences and engagement with educational institutions, including higher education.

Introduction

I am a Yidinji Jirrbal woman of Far North Queensland, living in South East Queensland. I am currently undertaking a Doctor of Philosophy (PhD) within the Faculty of Medicine at the University of Queensland (UQ) and my research aims to explore the work of Aboriginal and/or Torres Strait Islander Health Workers and Practitioners (A&TSIHWs) and the ways in which they conceptualise 'health' and 'health care'. I am a trained and experienced A&TSIHW and have worked in Indigenous health research for several years. My scholarship seeks to illuminate the work of A&TSIHWs beyond that which the health system expects them to do recognising that despite being a most critical part of the Indigenous health workforce, the A&TSIHW tends to be relegated to the role of 'assistant' rather than a clinician in their own right. In this paper, I want to explore the more specific challenges of the A&TSIHW academic who too is seeking recognition beyond that of 'assistant' within the research enterprise, drawing upon my own experiences and engagement with educational institutions, including higher education.

Within the health research workforce, we observe a certain recognition of nurse academics, allied health professional academics and doctors, for example, who are recruited to research teams to impart their expertise knowledge and skills, but what about the A&TSIHW academic? There are many A&TSIHWs across the country in urban, regional and remote areas who are invited to be part of research teams, on research projects relating to Indigenous health and wellbeing, though in my observation they often are not included as members of investigative teams, rather they are confined to the role of 'research assistant' doing what can be considered the 'dirty work' of data collection. Despite the wealth of embodied knowledge, cultural understandings and clinical skills they bring into research spaces, it would seem that their intellectual contribution to research is undervalued.

This paper traces the pathway of A&TSIHW to A&TSIHW academic—a pathway that has yet to be considered in the health research workforce literature. It deals with two interrelated tensions—the undervaluing of the A&TSIHW as a clinician and the undervaluing of the A&TSIHW as a researcher/academic—both of which I have had to navigate. Here I tell my story alongside the story that is told about the A&TSIHW and their capabilities, and discuss the danger of capacity-building agendas in Indigenous health workforce and Indigenous

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health research that insist Indigenous peoples remain as assistants to both the 'real' clinicians and the 'real' knowers.

In telling my story here, I am claiming my sovereignty as a Yidinji Jirrbal woman. Moreton-Robinson's Indigenous Women's Standpoint Theory recognises the centrality of Indigeneity, and my story and experiences as integral to the process of knowledge production, rather than from the perspective of an observer, and enables my Indigeneity to be at the forefront (Moreton-Robinson, 2013). This scholarly positionality draws from my lived experiences as an Aboriginal woman and as someone who has occupied the role of A&TSIHW, situated at the bottom of the health hierarchy. This under-recognition of the A&TSIHW workforce is reflected in its positioning at the bottom of the health system hierarchy, wage recognition and inadequate career pathways (Mitchell and Hussey, 2006; Abbott *et al.*, 2007; Health Workforce Australia, 2011; McGilvray, 2014; Briscoe, 2019; Wright *et al.*, 2019). It is from this vantage point that I tell this parallel story of disempowerment in various employment and educational contexts. Telling my story is important in that it will help bring to life and humanise the issues faced by A&TSIHWs and A&TSIHW academics, empowering them to speak out, and motivate others, i.e. other health professionals and staff, policy and decision makers, health care services and training and higher education institutes to make positive changes. I have taken care, as I believe it is ethical, to protect the anonymity of individuals and organisations as the issues discussed here are not specific to any particular individual or organisation. In the context of ongoing colonisation, these are systemic issues which can be found anywhere.

Background: the significance of A&TSIHWs as a clinician or health professional

The A&TSIHW workforce is unique in that in addition to the clinical skills that they provide, A&TSIHWs respond to specific social and cultural needs of the communities they serve. Typically, this knowledge is not derived from formal training, but from the lived and embodied knowledges possessed by Aboriginal and Torres Strait Islander peoples. The requirement for cultural knowledge and expertise sees the A&TSIHW workforce as the only ethnic-based health workforce in Australia (Briscoe, 2019; National Aboriginal and Torres Strait Islander Health Worker Association, 2019).

Describing A&TSIHW roles is not straight forward due to the varying job titles an A&TSIHW may hold and the diverse scopes of practice and speciality areas they work within. A&TSIHWs work across the Aboriginal Community Controlled Health Services (ACCHS) sector, the private health sector (i.e. general practice) and the public health sector, within primary health care, allied health, specialist care and hospital settings across urban, regional and remote areas. A&TSIHWs often work within multi-disciplinary teams with other health professionals, such as doctors, dentists, nurses and midwives, allied health professionals, researchers, policy makers and educators (NSW Government, 2018; Aboriginal Health Council of South Australia, 2019). A&TSIHWs work not only to improve health outcomes for Indigenous people but also to improve their experiences with the health system. A&TSIHWs also act as cultural brokers within these teams, breaking down cultural barriers that exist between Indigenous people and non-Indigenous health professionals and staff (Mitchell and Hussey, 2006; Abbott *et al.*, 2007; Hudson, 2012; Hill, 2018).

A&TSIHWs have led innovations in Indigenous health improvement long before mainstream services began to focus on an Indigenous health workforce agenda (Glover, 1987; Abbott *et al.*, 2007; Abbott and Elliott, 2013; Best and Fredericks, 2014; Robson, 2016; Riley, 2018). The A&TSIHW workforce first began in the tradition of Ngangkari and midwives in the Northern Territory with Aboriginal people, usually women, being employed as leprosy workers and medical assistants in the 1950s (Abbott *et al.*, 2007; Abbott and Elliott, 2013; Robson, 2016; Riley, 2018). Aboriginal traditional midwives have practiced within communities for tens of thousands of years. It was not until the 1950s that Aboriginal and Torres Strait Islander women began birthing in western health facilities and some A&TSIHWs received speciality training in midwifery (Glover, 1987; Best and Fredericks, 2014).

The A&TSIHW role has been flexible with a diverse scope of practice that continues to evolve to meet local needs with program-based funding models largely influencing the types of roles in demand. The variability in these roles contributes to the lack of understanding and subsequent undervaluing, limiting potential impact of this workforce (Abbott *et al.*, 2007; Health Workforce Australia, 2011; Hill *et al.*, 2018; NSW Government, 2018; Briscoe, 2019; Wright *et al.*, 2019). Despite possessing invaluable skills, A&TSIHWs remain to be the lowest paid and least recognised of the health professional groups within the Australian health system (Mitchell and Hussey, 2006; Abbott *et al.*, 2007; McGilvray, 2014). This under-recognition is also reflected in the A&TSIHWs positioning at the bottom of the health system, and inadequate career pathways (Mitchell and Hussey, 2006; Abbott *et al.*, 2007; McGilvray, 2014).

The A&TSIHW workforce emerged and grew in response to the needs and priorities of a health system that has typically failed Aboriginal and Torres Strait Islander peoples (McGilvray, 2014). The responsibility placed on the shoulders of A&TSIHWs to fix the health systems' failings whilst trying to overcome structural barriers that are causing Indigenous health inequalities is enormous. Improving the health of Aboriginal and Torres Strait Islander people not only requires A&TSIHWs to perform biomedical health care intervention, it also requires advocacy, activism and education of other health care professionals. A&TSIHWs have tirelessly performed this work for decades from the least powerful position of an oppressive structure (Sherwood, 2013; Watson, 2016). Even the move to professional registration, meaning that the clinical proficiencies of A&TSIHWs are now recognised, has not solved the issues surrounding power imbalances and in some cases has impacted negatively by limiting A&TSIHW practice (Briscoe, 2019). A&TSIHWs are typically not university trained as a requirement of the job but are required to complete vocational training in Aboriginal and Torres Strait Islander Primary Health Care. Many A&TSIHWs have sought out various educational opportunities beyond the standard vocational training required, from short courses, to undergraduate and postgraduate programs including PhDs.

A&TSIHW discourse

There is no shortage of evidence to support that multidisciplinary teams which include A&TSIHWs produce greater outcomes in terms of improving Aboriginal and Torres Strait Islander peoples' health and experiences with health services (Abbott *et al.*, 2007; Taylor *et al.*, 2009; McDermott *et al.*, 2015; Briscoe, 2019; Lowitja Institute, 2019; National Aboriginal and

Torres Strait Islander Health Worker Association, 2019; Wright *et al*., 2019). For example, A&TSIHWs increase the effectiveness of cardiovascular risk assessments and improve health education and management of conditions in Aboriginal and Torres Strait Islander people through contributing a unique and holistic perspective (Deshmukh *et al*., 2014). A&TSIHWs significantly improve the cultural safety of health care for Indigenous patients in hospital, reduce discharges against medical advice, improve client follow-up, improve pathways to primary health care services, increase patient participation in cardiac rehabilitation, and reduce repeat hospitalisations and potential mortalities following heart attacks (Taylor *et al*., 2009). Partnerships between midwives and Aboriginal Maternal and Infant Care (AMIC) workers, where AMIC workers are in a leading cultural role, have resulted in increased uptake of programs and maternal and infant care services (Stamp *et al*., 2008). A&TSIHWs delivered culturally appropriate and comprehensive screening of sexually transmitted infections and blood-borne viruses to Indigenous males within a juvenile detention centre, significantly increasing the detection of infections, contributing to an overall reduction in Aboriginal and Torres Strait Islander populations (Templeton *et al*., 2010). A&TSIHWs are also best placed to address high tobacco smoking rates in Indigenous communities due to their frontline service delivery and critical role of delivering health information and education to community members (Thompson *et al*., 2011).

One would think that evidence of these outcomes alone would be enough to value the contributions of the A&TSIHW workforce. However, as mentioned previously, the lack of understanding of A&TSIHW roles by other health professionals, particularly the cultural component, contributes to the undervaluing of the A&TSIHW workforce. A&TSIHWs sense of belonging to community is connected to the importance they place on cultural brokerage and advocacy with social and cultural obligations often clashing with organisational accountabilities (Topp *et al*., 2018). Other health professionals also tend to lack understanding of Indigenous community engagement, health promotion activities and cultural activities which are often perceived as A&TSIHWs 'slacking off' (Bond, 2002).

Despite the plethora of evidence attesting to the value of the A&TSIHW in improved health outcomes, they are typically not valued as clinicians in their own right. For instance, historically and presently, A&TSIHWs have been referred to as a type of 'assistant' or 'nurse aide' (Jackson *et al*., 1999; Bailey *et al*., 2006; Hooper *et al*., 2007). Whilst there may be requirements in A&TSIHW roles to support and provide education to other health professionals, the use of terms such as 'assistant' or 'aide' does not benefit the call for recognition of A&TSIHWs as professionals in their own right and therefore contributes to the undervaluing of the A&TSIHW workforce.

Discourses 'about' A&TSIHWs typically focus on the need to upskill, develop, empower and enhance A&TSIHW capabilities and even rendered the A&TSIHW as part of the problem in terms of barriers to improving the health of Indigenous peoples through high smoking rates, high job turnover, lacking awareness of specialists roles and having low literacy and numeracy (Bond *et al*., 2019). The question has been raised as to why the validation of this ethnic-based health workforce continues to feature so predominantly in the workforce literature when the same is not required for other health professions within Australia such as doctors and nurses (Bond *et al*., 2019), and why the A&TSIHW is problematised as a barrier to better health. Here, we are constantly reminded about the lack of education of A&TSIHWs, not recognising that the skills and capabilities required are not necessarily taught in western academic institutions. This reflects a lack, not of the A&TSIHW, but of formal health education programs, many of which have yet to master how to embed Indigenous knowledges despite the substantial investments across the higher education sector.

Reimagining the A&TSIHW as a clinician and knower

The *Aboriginal and Islander Health Worker Journal* (AIHWJ) published 177 issues from 1977 to 2016 and represented the voices of A&TSIHWs across Australia giving a very different perspective of the work of the A&TSIHW and matters of concern to A&TSIHWs. The AIHWJ was designed 'to strengthen the hand, and the professional role, of those responsible for health in Aboriginal communities' and its articles exist as an invaluable archive for Indigenous health discourse today (Cawte, 1977; Bond *et al*., 2019). A number of A&TSIHWs who made intellectual contributions to the AIHWJ were not only A&TSIHWs, they were also advocates for their people and in some cases leading Aboriginal and Torres Strait Islander civil rights activists who are today honoured as trailblazers, and are acknowledged and thanked for paving the way for subsequent generations of Aboriginal and Torres Strait Islander people.

The AIHWJ told a different story, one about the limitations of the health system in its ability to care for Aboriginal and Torres Strait Islander peoples. Rather than focussing on 'fixing' the A&TSIHW workforce via 'upskilling, developing, empowering and enhancing' A&TSIHW capabilities, the journal emphasised listening and learning from A&TSIHWs, recognising their leadership and scholarship (Bond *et al*., 2019). The AIHWJ celebrated achievements of A&TSIHWs, shared positive stories and successes, honoured Elders and honoured those who made significant contributions to Indigenous health (Albany, 2010).

A&TSIHWs have often been drawn to the A&TSIHW role due to a strong desire to improve the lives of Aboriginal and Torres Strait Islander people and foster change within their communities. A drive for social justice has also played a part, due to the witnessing of mistreatment and injustices inflicted on their people and early morbidity and mortality (Soong, 1977; Yikaniwuy, 1997). The journal recognised the work of A&TSIHWs as cultural brokers and as advocates being a voice for Aboriginal and Torres Strait Islander people in their care when needed and providing them with holistic health care which often required them to work beyond their scope of practice (Miller *et al*., 1977; Bulin *et al*., 1978; Buckskin, 1987). A&TSIHWs shared knowledges into Indigenous concepts of 'health' that embodied survival and wellbeing of individuals and their communities (Glover, 1987) and discussed how better understandings by other health professionals in terms of Indigenous concepts of health, nutrition and disease could impact greater on the health of individuals (Jakamarra and Peile, 1977; Miller *et al*., 1977).

A&TSIHWs identified the severe limitations of working within Western frameworks to address Indigenous health issues and the need for the health system to be reconfigured to encompass Indigenous models of health care. Indigenous Primary Health Care service delivery models differ from western frameworks which focus on evidence-based care, community resources, patient self-management, co-ordinated care and health promotion with the absence of culture (Harfield *et al*., 2018). Indigenous models of health care encompass the physical, social, emotional and cultural wellbeing of both individuals and the whole

community (Gee *et al*., 2014). This need for reconfiguration was described as being fundamental to enable the delivery of appropriate health care services to Aboriginal and Torres Strait Islander peoples and in order to progress as a distinct health professional group (Buckskin, 1987; Bond, 2002). A&TSIHWs were aware of their positioning at the bottom of the health system hierarchy which limited their ability to effect change within their workplaces from this bottom positioning (Flick, 1995; Bond, 2002). There were articles that discussed both A&TSIHWs and patients' experiences of power imbalances and racial discrimination by other health professionals and administrative staff (Buckskin, 1987).

The AIHWJ references I have included above are not recent which demonstrates that the issues highlighted are not new—it is no wonder that A&TSIHWs find frustration in continuing to raise the same issues they have raised for decades (Flick, 1995; McGilvray, 2014). Although much evidence validates the benefits of including A&TSIHWs to models of care and the need to build the capacity of A&TSIHWs, little recognition is given to the knowledge and diverse skillsets A&TSIHWs bring and the transformative contributions they make to the health system. The discussion of race and how race and power dynamics operate between A&TSIHWs and other health care professionals is absent from health workforce literature; however, it is highly visible to A&TSIHWs and the community members they serve, and is evident in the AIHWJ articles written by A&TSIHWs.

My pathway to A&TSIHW

I grew up thinking that university was not an option for me. At high school, I loved Biology, History, English and Art, but my grades did not reflect this in my senior years and my Overall Position score was something I would rather not mention. None of my immediate family members had been to university and the fact that not one of my teachers ever mentioned the possibility of university to me meant that my natural progression after leaving school was to apply for jobs and take whatever I could get. I found myself working in administrative roles for corporates and governments for the first 10 years of my working life but felt a sense of emptiness and guilt that I should be utilising my skills to benefit my community. Aside from administration, I did not feel that I had any skills to contribute and did not think I could afford to study full-time so I sought opportunities where qualifications were not essential.

I was fortunate to land a Project Officer position, working in Canberra for a not-for-profit organisation with Indigenous communities nationally on community development projects. This was a great experience to expand networks and learn more about the diversity of our people as I previously spent most of my life in Queensland. I found it hard to understand how a team of Project Officers could each be doing the same job, but those who had bachelor degrees (in this case they were non-Indigenous) were on higher pay rates than those who did not have bachelor degrees (in this case they were Indigenous). It seemed that the skills and knowledge we, as Aboriginal and Torres Strait Islander people, brought to the role to work with our own communities were not valued monetarily or structurally. This caused a rift between the Indigenous and non-Indigenous workers, which I would continue to notice throughout my career, regardless of where I worked.

After starting a family, I continued to work in varied jobs within the Indigenous community services sector, some which saw me acting up in higher positions where I was able to develop—in being given tasks that were beyond my skillset at the time. It is interesting on reflection, that it was an Indigenous community-controlled organisation which saw my capability and provided me with an opportunity for growth in a position where I was needed at the time. Following a second period of family leave, I again endeavoured to re-enter the workforce. It was 2008 and I did not know exactly what I wanted to do, but realised that I needed to gain some type of qualification. I searched the job vacancies for anything in 'Indigenous affairs' to see what jobs were most frequently available and found that there were numerous vacancies state-wide for A&TSIHWs. I thought to myself at the time that if I became a qualified A&TSIHW, I would never be out of work because there are so many available positions. I did not consider at the time why this may have been so, however my personal journey told here reveals some of the contributors to high A&TSIHW job turnover rates and vacancy rates.

I secured a 12-month traineeship with Queensland Health (QH) and found it ironic that I had transitioned from Co-ordinator to trainee but I did not care as it was not about income or status, it was about serving my community. During this time, I learned the ropes of being an A&TSIHW and gained experience across Queensland communities, urban, regional and remote, as well as obtained a Certificate III in Aboriginal and Torres Strait Islander Primary Health Care. I loved this role and believed that I had found my purpose, and could not wait to gain more knowledge and qualifications. I felt it was important work and looked up to the senior A&TSIHWs aspiring to be like them. I later realised that they had somewhat sheltered me as I became aware of long-standing issues experienced by the A&TSIHW workforce having had the same discussions and raising the same issues with QH 10 years prior. This explained to me the reasons for the numerous vacant A&TSIHW positions across the state.

After completing my traineeship, I applied for another contract with QH as an A&TSIHW Advanced in a different health service district and was successful. In this role, I worked as part of a school health nurses team and completed the Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care. It was here that I began to really experience hierarchy and racism within the health system. Prior to me starting in this role, the school health nurses had been conducting ear health screenings on all children, including the Indigenous children, in the jurisdiction, and did not see my presence as necessary. I wondered however, whether they had taken the same care to build trust with the children, play games with them to teach them about preventative strategies for ear diseases and reassuringly explain the functions of the otoscope, tympanometer and audiometer to alleviate any worry they may have had. I also wondered if they contacted parents that were sent referrals for their child to see an Ear Nose Throat Doctor or an Audiologist to explain why it was recommended their child should see them and find out if they needed any support in making appointments or getting to and from the appointments. My thoughts were 'probably not'. I found this position to be quite isolating and disempowering and eventually I resigned to take up another opportunity.

It was now 2010 and Closing the Gap (CTG) was in full swing. I started working for a Division of General Practice (which transitioned into a Medicare Local). My role was Indigenous Health Project Officer (IHPO), one of the specific funded positions under CTG, but I was given the title of CTG Program

Manager. With a supportive CEO and access to further CTG funding, our team grew to 13 Indigenous staff which included Indigenous Outreach Workers, Healthy Lifestyle Workers, Tobacco Action Workers and Care Co-ordinators. We often felt we were under surveillance by other staff, whether we were being scrutinised over cab vouchers, work vehicles, home visits and appointments, or being questioned why our team meetings were usually held outside the office, for example, under a tree in a park by the ocean. Our team built a positive relationship with the local ACCHS and became co-located within the ACCHS which I found so valuable in learning how differently ACCHS operate in contrast to government health care services and general practices.

My pathway from A&TSIHW to A&TSIHW Academic

After 3 years in that role, I decided it was time to start a new chapter in my life and moved interstate to Adelaide where I was introduced to Indigenous health research and my eyes were opened up to a whole new world. I wanted to continue a career in Indigenous health and had not previously considered a role in research but applied for one and was successful. I was on a huge learning curve being new to research, and over the next 5 years, I worked on research projects as a Research Officer and in Project Officer/Management roles for an ACCHS peak body organisation, a state government health department, a not-for-profit research institute and a university.

On reflection of my experience working in research, some common themes emerged which I consider problematic. Within each of the organisations that I worked, the senior management, i.e. people in Director and Chief Executive Officer level positions, were Indigenous, but were not very accessible to staff due to their high workloads and busy schedules. People working in middle management, i.e. team/project leaders, were usually non-Indigenous and senior management often relied on them to lead projects and make operational decisions, and I would not say that they all had appropriate knowledge or experience in working with Indigenous staff and community members.

The Indigenous team members were usually research officers/assistants or administration officers who had come from A&TSIHW and administrative backgrounds. In my experience, there was no involvement of Indigenous team members in the research design, as though it was presumed that we had nothing of value to add. There was a lack of mentoring and teaching and research meetings took place with technical jargon being thrown to and fro. Basically, we were only there to do the labour, i.e. the community engagement and data collection, sometimes the analysis and interpretation, and seldom asked to write, but occasionally asked to review journal articles and have our names included as co-authors. Some would call this tokenism, or even exploitation. And then when one project finished, it was on to the next. I had looked upon each new appointment with anticipation but not all delivered the same opportunities for me as an A&TSIHW.

I then started a new research project employed by a university and was grateful to be supported to undertake a Graduate Certificate in Public Health part-time. I had worked in research for 3 years at that stage and it was not until then that I began to learn about theoretical perspectives, methodologies and methods, which made me feel a little resentful that no one had bothered to explain these to me before. It seemed that we were only on a need to know basis, and I assumed this was something they did not think we needed to know. When reading research proposals and ethics applications for research projects I had worked on, I would often see a section that referred to 'Aboriginal and Torres Strait Islander Capacity Building' and would often see my name or position in that field, but EndNote and NVivo training was as far as it went. This project allowed me to work more autonomously as a researcher, and although I was not involved in the research design, I was able to lead the research process right through to publishing my first journal article as a lead author. It was then that I began to see glimpses of myself as a future senior researcher, and planned to complete a Master in Public Health part-time, and maybe one day, undertake a PhD, in the distant future.

'Moving beyond the front line'

I then returned to Queensland and my next role was with the University of Queensland (UQ) where I was the primary Research Officer on the 'Moving beyond the front line: A 20-year retrospective cohort study of career trajectories from the Indigenous Health Program at the University of Queensland' (MBTFL) project which was funded by The Lowitja Institute and led by an Indigenous Senior Research Fellow. This experience was one that transformed my perceptions of my capabilities and enabled me to progress my education.

The Bachelor of Applied Health Science (Indigenous Primary Health Care), also known as the Indigenous Health Program (IHP), was delivered at UQ from 1994 to 2005 with over 70 mostly Indigenous graduates. Its aim was to provide greater training and professional recognition for the growing A&TSIHW workforce and centred Indigenous knowledges. The IHP was attended by Indigenous school leavers as well as mature age students with existing health careers and alternative entry was considered based on experience which would have been an ideal opportunity given my circumstances had I been told about the program or come across it by searching the Queensland Tertiary Admissions Centre (QTAC) booklet. Like myself, many of these students were the first in their families to go to university (Bond *et al.*, 2020).

MBTFL privileged the narrative accounts of members of this cohort, and I had the honour of interviewing many of them. The IHP cohort was not large in number but their individual achievements in Indigenous health are significant with many occupying health and other leadership roles across Australia (Bond *et al.*, 2020). I found it so inspiring to see the types of Indigenous health professionals the IHP produced, i.e. ones better equipped to make tangible changes, with a community development and social determinants approach. The IHP empowered students and developed advocates and activists, and their confidence and self-efficacy was evident which enabled them to speak up and address racism in the workplace. This cohort was a community in itself and provided students with a sense of belonging which established strong lifelong relationships, increasing their cultural capital and provided a network to draw on throughout their careers. Unlike my experience at university, the Indigenous students were the majority and they experienced strength in numbers and were validated. The IHP was an active research centre where students gained foundational research skills and experience in communities, learned by Problem Based Learning, and many went on to pursue further study.

I admired their common perception of non-hierarchical leadership, i.e. it is not about how high you climb—but how many you

bring with you, and the belief that raising up their own families and communities was equally as important as leadership in the workplace. Most participants chose to enrol in the IHP, to understand the inequalities and injustices they were witnessing and to find out what they could do to make a difference. Once they acquired this knowledge and were able to articulate it, they felt a responsibility to act on it, and in doing so, became the best types of advocates for their people having shared lived experiences.

Reflecting on my experiences of working on the MBTFL project, I feel privileged to learn from the inspiring and very personal stories of the IHP graduates, the challenges and set-backs they faced, and their continued advocacy and activism in making change for the betterment of Aboriginal and Torres Strait Islander peoples. I enjoyed the informal yarns with the Indigenous Senior Research Fellow, who was also a former A&TSIHW, about the interview data, analysing and interpreting it our way, and having further discussions with the Investigative Team. It was fitting that the project was led by and undertaken by former A&TSIHWs in that there was a clear repositioning of the A&TSIHW in this research—not as assistants but as sovereign beings. It was also refreshing to work on a project that everyone was so passionate about. Recruitment was easy because people wanted to tell their story and felt it was important to do so to inform curriculum development for the benefit of future Indigenous students coming through.

To be honest, I could not help to feel a little envious that I was not a part of it as the IHP, in empowering its graduates, and providing them with a unique set of skills, positive higher education experience and a qualification, it gave them direction and a significant head start to their careers and tools for life. In comparison, I have been in the workforce now for 26 years and although I am proud of what I have achieved, my career has had many twists and turns, depending on life events, opportunities and community needs at the time and its progression has been slow and even stagnant at times.

MBTFL was the first research project I had worked on where I was guided and mentored by an Indigenous lead researcher and if it was not for her support and belief in me, I would not be undertaking a PhD currently. She is also an A&TSIHW academic and a graduate of the IHP and her leadership style, drive to make change and success are certainly reflective of the types of Indigenous Health Professionals in which the IHP produced.

Discussion

I decided to become an A&TSIHW to pursue my interest in Aboriginal health and as a result of my desire to improve the lives of my people. However, in this role, I experienced first-hand the hierarchical nature of the health system workforce, being positioned at the bottom as an A&TSIHW. I also experienced first-hand the undervaluing of the A&TSIHW role, despite the diverse skills and unique expertise and knowledge we bring, and the consequent lack of career opportunities to which senior A&TSIHWs had been advocating for recognition and better conditions for A&TSIHWs for decades prior. I also witnessed how institutional racism is perpetuated which mirrors the racial hierarchy that too places Aboriginal and Torres Strait Islander peoples at the very bottom. I proudly consider myself an A&TSIHW at heart as my clinical training and frontline service delivery is foundational to my career in Indigenous health. Even when I furthered my career into program management and research, my experiences in these roles were not too dissimilar to my experiences in specific A&TSIHW roles.

I understand it is rare that anyone's career progresses exactly to plan, but I wonder how my journey would have differed had I undertaken a program such as the IHP after I graduated from Year 12 in 1992; or more to the point, had my capabilities as an Aboriginal person been more valued and respected in my work. As mentioned earlier, throughout high school, I did not consider going to university an option for me at all and neither did my teachers or family, nor was there anyone around me who had been to university that I could be inspired by. It was not until 2018, i.e. 24 years later, that I had completed my first degree.

I think about my two sons who are aged 15 and 12 and how I want them to have opportunities that I never had. I am always pushing them to do their best at school, so that they can achieve the best grades they possibly can in order to have more higher education and employment opportunities. On school holidays, I usually bring them on campus for a day, to expose them to the higher education environment and to mix with other Aboriginal and Torres Strait Islander people that they can look up to and see as role models. I want them to know that universities are places that they can belong in and I want them to be able to visualise themselves undertaking studies there, should they choose that pathway in the future.

I wonder what greater impact the A&TSIHW workforce would have had on the Australian health system had many more A&TSIHWs been more valued and respected in their work too, not as assistants to the knowers, but as knowers. To have a much larger cohort of A&TSIHWs who are empowered change makers equipped to push back and challenge systems, what a force to be reckoned with we would be. Not only that, but a health system reconfigured to enable the delivery of appropriate health care services to Aboriginal and Torres Strait Islander people through an Indigenous health model of care which includes social factors enabling the A&TSIHW workforce to progress as a distinct professional group (Bond, 2002).

Conclusion

I used to think that the research process was superfluous and with so much technical jargon it really can feel like an elitist club that is elusive to Indigenous peoples. I came to realise after working in Indigenous health research for some time that it can be a powerful advocacy tool. We (Indigenist researchers) have to play the game, but in applying Indigenous methodologies and methods, the voices of our people can be heard when they otherwise may not (Rigney, 1999). When I was young, I thought Indigenous activists were only those who led our marches and rallies with a megaphone in their hand, fighting for the rights of our people. Before I started working in research, I did not personally know any Indigenous person with a PhD, but now, I have learned that there is a small and growing army out there, many of whom are working in isolation. I can see the need for more relevant and innovative Indigenous-designed and led research that will lead to change for the betterment of our people and the need for increasing this army of Indigenous researchers and allies. My pathway has led me to this point for a reason and I feel a responsibility to my people to be part of that army. It is another strategy, i.e. not megaphones but evidence-based research that will better arm us for the present and future.

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