UTS UNIVERSITY OF TECHNOLOGY SYDNEY

The Bunya Project: Indigenous communities leading healthcare curricula

by Danielle Manton

Thesis submitted in fulfilment of the requirements for the degree of

Doctor of Philosophy

Under the supervision of Professor Megan Williams and Professor Andrew Hayen

University of Technology Sydney
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June 2024

CERTIFICATE OF ORIGINAL AUTHORSHIP

I, Danielle Manton, declare that this thesis is submitted in fulfilment of the requirements for the award of Doctor of Philosophy: Indigenous Health in the School of Public Health at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

This research is supported by the Australian Government Research Training Program.

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This thesis includes Indigenous Cultural and Intellectual Property (ICIP) belonging to the individuals and communities that have participated in this project.

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Acknowledgment of Country

We would like to acknowledge the Gadigal People of the Eora Nation upon whose ancestral lands our City campus now stands. We would also like to pay respect to the Elders both past and present, acknowledging them as the traditional custodians of knowledge for this land (UTS, 2019)

The research in this Bunya Project is Indigenous-led research, conducted on the unceded Aboriginal land of the Darkinjung, Wiradjuri, Yuin, Dharug and Gadigal peoples in NSW.

Abstract

The thesis explores the integration of Aboriginal and Torres Strait Islander perspectives into healthcare education, aiming to bridge the gap between policy rhetoric and actionable strategies. Through collaborating with Indigenous healthcare providers, the Bunya Project seeks to embed Indigenous leadership and perspectives into healthcare curricula to enhance staff and student awareness of self, and the intersectionality of Indigenous experiences and health outcomes, to promote health equity.

It utilises participatory action research grounded in Indigenous epistemologies, the project celebrates Indigenous expertise and advocates for community-led teaching and learning. The thesis unfolds through literature reviews, methodological outlines, findings from qualitative and quantitative data, and discussions on the potential impact and future directions. It emphasises the importance of Indigenous leadership, cultural safety, and inclusive education to improve healthcare outcomes and address systemic challenges in tertiary healthcare education, calling for ongoing research and community engagement to sustain progress.

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Acknowledgements

Undertaking this PhD has been a journey, despite the events and challenges (getting married, having a baby, buying a house and a global pandemic) this journey has provided me with the privilege and opportunity to collaborate with so many wonderful people. This is not an exhaustive list as there are so many deadly and amazing people that have influenced this journey, some without even realising it.

This PhD would not have been possible without the leadership and generosity of the Aboriginal Community Controlled Organisations, The Glen Group, Bimbadeen College, Katungal and Babaayn that participated in the research. I deeply thank you for supporting me through this PhD and trusting me to do something with your stories and experiences.

It is extremely difficult to express the love, respect and gratitude I have for the people who have walked with me through this journey (and put up with me).

This document would not be possible without the mentorship, friendship, guidance and expertise of my supervisor Megan Williams. Megan taught me to think, to listen to reflect. Megan embodies 'blakspertise' and models this in every interaction with care, consideration and humility, while also being a fierce advocate, true to her values and principles and what is right, 'proper ways' of working.

Andrew Hayen has been so relaxed throughout the process, and it was a long process. Thank you, Andrew, for your expertise and dad jokes. Andrew has and continues to demonstrate how Indigenous and Western knowledge systems can work together. An extra shout-out to Andrew who managed a lot of the administrative tasks that were so convoluted and stressful.

Over the years I have heard stories of PhD students and supervisors, however, I was 'blessed with the best'. Not only were my supervisors amazing individuals, but they also worked seamlessly and collaboratively through the process.

Mark Ragg, my PhD Dad! Thank you Mark for your patience, guidance and always being there. Mark talked me through so much of my writing and taught me how to approach and structure my writing as well as some cool Microsoft Word tips.

Sally Fitzpatrick, the walking database, who always challenged my thinking through the process and always provided great direction for further reading. And who kept the laughter flowing.

Jo Travaglia started the journey with me as a valued reviewer and adviser. Unfortunately, Jo could not complete the journey with us, but we carry her spirit and wisdom in all that we do.

A heartfelt and deep thank you to my husband, who travelled NSW with me to have many yarns all about the same thing. He had so much patience to continue to smile, nod and agree as I talked about the

same thing for so many years. Also for the patience to keep our son safe and happy while I worked what seemed like endless hours at the computer.

It is common for Indigenous peoples to have an Elder and a young person with them literally and figuratively, this project carries with it and is dedicated to my nan and my son. My Nan taught me what knowledge is, that our knowledges are not limited to what we know our knowledges are in our interactions, how we treat and care for one another, how we build and maintain relationships, how we always show up and the importance of hard work. My son inspires me and reminds me every day that he is exceptional and deserves every opportunity in life. That his culture is not only who he is but is part of what makes him exceptional. At the most basic he deserves access to healthcare free from racism. Australia has the opportunity to learn so much from him and I hope this project helps to recognise that.

I would also like to acknowledge and thank Matthew Sidebotham for his copyediting and proofreading of this thesis in accordance with the UTS thesis submission requirements and the *Guidelines for Editing Research Theses* (3rd edition).

The images of Bunya trees used at the beginning of each chapter have been personally taken and collected by myself, my husband Terry Manton and PhD supervisor Professor Megan Williams.

COVID-19 impact statement

COVID-19 forced the world to change significantly, very quickly. Tertiary education providers in many instances had to change delivery modes in a very short time frame, placing enormous pressure on academic staff and students. Over the two years of sporadic Covid- 19 lockdowns and public health measures, academics and students became increasingly fatigued by online engagement.

The planned timeline and milestones of the Bunya Project were significantly impacted by the COVID-19 pandemic, requiring changes and adaptations to the research methodology and participant engagement strategies. Impacts include:

1) Lockdown measures heightened community caution, increased cultural responsibilities and stretched participants thin amidst the pandemic, further exacerbating the project's difficulties and reliance on investing time in building relationships with participant organisations and community members.

   Despite efforts to adapt events to online platforms, cancellations, competing priorities and hesitancy to engage persisted, hindering the project's ability to fully capture the intended breadth of perspectives and experiences.

2) Originally designed to include face-to-face interviews with representatives from six organisations and 36 participants, pandemic-related restrictions forced unavoidable alterations. These changes led to delays as the research team had to amend ethical approvals to transition interviews to an online format, affecting the overall project timeline.

   Consequently, the project was conducted with four organisations and 24 participants, resulting in a smaller number of Aboriginal and Torres Strait Islander interviewees than planned, although data saturation was still achieved within this reduced cohort.

3) The quantitative data collection process also faced substantial challenges due to the shift from in-person to online survey methods. While the initial survey garnered responses from over 200 participants, the transition to online administration resulted in a reduced response rate, with just over 50 respondents. This decline underscores the difficulties posed by the pandemic in maintaining the reach and integrity of research endeavours.

4) Curriculum delivery had an impact on this project as academic staff were designing courses for online delivery in extremely short time frames. The Bunya Project was perceived as an added burden by staff for both staff and students. Additionally, before the pandemic the institution had commenced transitioning courses from one learning platform (Blackboard) to a different learning platform (Canvas). Not only were academic staff redesigning course and subject materials they were also doing so on a less familiar system, with the added pressure of

navigating ZOOM class, technical difficulties etc. The Bunya Project planned to incorporate teaching resources developed through the process to be embedded into subject materials informing the quantitative data. Due to the extensive disruptions because of COVID, it is impossible to ascertain if the resources were used, how they were used and if any impact experienced by students was attributed to the Bunya Project or any of the many changes that occurred in their education during this time.

Foreword

'The Bunya Project is inspired by the tall Bunya tree of eastern Australia – *Araucaria bidwillii* – which grows slowly and, through its development, produces large pinecones that separate into edible nuts for current generations to be nourished by' (Manton et al., 2023). The Bunya pine and the Bunya nut are significant for several reasons, firstly the Bunya pine has cultural significance to the first author, it grows abundantly on her grandmother's Country and her grandmother has shared fond memories strongly connected to the Bunya pine and the Bunya nut. Secondly, the Bunya nut is significant in its process, becoming the inspiration and metaphor for the project.

The Bunya tree only starts producing nuts after approximately 100 years of growth. The nuts then take three years to grow. They are large cones consisting of between 30 and 100 smaller edible nuts. The nuts grow high in the trees over 20–50 metres off the ground and drop without warning, which can prove extremely dangerous for anything under the tree (Wright, 2018). The nuts themselves are nutritious and delicious, likened to a chestnut in one study (Moura Nadolny et al., 2022). The nuts are also culturally significant: the harvest period is a time for gathering and ceremony, sharing knowledges and building futures for local peoples. In recent years this festival has been inclusive of all peoples.

The Bunya project reflects a similar pattern. Like the Bunya tree that grows tall over 100 years, Indigenous knowledges and practices have grown strong and adapted over thousands of years. However, the influence of colonisation by British forces of this land known as Australia over the past 250 years has required Indigenous peoples to grow and adapt in the harshest of conditions. Indigenous leadership is likened to the nuts; it took time to develop, but from the 1970s action was visible – like on the Bunya tree, the 'nuts' were beginning to grow. In the 1970s many Aboriginal community-controlled organisations were established, including the Aboriginal Medical Service in Redfern.

Indigenous peoples continue to grow and demonstrate our expertise in healthcare leadership and practices, most recently in the COVID-19 pandemic management and response (Crooks et al., 2020). However, the failure of the mainstream health and tertiary education system to recognise and value our knowledge impedes a better future for all Australians. There is an opportunity to gather, share knowledge and build a future if non-Indigenous Australia join us, like of the Bunya Mountain during Bunya Festival to value our knowledges, privilege our voices and expertise in tertiary education and do the work.

Change can begin in the classroom where students eventually become leaders. Like teaching the Bunya nut can be prepared and cooked in a variety of ways equally delicious and nutritious, and even replanted to continue the cycle. However, it can be cooked to the point where the nuts explode and are of no benefit to anyone, least of all the nut. Finally, if the nut is not planted promptly it will not germinate and the cycle will discontinue with that seed.

List of publications

Publications and manuscripts included in this thesis

Chapter 4

Manton, D., & Williams, M. (2021). Strengthening Indigenous Australian perspectives in allied health education: A critical reflection. *International Journal of Indigenous Health, 16(1).* https://jps.library.utoronto.ca/index.php/ijih/article/view/33218

Danielle Manton conceived of the study, performed the literature review and drafted the manuscript. Megan Williams participated in the design of the study, reflective discussions pertaining to the study and helped to draft the manuscript.

Chapter 5

Manton, D., Williams, M., & Hayen, A. (2023). The Bunya Project: Protocol for a mixed-methods approach to developing a culturally informed curriculum. *JMIR Research Protocols*, *12*(1), e39864.

Danielle Manton conceived of the study, prepared the protocol and drafted the manuscript. Megan Williams and Andrew Hayen participated in the design of the study, reflective discussions pertaining to the study and helped refine the manuscript.

Chapter 6

Manton, D., Williams, M., & Hayen, A. (accepted) 'It's about rights': The Bunya Project's Indigenous Australian voices on healthcare curriculum and practice. *Health and Human Rights Journal.*

Danielle Manton conceived of the study, conducted the interviews, analysed the data and drafted the manuscript. Megan Williams and Andrew Hayen participated in the design of the study, reflective discussions pertaining to the study and helped refine the manuscript.

Chapter 7

Manton, D., Williams, M., & Hayen, A. (submitted, under review). The Bunya Project andragogy framework for healthcare education. *Australian Journal of Clinical Education*

Danielle Manton conceived of the study, designed the framework based on the Bunya Project findings and drafted the manuscript. Sally Fitzpatrick reviewed and refined the subsequent drafts of the

manuscript. Megan Williams and Andrew Hayen participated in the design of the study, reflective discussions pertaining to the study and reviewed and refined the manuscript.

Conference abstracts and presentations related to the thesis

Manton, D. (2024). *Aboriginal health in Aboriginal hands: Enhancing Indigenous health outcomes through supporting Indigenous diabetes educator students.* UTS Teaching and Learning Awards

Manton, D., Williams, M., & Hayen, A. (2022). Bunya Project – Self-determining allied healthcare education. *World Indigenous Peoples Conference on Education*, Adelaide

Manton, D., Debono, D., Hor, S. (2021) *Indigenous curriculum, it's a journey*. Oral presentation, Council of Public Health Institutions Australasia (CAPHIA) 2021 Teaching and Learning Forum. Public Health Education in a Time of Disruption. University of the Sunshine Coast, Queensland, 15 & 16 July 2021.

Manton, D. (2019). *The Bunya Project: Development and evaluation of the Graduate School of Health curriculum*. Impact, Engagement, Transformation. 2019 AIATSIS National Indigenous Research Conference, Brisbane, Australia.

Manton, D., & Turnbull, H. (2020a). *A powerful voice: Integrating pre-recorded lectures into 'live and online' classes*. Teamwork. Teaching & Learning Forum 2020, Sydney.

Manton, D., & Turnbull, H. (2020b). *Our Bunya journey: Embedding the Indigenous Graduate Attribute into speech pathology*. UTS Speech Pathology Online SEER Research Symposium, Sydney.

Manton, D., & Turnbull, H. (2021). *The Bunya Nuts: Speech pathology involvement in an action research project to strengthen Indigenous Graduate Attributes in allied health education*. Local Contexts, Global Practice. Speech Pathology Australia National Conference, Online.

Manton, D., Williams, M., & Hayen, A. (2018a). *Bunya Project: Strategic engagement, research, development and evaluation to inform and embed UTS Graduate School of Health Indigenous Graduate Attribute (IGA)*. Our Knowledge, Our Wisdom, Our Promise – For Our Grandchildren's Grandchildren. Healing Our Spirit Worldwide, Sydney.

Manton, D., Williams, M., & Hayen, A. (2019). *Bunya Project: Development & evaluation of health curriculum*. Thinking Speaking Being First Nations Solutions for Global Change. Lowitja Institute International Indigenous Health and Wellbeing Conference, Darwin.

Manton, D., Williams, M., & Hayen, A. (2019b). *What do Aboriginal and Torres Strait Islander people want in health care education?* Pouhine Poutama: Embedding Indigenous Health Education. Leaders in Indigenous Medical Education, Christchurch.

Other publications during candidature

Anne Marie Eades, Danielle. Manton., Juanita Sherwood, Faye McMillan, Demelza Marlin, Megan Williams, Carolyn Lewis. (in press). Communicating with Aboriginal and Torres Strait Islander people In T. L. Jones (Ed.), Critical conversations for patient safety: An essential guide to healthcare (3rd ed.). Pearson.

Manton, D. (2024). *Following our process, making progress and finding power at the Third World Indigenous Cancer Conference*. Croakey Health Media. https://www.croakey.org/following-our-process-making-progress-and-finding-power-at-the-third-world-Indigenous-cancer-conference/

Manton, D., & Ragg, M. (2023). *ADARRN model of care evaluation 2023*. University ot Technology Sydney.

Manton, D. (2023). *First Nations rights-based approaches to climate justice will make the world a better place*. Croakey Health Media. https://www.croakey.org/first-nations-rights-based-approaches-to-climate-justice-will-make-the-world-a-better-place/

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Manton, D. (2023). *'We have the knowledge, the expertise and the solutions': International Indigenous Health and Wellbeing Conference*. Croakey Health Media

Williams, M., Manton, D., Fitzpatrick, S., & Ragg, M. (2023, 15 Jan). *Alignment of Indigenous knowledges, evaluation methodology and workforce development.* https://yulang.com.au/starburst-indigenous-evaluations/alignment-of-indigenous-knowledges-evaluation-methodology-and-workforce-development/

Lock, M., Williams, M., Lloyd-Haynes, A., Burmeister, O., Came, H., Deravin, L., ... & Bennett, B. (2021). *Are cultural safety definitions culturally safe? A review of 42 cultural safety definitions in an Australian cultural concept soup*. Research Square.

Williams, M., Ragg, M., & Manton, D. (2020). *Aboriginal allied health workforce pathways scoping project: Final report*.

Williams, M., Ragg, M., & Manton, D. (2019). *Aboriginal allied health workforce pathways: Education pathways*.

Conference abstracts

Manton, D. (2023). Inclusion keynote address. ATCA Conference 2023: Inclusion. Innovation. Impact. Sustainability, Sydney.

Manton, D., Taylor, S. & Henderson, N. (2023) Secondments realistic viewpoints. NADA, Sydney

Manton, D., & More, A. (2023). Secondment as AOD workforce professional development.8th Australian & New Zealand Addiction Conference, Gold Coast.

Manton, D., & Lee, A. (2023). Sharing joy to flourish in recovery. 3rd International Indigenous Health and Wellbeing Conference. Lowitja Institute, Cairns

Manton, D., & Mason, C. (2022). ADARRN Model of Care. Indigenous Wellbeing Conference, Australian & New Zealand Mental Health Association, Adelaide

Manton, D.(2022). ADARRN Model of Care, identifying the indicators. Social and Emotional wellbeing. AH&MRC, Wollongong.

Mason, C., & Manton, D. (2022). Implementing the ADARRN Model of Care. 7th Australian & New Zealand Addiction Conference, Gold Coast.

ADARRN, Manton, D., & Coyte, J. (2021). ADARRN Model of Care report. Enhancing Connections. NADA, Sydney.

Coyte, J., Manton, D., & Bailey, C. (2020). The Glen For Women community based program. 6th Australian & New Zealand Addiction Conference, Gold Coast.

Manton, D. (2020). The Glen for women. International Women's Day Forum. Network of Alcohol and other drugs agencies, Sydney.

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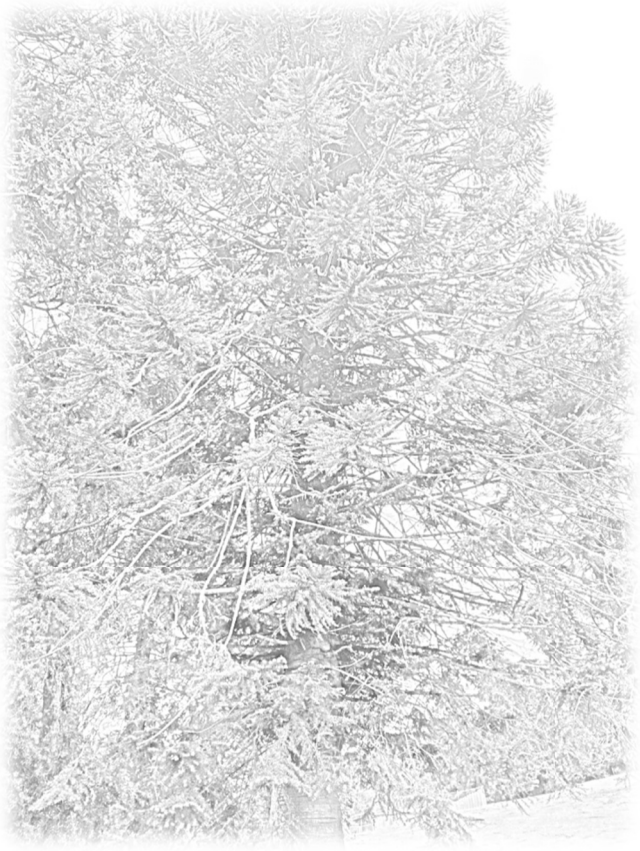
Abbreviations

ACCHO	Aboriginal community-controlled organisations
AHMRC	Aboriginal Health and Medical Research Council
Ahpra	Australian Health Practitioner Regulation Agency
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
AMS	Aboriginal Medical Service
AQF	Australian Quality Framework
CTG	Closing the Gap
IAHA	Indigenous Allied Health Australia
IGA	Indigenous Graduate Attribute
NACCHO	National Aboriginal community-controlled organisations
NATSIHWA	National Association of Aboriginal and Torres Strait Islander Health workers and practitioners
NHMRC	National Health and Medical Research Council
NSW	New South Wales
PAR	Participatory action research
TEQSA	Tertiary education quality and standards agency
UA	Universities Australia
UN	United Nations
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples
UTS	University of Technology Sydney



Bunya tree, Booburrgan Ngmmunge (Bunya Mountains, Qld) [photograph], by Danielle Manton

Chapter 1: Introduction to the Bunya Project

Preface

The image above captures a tree in the majestic Bunya Mountains in Queensland, which mark the boundary leading to the ancestral lands of my family. Standing amid countless others on Bunya Mountain, the Bunya tree holds profound significance. Every aspect of this tree serves a purpose; its wood is prized as ‘tonewood’ for crafting musical instruments and the tree produces nutritious seeds high in fibre and minerals. Growing over centuries, with ancestry dating back to the Jurassic era, these trees can reach towering heights of up to 50 metres, their protective leaves armed with sharp points. The Bunya nuts they bear are not only highly nutritious but also historically traded and dispersed by nature.

For my family and ancestors, the Bunya tree holds deep meaning, reflected throughout the Bunya Project. Like these enduring trees, the project aims to stand tall over time, guided by the wisdom of

Indigenous leaders. It seeks to be a valuable resource in every sense, nurturing individuals much like seeds that grow into nourishing graduates entering the healthcare workforce. By drawing on Indigenous leadership and culturally safe practices to work with Indigenous peoples, the project endeavours to benefit all access care, fostering a more inclusive and equitable healthcare system.

1.1 Chapter overview

The positionality statement preceding the thesis acknowledges the researcher's perspective as an educated Aboriginal woman of Barunggam descent, raised on Dharug land within the Eora Nation. It demonstrates the significance of personal experience, self-reflection and Indigenous viewpoints in shaping the research. The researcher highlights their multifaceted role within family and community, expressing a dedication to addressing healthcare disparities experienced by Indigenous Australians. Additionally, the statement advocates for Indigenous leadership and self-determination in shaping tertiary healthcare education. Clear terminology and research objectives are outlined, emphasising the collaborative and community-centred approach of the Bunya Project.

The research methodology is anchored in Indigenous epistemologies and participatory action research principles, with a specific focus on amplifying Indigenous voices and experiences. Below the structure of the thesis is summarised, encompassing literature reviews, methodology, findings and discussion sections. Overall, this establishes the framework for the thesis, grounded in the researcher's Indigenous identity and values, and aims to influence change.

Key aims for this chapter include:

1. The thesis intent and aim highlight the importance of Indigenous leadership and knowledge in shaping tertiary education and the healthcare workforce.
2. Terminology and context explain the deliberate use of the term 'Indigenous' to encompass Australia's First Peoples, Aboriginal and Torres Strait Islander peoples.
3. Clarifies that the Bunya Project is Indigenous-led research conducted on unceded Aboriginal land.
4. Provides a thesis overview of how each chapter contributes to understanding Indigenous healthcare education, leadership and perspectives, with practical frameworks and recommendations for future practice.

1.2 Positionality statement

Before I present my thesis, I think it is important to articulate my standpoint and the influence my personal experience, knowledge and view of the world has on this research. I also recognise the importance of self-reflexivity and take this opportunity to model reflexivity in practice.

I acknowledge my standpoint as an educated Aboriginal woman. I am a Barunggam descendant, raised on Dharug land in the Eora Nation. I am a mother, wife, granddaughter, daughter, sister and cousin. I am an active member of the community, which is manifested in advocacy, education, research and just turning up. The role I play in my family and my community is the reason, the 'why', of the Bunya Project. I am devastated that my family, my community and any Indigenous person in Australia cannot access safe healthcare in Australia free from racism, largely due to ignorance and lack of education. As an Indigenous woman I am accountable to the community to which I belong, and I wonder shouldn't everyone be accountable to the sovereign owners of this country.

I know the future is bright; the solution is in our communities and can be in our universities. Students educated by community to work with the community will value Indigenous knowledges, perspectives and experiences. Students will influence the workforce to be healing-informed and trauma-aware. Universities will be safe places for Indigenous peoples to learn and influence the workforce according to their knowledges and experiences and the needs of their communities. In the words of Nelson Mandela, 'education is the most powerful weapon which you can use to change the world' (Mandela, 2014).

1.3 Terminology used

The Bunya Project has deliberately selected the name 'Indigenous' in most cases to include Australia's First Peoples, the Aboriginal and Torres Strait Islander peoples. At times throughout this thesis the term is interchangeable with Aboriginal and Torres Strait Islander peoples to specify the Australian context. We have chosen to use the word 'Indigenous' to recognise our brothers and sisters internationally.

1.4 Research aims and objectives

This thesis contributes to the exploratory evidence that describes how to approach embedding Aboriginal and Torres Strait Islander perspectives into curricula as well as what Aboriginal and Torres Strait Islander peoples want to see in healthcare education. There are many policies and framework documents containing rhetoric around the commitment of government departments and institutions to include Aboriginal and Torres Strait Islander voices and knowledges on education. However, there is a disconnect between the why and the how, where to start and clear actions to take.

This research has been conducted in collaboration with four Aboriginal Community Controlled Health Organisations with the aim of developing a clear approach to embed Aboriginal and Torres Strait Islander perspectives and Indigenous Graduate Attribute and improve staff and student's knowledge and awareness of their role in improving health equity between Indigenous and non-Indigenous people.

Through participatory action research this project has four overarching objectives:

1) Provide a framework to engage community, Aboriginal and Torres Strait Islander experiences,

2) Amplify the voices of participants' perspectives, knowledges and aspirations for their own health and wellbeing and what they would like to see in healthcare education regarding Indigenous peoples and knowledges,

3) Develop explicit and implicit teaching and learning strategies

4) Measure how teaching resources impact on the knowledge and awareness of students.

1.5 Research approach

The Bunya Project occurred in collaboration with Indigenous healthcare providers and users to create informed, authentic, community-led teaching and learning in tertiary healthcare education. The Bunya Project recognises the expertise in the community and the leadership of the community to shape how and what staff and students are taught regarding Indigenous professional capabilities, knowledges and perspectives.

The Bunya Project research approach has been strongly influenced by Indigenous epistemologies, ways of knowing, being and doing (Martin et al., 2017; Martin & Mirraboopa, 2003; Yunkaporta, 2009, 2019) and global Indigenous rights principles (UN General Assembly, 2007). The Bunya Project research has been conducted in line with the ethical expectations and principles for research with Indigenous peoples in accordance with ethical guidelines. The research has been approved by both the Aboriginal Health Medical Research Council NSW (ethics approval number 1451/18) and the National Health and Medical Research Council (ethics approval number) (NHMRC, 2018).

Bunya is a participatory action research project focused on the positive contribution Indigenous professionals and community members can make to healthcare practices. Through the participatory action research framework, culturally safe, respectful and appropriate data collection tools including yarning and kapati time, are used (Geia et al., 2013; Ober, 2007).

The participatory action research method was integral to the research design and implementation. This occurred by actively involving participants throughout the process. The process began with focus group discussions at six sites (locations selected by each community) which informed the interview questions (reflected in Chapter 6). Data and draft papers were returned to participants for feedback. Indigenous researchers in the research environment translated data into the Bunya Research andragogy (Chapter 7), which was also shared back to participants for feedback and approval.

This Bunya Project celebrates the expertise, knowledge and experience of Indigenous Australians and our right to self-determine the health services of the future. Participatory action research is integral to this project as it relies on the participation of Indigenous communities. Participatory action research provides community control over the direction, processes and outcome of the project (Dudgeon et al.,

2017). Community-based participatory action research method is used as it is action-oriented, agile and responsive while upholding Indigenous epistemologies and Aboriginal ways of knowing, being and doing (Martin & Mirraboopa, 2003; Williams et al., 2023).

1.6 Data sources

This thesis consists of four sections. Following this chapter is a detailed review of literature relating to the Indigenous healthcare education context, Indigenous leadership and Indigenous perspectives in allied health education in Australia (Chapters 2–4). The second section, Chapter 5, outlines the method of the Bunya Project through a peer-reviewed protocol paper. Section 3 outlines the findings informed by Section 1 and arising from the qualitative and quantitative data collected during Section 2 (Chapters 6–8). The final section of the thesis (Chapters 9 and 10) includes the discussion and conclusion of the project, including the key learnings of the project. Based on the learnings this section identifies the potential impact and opportunities for future professional practice.

1.7 Thesis chapter summaries

Chapter 1 – This chapter provides an overview of the thesis. The project focuses on fostering culturally safe and appropriate tertiary healthcare education through Indigenous community leadership. The research comprises four sections, including literature reviews on Indigenous healthcare education, a protocol paper outlining the Bunya Project's methodology, findings from qualitative and quantitative data and a discussion and conclusion section. The thesis seeks to answer questions about the healthcare needs and aspirations of Aboriginal and Torres Strait Islander people and recommendations for tertiary healthcare education, emphasising the importance of Indigenous leadership and expertise in tertiary education and the potential impact this will have on the future healthcare workforce.

Chapter 2 – This chapter outlines contextual information to inform and guide the reader through the thesis. The information draws on critical points Australian tertiary education must address such as the ongoing impact of racial discrimination against Indigenous Australians and the role of decolonising its practices and integrating Indigenous expertise, to guide graduates to develop culturally safe professional practices. Key frameworks such as the Australian Health Curriculum Framework and Universities Australia Indigenous Strategy are drawn on, highlighting key resources and organisations resources like the Closing the Gap Report and Indigenous knowledge institutions such as the Lowitja Institute which support this critical journey towards inclusivity and respect.

Chapter 3 – This chapter argues that Indigenous leadership in health education is crucial for achieving equity, addressing the intersection of Indigenous knowledge, healthcare, education and leadership in Australia. The chapter emphasises the rich heritage of Aboriginal and Torres Strait Islander peoples, who have held vast knowledge systems for millennia. It explores the silencing and exclusion of Indigenous knowledge, historical legacies influencing healthcare practices, and the need for change in

practice to ensure culturally safe approaches throughout Australian healthcare. Indigenous leadership in healthcare and healthcare education is imperative for a healthier future.

Chapter 4 – This chapter provides a critical perspective on the challenges and opportunities associated with increasing the participation of Indigenous Australians in allied health. It is a valuable resource for anyone interested in improving health outcomes for Indigenous Australians.

Chapter 5 – The Bunya Protocol paper demonstrates a multilayered process to advance Indigenous community-led teaching and evaluation. The protocol outlines strategies to work with Community to embed an Indigenous Graduate Attribute in university curricula in Australia. The process is centred on relationships with Aboriginal community services to lead education design with Indigenous peoples.

Chapter 6 – This chapter calls for universities to recognise the immense value of Indigenous peoples to tertiary education. It argues that universities should include Indigenous leadership in curriculum design and partner with Indigenous communities to improve health care for Indigenous Australians. Drawing on the voices of 24 Indigenous participants, this chapter presents the importance of cultural safety in health care and the community's desire to have their basic human rights met when accessing mainstream healthcare.

Chapter 7 – This chapter is a practical framework for educators of adult teaching and learning, grounded in cultural values and privileging Indigenous voices. It is a tool, drawing from the information and experience presented in the previous chapters. This chapter provides a pragmatic guide to teaching and learning, including topic ideas and classroom strategies to include culturally safe elements in the classroom.

Chapter 8 – This chapter uses the quantitative data collected from student surveys to understand the impact of this work on student attitudes and knowledge regarding working with Indigenous peoples as culturally safe health care providers.

Chapter 9 – This chapter draws together the critical points made throughout the Bunya Project, including the role of Indigenous leadership, perspectives and knowledge in healthcare education in Australia. Key findings of the Bunya Project highlight the necessity of Indigenous leadership in tertiary education to address cultural determinants of health, promote cultural safety and minimise racism in healthcare settings. The chapter acknowledges the challenges and opportunities of the project, particularly amid the COVID-19 pandemic, calling for further research to validate the project's impact, expand its reach to diverse Indigenous communities and better understand the transition from student learning to professional practice and community-university relationships.

1.8 Chapter conclusion

This chapter has demonstrated the centrality of Indigenous epistemologies through the Bunya Project. Indigenous perspectives, knowledges and leadership are woven throughout the research process and content of each chapter, from initial positionality and terminological considerations to the presentation of findings and recommendations.

The next chapter provides context, introducing salient points and information including the past, present and future of healthcare and healthcare education for Indigenous peoples in the continent referred to as Australia.

Bunya tree line from the top of the Bunya Mountains, QLD

Chapter 2: Introduction

Preface

The Bunya Mountains serve as a poignant symbol of colonisation, reflecting the legacy of European exploration and exploitation. Within a short span after their 'discovery', these ancient trees, dating back to the Jurassic era, faced an imminent threat as numerous sawmills sprang up around the mountain's base. Despite the declaration of the Bunya Mountains as a National Park in 1908, the last sawmill persisted until 1961, highlighting the prolonged impact of logging on this sacred landscape.

The image captured atop Bunya Mountain overlooks the town where my grandmother grew up, where her father, my great-grandfather, existed without formal recognition, no birth certificate, no rights, no opportunities and no possibility of self-determining any aspects of his life.

Throughout a century of logging, the threat extended beyond individual trees; it disrupted soil integrity, altered landscapes and affected climate conditions, depriving younger trees of the protection offered by their Elders. Similarly to the mistreatment of logged trees, many Indigenous peoples carry deep-seated trauma from over 250 years of mistreatment. Also similar to the Bunya trees, we both are fighting an introduced disease that seeps in from the soil, preventing us from growing, from flourishing.

Our connection to Country and to life has been fractured, akin to the disrupted soil of the Bunya trees, perpetuating an ongoing struggle to establish roots deep enough to nourish growth and prosperity. This intergenerational trauma continues to reverberate through my family and ancestors. The landscape of

discrimination experienced by Aboriginal peoples in Australia persists despite efforts for change, highlighting the urgent need for further action.

2.1 Chapter overview

This chapter provides an overview of the contextual landscape including the policies, frameworks and resources pertaining to Indigenous healthcare education. The chapter introduces the critical issue of addressing historical biases and systemic injustices in healthcare education through decolonisation and incorporating Indigenous perspectives and expertise. It emphasises the importance of cultural safety and attributes in healthcare graduates, highlighting the ongoing impact of racism on Indigenous health outcomes and the need for culturally responsive healthcare practices.

The key aims of this chapter are to:

1. Introduce and unpack the impact of colonisation on Indigenous health.
2. Describe decolonisation, removing colonial legacies and integrating diverse perspectives.
3. Highlight the significance of Indigenous knowledges, describing peak Indigenous organisations that contribute to an inclusive evidence base for education and healthcare practice.
4. Outline the importance of cultural safety training for healthcare professionals.
5. Describe the influence of racism on Indigenous healthcare access.

2.2 Introduction

Aboriginal and Torres Strait Islander cultures are one of the longest-surviving cultures in the world (Jones et al., 2018; Salmon et al., 2018). The resilience and adaptability of Indigenous Australians are apparent in the wilful and strong presence of culture that exists today (Dudgeon et al., 2010; O'Sullivan, 2019). Before colonisation in Australia, the health of Indigenous Australians is thought to have been superior to their European counterparts (Gracey & King, 2009). Post-colonisation, after 1788, there was and remains a significant deficit gap in health outcomes between Indigenous Australians and non-Indigenous Australians due to introduced diseases, foreign food supplies and massacres (Gracey & King, 2009). Colonisation has impacted, and continues to impact, the lives of Aboriginal and Torres Strait Islander peoples in the worst ways, causing physiological and psychological distress and pain as well as creating conditions for Indigenous peoples to have an inferior quality of life (Butler et al., 2019). The ongoing impact of colonisation means that Aboriginal and Torres Strait Islander peoples continue to live with a legacy of intergenerational trauma coinciding with repeated experiences of racism and oppressive systems (Griffiths et al., 2016).

2.2.1 Racial discrimination

Racial discrimination refers to situations and environments where a person is treated unjustly specifically because of their Aboriginal and or Torres Strait Islander heritage (Antar, n.d). This includes overt experiences such as derogatory comments and behaviours as well as more subtle experiences such as stereotyping and assumptions which can directly affect how the individual is able to interact with the world (i.e. feeling safe to access healthcare services).

Throughout the Bunya Project racial discrimination was a reoccurring theme: identified as a key factor in healthcare outcomes for Aboriginal and Torres Strait Islander peoples, racism influences access to treatment, follow-up care and treatment compliance (Manton et al., 2024). Racism and stereotyping are also present across all the social determinants of health, undermining social and emotional wellbeing frameworks and strategies and adding a complex layer to concurrent factors that influence health outcomes (Anderson et al., 2023; Calma, 2006).

To combat racism in healthcare, education plays a crucial role. Implementing comprehensive diversity training for healthcare professionals, fostering cultural safety and promoting awareness of implicit biases are essential steps (Parter et al., 2021; Thomas & Booth-McCoy, 2020; Vora et al., 2021). Additionally, integrating diverse perspectives into medical curricula can help address healthcare disparities and ensure equitable patient care (Manton & Williams, 2021).

2.2.2 Decolonisation

Decolonisation centres on the true history of Australia, recognition of Aboriginal and Torres Strait peoples experiences throughout the history of Australia, including today (Bradfield, 2024). Decolonisation is a process of moving forward by ensuring we do not repeat the mistakes of the past. It involves creating space for Indigenous leadership and ensuring genuine self-determination in decision-making across all aspects of life, free from power imbalances (Rademaker & Rowse, 2020).

Decolonisation can occur through people, attitudes, approaches and the implementation of culturally safe values and principles that promote Indigenous ways of knowing, being and doing. Decolonising healthcare education is crucial to addressing historical biases, systemic injustices and power imbalances that have influenced healthcare practices (Wong et al., 2021). It involves recognising and disempowering colonial legacies by empowering people with knowledge through the integration of diverse perspectives and promoting cultural safety strategies (Jackson Pulver et al., 2019; Whiteside, 2009). Decolonisation fosters a more inclusive, equitable and respectful approach to healthcare that acknowledges the varied needs and contributions of different communities (Came et al., 2020; Chandanabhumma & Narasimhan, 2020). Decolonising healthcare upholds the principles outlined in the Aboriginal definition of health, which

> means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their Community. It is a whole-of-life view and includes the cyclical concept of life-death-life. Healthcare services should strive to achieve a state where every individual is able to achieve their full potential as a human being and this brings about the total well-being of their community. (National Aboriginal Health Strategy Working Party, 1989)

Decolonisation is complex in healthcare education and the workforce as it requires both education and healthcare institutions to critically reflect and transform the systems and structures designed to oppress Indigenous peoples to be inclusive, equitable and respectful (Lokugamage et al., 2020; Mbaki et al., 2021). This may occur over many generations, if at all (Gatwiri et al., 2021). We can use principles of decolonisation to influence change from within, changing the attitudes, perspectives and actions of the workforce through tertiary education, influencing a cultural shift that will slowly influence systemic and intuitional change.

2.2.3 Indigenous expertise

We have the solutions, but we need to be let in (Manton, 2023; Manton et al., 2024). Indigenous expertise is invaluable in healthcare education as it brings culturally sensitive insights, knowledge of community social structures and contexts (Yunkaporta, 2019), traditional healing practices and a holistic approach to wellness (Dudgeon & Bray, 2018). Incorporating Indigenous knowledge enhances practitioners' understanding of diverse health perspectives, fosters respect for cultural differences and contributes to more effective and equitable healthcare for all patients (Baskin, 2022; Francis-Cracknell et al., 2023).

Aboriginal and Torres Strait Islander voices and expertise have been silenced and excluded from the healthcare workforce (Parter et al., 2021) and often permitted only on the periphery of education as one-off classes or a lone subject that is abstracted from professional capabilities. Generally, academics understand the importance and want to include Indigenous content in their curricula but are not confident to teach the content (Norman, 2014). Including Indigenous peoples and communities in higher education can alleviate some of this pressure, as the curriculum is developed collaboratively with Indigenous leadership (Bunda et al., 2012; Povey et al., 2022) in a process that builds the capabilities and confidence of the academics. Higher education needs to ensure Indigenous perspectives and voices are woven throughout the curriculum; grounded in self-determination reflective of Indigenous knowledges. Higher education must include a focus on cultural safety, self-awareness and understanding, as well as skills that are relevant to the specific needs and aspirations of Indigenous communities as determined by the community (Bartlett et al., 2012; Stein et al., 2021).

2.2.4 Indigenous Graduate Attributes

Graduate attributes are used to define the skills and abilities achieved through a specific course, identifying to students and employers how the course has prepared them for the nuances of their professional practice (Hammer et al., 2021). An Indigenous Graduate Attribute refers to the skills, knowledge and attitudes that a university or educational institution seeks to instil in its graduates concerning Indigenous perspectives, cultures and issues to enhance their knowledge, understanding and professional capabilities (Bullen & Flavell, 2022). This may include understanding Indigenous histories, respecting diverse worldviews and demonstrating cultural safety (Manton & Williams, 2021). These attributes aim to prepare graduates to engage thoughtfully with Indigenous communities, contribute to ensuring culturally safe environments and work effectively in diverse and culturally sensitive contexts (Hossain et al., 2022).

Generally, through the inclusion of an Indigenous Graduate Attribute in a healthcare context it is reasonable to expect graduates should develop an understanding and respect for the cultural diversity and perspectives of Indigenous peoples (Behrendt et al., 2012; Manton & Williams, 2021). Education programs may aim to incorporate Indigenous knowledge systems, traditions, cultural immersion, on-Country experiences and perspectives into the curriculum to provide a more holistic and inclusive education (Drummond, 2020). Graduates are encouraged to engage in social justice, advocacy and community development initiatives (Gates et al., 2023) in support of Indigenous communities by implementing skills in effective communication with Indigenous communities and individuals, as well as the ability to build positive relationships (Manton et al., 2023). Graduates should be encouraged and prepared to advocate for Indigenous rights and participate in leadership roles to effect positive systemic change (Wylie et al., 2021). These approaches are underpinned by the development and implementation of ethical principles and practices in working with Indigenous communities and respecting (Sherwood & Anthony, 2020) their intellectual and cultural property rights and sovereignty over that knowledge and data (Harfield et al., 2020). Healthcare graduates should understand the concept of cultural safety and work to create safe and inclusive environments for Indigenous peoples to safely work and access healthcare in (McGough et al., 2022).

2.2.5 Cultural safety in education

Cultural safety in tertiary education teaching and learning is an essential concept that promotes an inclusive and respectful learning environment for students (Markey et al., 2021). Cultural safety ensures that all students, regardless of their cultural or ethnic background, feel welcome and valued in the educational setting (Cerna et al., 2021). This inclusivity fosters a sense of belonging and encourages participation and engagement in the learning processes (Tuitt et al., 2023). Cultural safety promotes respect for these differences and encourages the recognition and celebration of

various cultural perspectives, beliefs and practices. When students feel safe and respected in their learning environment, they are more likely to be engaged and motivated to learn (Felten & Lambert, 2020). It enhances the effectiveness of teaching and learning by creating a supportive atmosphere in which students can freely express themselves and ask questions (Fleming et al., 2020). Cultural safety actively addresses biases and prejudices that can exist within educational institutions. It encourages educators to reflect on their own biases and work to eliminate them, promoting fair and equitable treatment for all students.

Tertiary education should prepare students for the realities of a diverse world (Corporal et al., 2020). Cultural safety helps bridge the gap between the classroom and the real world by modelling and teaching students to navigate and engage with diverse cultures effectively (Mills & Creedy, 2021). When students feel culturally safe, they are more likely to succeed academically. They are also better prepared to work in diverse workplaces and contribute positively to society (Flavell et al., 2013).

Incorporating cultural safety into tertiary education involves creating policies, practices and curricula that prioritise cultural respect and inclusion (Wylie et al., 2021). It encourages ongoing dialogue, self-awareness and professional development for educators to ensure they are equipped to provide a culturally safe learning environment (Best et al., 2022; Dawson et al., 2022; Power Wiradjuri et al., 2021). Ultimately, cultural safety in tertiary education benefits not only the individual students but also society by fostering greater understanding and harmony among diverse populations (McGough et al., 2022).

Cultural safety attributes can vary depending on the specific goals and context of the higher education institution and the needs of the Indigenous communities being served (Manton et al., 2023). The aim is for universities to produce graduates who can hold space for Indigenous leadership and contribute positively to Indigenous communities and promote cultural responsiveness and safety (Manton & Williams, 2021).

2.2.6 Cultural safety in healthcare

In 2021 the Australian legislation regarding Australian Registered Health practitioners was amended to explicitly recognise the importance of cultural safety and the elimination of racism in healthcare access and equity. Under section 3A Guiding Principles in NSW, the legislation states:

> *the scheme is to ensure the development of a culturally safe and respectful health workforce that –*
>
> *(i) is responsive to Aboriginal and Torres Strait Islander peoples and their health; and*
>
> *(ii) contributes to the elimination of racism in the provision of health services.*

The amendment to the legislation demonstrates the shift in accountability towards creating a culturally safe and respectful health workforce, which is a significant step forward. This legislative change is also a significant driver in holding universities accountable to ensure students are adequately prepared to be culturally safe practitioners (Brumpton et al., 2023).

2.3 Upstream drivers of change and key resources

This section examines how sectorial drivers for change, including resources have impacted healthcare outcomes, as well as the ongoing challenges in achieving culturally safe education and practice.

Four key focus areas were evident in appraising the grey literature for upstream drivers and community-level pressure to bring about and sustain reform to health professional curricula. The grey literature reviewed is influential in the sector. The reports guide resources in healthcare and healthcare education including to inform peak Indigenous organisations, Government agencies, as well as tertiary education and healthcare sectors.

2.3.1 Establishing consensus

Over the past 50 years, calls for reform have led to the development of a series of competency and capability frameworks (Behrendt et al., 2012; Skochelak, 2010). In recent years this has triggered alignment with industry, with accrediting and registration bodies increasing their standards and evidence required to demonstrate cultural safety (Milligan et al., 2021). This change and momentum have emerged from community expectations and upward pressure from Indigenous communities and the workforce, and extremely poor health outcomes (Dreise et al., 2021; Freeman et al., 2022; Norman et al., 2021).

2.3.2 Aboriginal and Torres Strait Islander Health Curriculum Framework

The Health Curriculum Framework was developed to provide support to universities to implement Indigenous content within their curriculum; it also provides a guiding structure for accrediting bodies to measure. According to the framework:

> Good health care outcomes for Aboriginal and Torres Strait Islander peoples require health professionals to be both clinically and culturally capable. (Department of Health, 2021a, pp. 1-5)

The framework was updated in 2014 through a multistaged process including an environmental scan of curricula and documents, interviews and workshops (Department of Health, 2021a, pp. 1-8). The publication of this document occurred just before the change in cultural safety legislation, providing some structure and direction. Since then, measures to assess the quality of cultural capabilities in

healthcare curriculum as well as graduate professional practice are only slowly improving with continuous quality improvement measures embedded in accreditation processes and the development of a validated cultural capability measurement tools (Blouin & Tekian, 2018; West et al., 2017). Academia is still not prepared or equipped to implement and assess a curriculum that is critically reflexive and assures culturally safe graduates (Francis-Cracknell et al., 2023). There is limited practical guidance for academics regarding implementation, especially at a course and subject level which have very specific and nuanced requirements.

2.3.3 Discipline-specific competencies

The 2021 legislative amendment requiring culturally safe healthcare practitioners under national law has triggered healthcare peak and accrediting bodies to increase accountability of education providers and practitioners to ensure cultural safety is included in the curriculum and professional development for practising healthcare professionals and academics (Cox & Best, 2022). The professional competencies and standards for each profession are aligned with the Australian Health Curriculum framework cultural capabilities, the Ahpra and National Boards cultural safety strategy and, in some cases, competencies/discipline-specific practice standards (Australian Physiotherapy Council, 2021; Poulos et al., 2021; Speech Pathology Australia, 2018; Wiggins et al., 2022).

In line with this development, there is increased commitment and accountability to improve cultural safety standards for practitioners and education providers (Milligan et al., 2021). This is demonstrated through increased Indigenous representation in accreditation governance in nursing and midwifery, physiotherapy and pharmacy. Indigenous representation is present at the board level and on the accreditation committee (ANMAC, 2021; Australian Pharmacy Council; Australian Physiotherapy Council, 2022a, 2022b). This may also be the case for other accrediting bodies; however, the information is not transparent on their websites or in annual reporting.

2.3.4 Indigenous-specific frameworks

Indigenous peoples and communities across the sector have recognised the need for improved direction and structure to guide all health practitioners and policymakers to work better with Indigenous peoples. As such, two peak organisations – the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA) and Indigenous Allied Health Australia (IAHA) – have independently developed frameworks specific to their sector of expertise. These frameworks are designed to influence improved professional skills of the workforce to develop a responsive and culturally safe healthcare environment in Australia for the Indigenous workforce as well as for Indigenous peoples accessing care.

NATSIHWA introduced the Cultural Safety Framework in 2013, almost 10 years before any significant change was made to ensure healthcare practitioner accountability. The initiative aimed at fortifying

healthcare systems through an empowerment-focused strategy. This framework aimed to improve the capabilities of healthcare professionals, ensuring the delivery of culturally safe and responsive care to Aboriginal and Torres Strait Islander peoples. Comprising seven distinct domains, complete with performance indicators and monitoring and evaluation prompts, the framework serves as a comprehensive guide for healthcare practitioners striving to navigate the intricacies of cultural safety (NATSIHWA, 2013).

Indigenous Allied Health Australia responded to the call for increased cultural capabilities within allied health professions by developing the Cultural Responsiveness in Action framework in 2015, updated in 2019. This framework represents a dynamic and practical approach, offering tangible strategies to strengthen the capabilities of the workforce. Grounded in a strengths-based methodology, the framework places a particular emphasis on Aboriginal ways of knowing, being and doing, thereby influencing transformative change at the individual, systemic and institutional levels (IAHA, 2019).

Together, these initiatives demonstrate a collective commitment to collaborative approaches for improving healthcare outcomes, acknowledging the diverse needs of Indigenous peoples, and promoting a respectful and culturally safe healthcare landscape.

2.4 Institutional leadership

Universities play a crucial role in shaping the future of higher education and are held accountable through various frameworks, such as the Australian Universities Accord and the Universities Australia Indigenous Strategy 2022–2025. These frameworks guide institutions in promoting inclusivity, advancing Indigenous knowledge systems, and ensuring cultural safety in higher education.

This section explores the efforts and challenges faced by Australian universities in implementing strategies, focusing on their commitment to Indigenous leadership, student support, and the integration of Indigenous values and perspectives into university structures and curricula.

2.4.1 Australian Universities Accord

The Australian Universities Accord has been tasked with developing a long-term plan for Australia's higher education system building on the work of the Bradley Review (Bradley et al., 2008) and the Behrendt Report (Behrendt et al., 2012). An Accord consisting of seven panellists has undertaken a review to provide recommendations for the future of the Higher Education sector in Australia. The Accord interim report recognises higher education is integral to the transformation of the nation, to enhance the industry through developing the workforce (O'Kane, 2024). The report also clearly identifies the importance of teaching and learning that reflects Indigenous ways of knowing, being and doing to the benefit of 'people in higher education, to the institutions themselves and in the broader community' (O'Kane, 2024, p. 35).

The interim report identified five priority areas, of which Priority Action 3 is specifically relevant in this context. The Australian Government has committed to Priority Action 3, 'Ensure that all First Nations students are eligible for a funded place at university', by extending demand-driven funding to metropolitan First Nations students.' (O'Kane, 2024, p. 13). This is a positive initiative in reducing barriers to accessing tertiary education; however, more supported places for students will have limited impact if the curriculum, classrooms and peers are not culturally safe.

Interestingly, the same level of commitment and focus to strengthen Indigenous peoples' sovereignty and leadership in higher education was not reflected in the discussion paper (Bodkin-Andrews et al., 2023; O'Kane, 2023). It is important to note the final report had not been released at the time of completing this thesis.

2.4.2 Universities Australia Indigenous Strategy

Universities Australia is the peak body for the tertiary education sector in Australia. Universities Australia launched its first Indigenous-specific strategy in 2017 (Universities Australia, 2017), taking a whole-of-university approach (Universities Australia, 2017, p. 28). Sharing the workload and building effective community partnerships were key targets for Universities Australia's Indigenous strategy in the 2017–2020 strategic plan (Universities Australia, 2017); however, the reporting mechanisms and accountability measures were inadequate, to say the least (Anderson et al., 2023; Universities Australia, 2020).

The succeeding Indigenous Strategy 2022–2025 (Universities Australia, 2022) identified the issues of 'university responsibility for Indigenous advancement' (p. 37) and 'racism and cultural safety' (p. 45) as well as the 'value Indigenous people and knowledges bring to the university and embedding Indigenous value systems and knowledges into university structures' (p. 53) as key targets. However, the 2023 Indigenous Strategy annual report (Universities Australia, 2023) identified that 'member universities' responses were generally not focused on equipping students with an awareness of Indigenous values and knowledges' (p. 4), indicating the focus has shifted or has been placed in the 'too hard basket'. The report also identified the important relationship between education and research, especially Indigenous research that informs curriculum (Universities Australia, 2023). This is unsurprising, as little data has been collected over the last seven years to evaluate the effectiveness of embedding Indigenous perspectives (Bodkin-Andrews et al., 2019; Norman, 2014), nor is this action reflected in any of the other governance structures. Data collected by Universities Australia is self-reported and subjective as there are no guiding principles or validated frameworks in place (Universities Australia, 2023., Bodkin-Andrews et al., 2019).

2.5 National benchmarks and targets

National benchmarks and targets play a critical role in advancing Indigenous health and well-being through frameworks like the Closing the Gap initiative. Key to this effort are partnerships with Indigenous organisations, such as the Coalition of Peaks, which advocate for Indigenous voices in policy development.

This section outlines the collaborative efforts between the Australian Government and Indigenous stakeholders, focusing on initiatives like the National Agreement on Closing the Gap, the Productivity Commission's information repository, and the role of the Australian Health Practitioner Regulation Agency (Ahpra) in promoting cultural safety within healthcare professions. These initiatives seek to transform government and institutional structures, ensuring they are accountable, culturally safe, and responsive to the needs of Indigenous communities.

2.5.1 National Agreement on Closing the Gap

In November 2005, Professor Tom Calma's Social Justice Report (Calma, 2006) called on Australian governments to commit to health and life expectancy equality for Aboriginal and Torres Strait Islander people within 25 years. This led to the Council of Australian Governments (COAG) committing to "Closing the Gap" in life expectancy on 20 December 2007, establishing a timeframe and accountability for this goal; the Close the Gap campaign was launched shortly after in April 2008.

The Closing the Gap initiative has undergone various iterations since its inception in 2008, with a renewed focus on partnership and engagement with Indigenous peoples. One significant development is the establishment of a formal partnership between the Australian Government and the Coalition of Peaks, as described in 2.5.2. Through the collaboration with the Coalition of Peaks, a National Agreement on Closing the Gap was established with four priority reform areas (Coalition of Peaks, 2020).

2.5.2 The Coalition of Peaks

The Coalition of Peaks is a representative body consisting of state and national Indigenous-controlled community organisations and peak bodies (Coalition of Peaks, 2023). It was formed to ensure that Indigenous voices are central to the development, implementation and monitoring of policies that affect Indigenous Australians (Dreise et al., 2021). The Coalition of Peaks plays an influential role in advocating for the rights and interests of Indigenous communities and is actively involved in shaping the Closing the Gap agenda. However, it has no significant power to hold organisations, institutions or government sectors to account.

The partnership between the government and the Coalition of Peaks is designed to facilitate shared decision-making, with the Coalition having a direct role in negotiating, designing and implementing policies that impact Indigenous communities (Dillon, 2021). This approach is intended to ensure that the Closing the Gap initiatives are culturally appropriate, community-driven and effectively address the unique needs and aspirations of Indigenous Australians; however, work still needs to be done, predominantly by the mainstream agencies (Kennedy et al., 2022; Productivity Commission, 2023b).

2.5.3 Productivity Commission Closing the Gap Information Repository

The Productivity Commission is the steward of the Closing the Gap information repository dashboard, which reports progress on the abovementioned priority reforms. The dashboard was developed as part of the National Agreement on Closing the Gap, an agreement made with key stakeholders, specifically Aboriginal Community Controlled Health Organisations and representatives, to provide transparent data (Productivity Commission, n.d.). The repository aims to collect all the government information regarding Closing the Gap in one place, organised by priority reform and target outcomes.

In implementing the national Closing the Gap, Priority reform area 3, 'Transforming government organisations', is particularly relevant to this thesis, with the specific outcome of:

> Ensuring mainstream government agencies and institutions that deliver services and programs to Aboriginal and Torres Strait Islander people undertake systemic and structural transformation to contribute to Closing the Gap. (Coalition of Peaks, n.d., p. 2)

There is still much work required to achieve this priority reform. Government organisations and the services they fund are required to honestly reflect on and commit to change (Productivity Commission, 2023a). Critical reflection and change are required urgently, including system and structural reform that includes transparent accountability measures and balancing of power (Commonwealth Government, 2023). Tertiary education is well placed to provide professional capability training across all professions to prepare graduates to be culturally safe in the workplace, preparing the future workforce.

2.5.4 Australian health practitioner regulation agency and National Boards

The Australian Health Practitioner Regulation Agency (Ahpra) is the national oversight body for 16 registered health professions in Australia. Ahpra and National Boards are responsible for registering and licensing healthcare professionals (National Health Practitioner Ombudsman, 2021; Pacey et al., 2017). This is achieved through setting and enforcing national standards for practice, including ethical and professional conduct, with cultural safety identified as a focus area for improvement (Milligan et al., 2021). Investigating complaints about healthcare professionals and taking disciplinary action if necessary, Ahpra also maintains

a public register of registered healthcare professionals. Fifteen National Boards work in partnership with Ahpra to regulate their respective health professions (National Health Practitioner Ombudsman, 2021). Each Board is made up of registered practitioners in that profession and is responsible for developing and upholding national standards for education, training and practice, through a process of accreditation, annual reporting and professional development requirements for registered practitioners (Ahpra & National Boards, 2023). The National Boards also provide advice to Ahpra on matters relating to their profession. Ahpra and the National Boards play a crucial role in promoting cultural safety as they set the national standards for cultural safety training and education for healthcare professionals and monitor and enforce these standards through the accreditation process, as well as investigating complaints of discrimination or culturally inappropriate care (Ahpra, 2020).

ABSTARR consultancy, an Indigenous-led consultancy, has developed training in cultural safety for accreditation contributors (ABSTARR Consulting, n.d.); this will improve the capabilities and expectations of accreditation assessors, increasing the acceptable quality for meeting accreditation requirements for education providers and is a significant step towards ensuring consistent and high-quality cultural safety training across all Ahpra-regulated healthcare professions.

Ahpra and the National Boards are working to create a healthcare system that is more culturally safe and responsive to the needs of Indigenous Australians and that is free of racism (*Health Practitioner Regulation National Law 2009* (NSW), section 3A).

2.6 Maintaining standards

Maintaining educational standards is crucial to ensuring the quality and accountability of tertiary institutions, particularly when it comes to addressing Indigenous perspectives. Regulatory bodies like the Tertiary Education Quality Standards Agency (TEQSA) and frameworks such as the Australian Qualification Framework (AQF) play vital roles in setting the benchmarks for quality assurance and graduate capabilities in higher education. However, gaps in explicitly addressing Indigenous inclusion and cultural safety persist, especially in the context of professional education. This section examines the role of TEQSA, the AQF, and other frameworks in maintaining standards within tertiary education, highlighting opportunities for embedding Indigenous knowledge and perspectives more effectively.

2.6.1 Tertiary Education Quality Standards Agency (TEQSA)

TEQSA is an Australian higher education independent quality assurance regulatory body. Its focus is ensuring and enhancing the quality and standards of higher education institutions (TEQSA, n.d.). It

assesses and monitors universities and other higher education providers to ensure they meet established standards in areas such as teaching, learning, research and governance (TEQSA, n.d.).

TEQSA regulations make no mention of Indigenous or First Nations peoples specifically. While there are standards related to equity and diversity (inclusive of international students) (TEQSA, n.d.), there is no clear direction or accountability for quality assurance specifically relevant to the sovereign owners of this country (Goerke & Kickett, 2013). This silence is deafening.

2.6.2 Australian Qualification Framework

The Australian Qualification Framework (AQF) outlines the learning benchmarks required to achieve each level of qualifications from senior secondary school, VET and tertiary education (Department of Education, 2013). The AQF is structured in a such a way that a graduate of that specific qualification can demonstrate knowledge reflective of that level, the ability to implement skills and apply the learning within the professional context related to the qualification and level (Department of Education, 2013; Wood & Auhl, 2020).

The structure is focused on the development of the professional capability of the graduates and can provide academics with a pathway to approach embedding Indigenous perspectives into a curriculum that is focused on professional capabilities rather than culture, creating an opportunity for academics to be more comfortable delivering the content. Interestingly, in further research undertaken as part of this Bunya Project the participants identified that it was important professional capabilities and basic human rights principles be reflected in Australian healthcare education (Manton et al., 2024).

2.7 Indigenous health knowledge repositories

This section examines key sources and repositories that are in the public domain, many of which rest on a legacy of First Nations stewardship and are generally non-controversial and trustworthy. These are sites and documents where educators can begin their own processes of self-directed learning.

2.7.1 Australian Indigenous HealthInfoNet

The Australian Indigenous HealthInfoNet is an online resource that provides information and resources related to the health and wellbeing of Australia's Indigenous peoples (Edith Cowan University, n.d.). It serves as a knowledge exchange platform, offering a wide range of materials, including research, publications and educational resources. The goal is to facilitate access to relevant and culturally appropriate health information, supporting efforts to improve Indigenous health outcomes in Australia.

2.7.2 Closing the Gap repository dashboard

The Closing the Gap repository is an online resource managed by the Australian Productivity Commission, as mentioned earlier. The dashboard provides access to the most comprehensive and recent government data relating to the targets and indicators agreed on through the National Agreement on Closing the Gap (Productivity Commission, n.d.).

2.7.3 The Healing Foundation

The Healing Foundation was established to address the historical trauma and healing needs of Australia's Indigenous peoples, particularly those affected by the forced removal of children from their families, known as the Stolen Generations (The Healing Foundation, 2024). The foundation focuses on promoting healing practices, supporting communities and raising awareness about the intergenerational impacts of trauma.

The Healing Foundation works collaboratively with Indigenous communities, organisations and individuals to foster a holistic approach to healing that incorporates cultural, spiritual and psychological aspects (The Healing Foundation, 2024). It plays a vital role in contributing to improving the wellbeing of Indigenous Australians.

2.7.4 The Lowitja Institute

The Lowitja Institute is dedicated to advancing Indigenous health research, knowledge and outcomes. The institute focuses on conducting and supporting high-quality research that addresses the health and wellbeing of Australia's Indigenous peoples (Lowitja Institute, n.d.).

The institute collaborates with Indigenous communities, researchers and policymakers to generate evidence, inform health policies and contribute to closing the health gap between Indigenous and non-Indigenous Australians (Rigney et al., 2022). The Lowitija Institute draws on strengths-based approaches that promote Indigenous sovereignty and empowerment that are responsive and community-led research approaches, recognising the importance of Indigenous perspectives in shaping health strategies and interventions (Fogarty et al., 2018).

2.7.5 UN Declaration on the Rights of Indigenous Peoples

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) is a comprehensive international instrument adopted by the UN General Assembly in 2007 (UN General Assembly, 2007). It outlines the collective and individual rights of Indigenous peoples globally, addressing issues such as culture, identity, language, employment, health, education and more.

Key principles of UNDRIP include the right to self-determination, free, prior and informed consent, protection against discrimination, and the right to maintain and strengthen Indigenous institutions, cultures and traditions. While it is not legally binding, it carries significant moral and political weight and is frequently used in advocacy and evidence to influence changes in systems, policies and approaches. It is a useful tool in education providing students and academic staff with principles to guide their engagement with Indigenous communities and fostering respect for their rights and wellbeing (Delaney et al., 2020).

2.7.6 UN Sustainable Development Goals

The United Nations Sustainable Development Goals (SDGs) are a set of 17 interconnected goals adopted by UN member states in 2015 (United Nations, 2015b). They provide a shared global strategy for addressing various social, economic and environmental challenges by the year 2030. The SDGs aim to promote peace, prosperity and wellbeing for both people and the planet.

These goals encompass a wide range of issues, from poverty and hunger to education, gender equality, environmental sustainability and peace. They provide a comprehensive framework for governments, businesses and civil society to work together to achieve a more sustainable and equitable future.

United Nations Sustainable Development Goal 3 (SDG 3) focuses on 'Good Health and Well-being' (United Nations, 2015a). The goal aims to ensure healthy lives and promote wellbeing for all at all ages. One of the key targets and indicators under SDG 3 is to 'strengthen the capacity of health systems, including the recruitment, development, training and retention of healthcare workers' (United Nations, 2015a). Education plays a critical role in making progress to achieve SDG 3 (Allen et al., 2020; Brand et al., 2021). Improving SDG can improve health outcomes worldwide, reduce health disparities and create a foundation for sustainable development by recognising the critical role health plays in fostering economic and social progress (Brand et al., 2021).

2.7.7 AIATSIS Guidelines 2020

AIATSIS (Australian Institute of Aboriginal and Torres Strait Islander Studies) has developed ethical guidelines to hold researchers accountable and ensure protective measures are in place when conducting research involving Indigenous communities or knowledge (AIATSIS, 2020). These guidelines emphasise respect, collaboration, reciprocity and sovereignty (McGuffog et al., 2023).

These guidelines required researchers to ensure ethical research practices protecting the rights of Indigenous peoples cultural and intellectual property and to promote positive and mutually beneficial collaborations between researchers and Indigenous communities (AIATSIS, 2020).

2.7.8 National Health and Medical Research Council, 2018

The National Health and Medical Research Council (NHMRC) is responsible for fostering and supporting health and medical research. It plays a key role in developing and maintaining ethical standards for research involving humans. The NHMRC also provides funding for research projects, fellowships and programs aimed at improving health outcomes and contributing to medical knowledge (NHMRC).

The NHMRC has developed guidelines that apply to all research with Aboriginal and Torres Strait Islander peoples and communities (NHMRC, 2018). The *Keeping research on track II* guidelines are designed to inform all aspects of the research project from developing the concept to planning, conducting and analysing the research as well as reporting, translating and disseminating the findings (NHMRC, 2018). The NHMRC guidelines are based on six core values that researchers must consider and include in any research that involves Aboriginal and Torres Strait Islander peoples. The core values are spirit and integrity (positioned as the central value), reciprocity, responsibility, cultural continuity, equity and respect (NHMRC, 2018, p. 7).

In summary, the field of Indigenous healthcare learning and teaching is well-trodden and richly described. So, we return to our central question, implementation – what should you do?

2.8 Chapter conclusion

The chapter has provided insight into racial discrimination, decolonisation, and the role of Indigenous leadership in reshaping healthcare education and practice in Australia. Recognising the deep and ongoing effects of colonisation is essential for fostering culturally safe environments in both healthcare and education.

The integration of Indigenous knowledge and expertise into healthcare education is crucial for achieving cultural safety and improving health outcomes for Aboriginal and Torres Strait Islander peoples. By embedding Indigenous Graduate Attributes into curricula, educational institutions equip students with the necessary skills, knowledge, and attitudes to engage effectively with Indigenous communities and create culturally safe environments. Despite the role of universities and regulatory bodies like TEQSA and the AQF in setting professional standards, significant gaps remain in embedding Indigenous perspectives into these frameworks.

National benchmarks, including the Closing the Gap initiative, highlight the importance of partnerships between the Australian Government and Indigenous organisations. Collaborative efforts by groups like the Coalition of Peaks and Ahpra's work in promoting cultural safety within healthcare professions demonstrate a commitment to structural reform. However, challenges continue to arise in the

mainstream adoption of culturally safe practices and the accountability of institutions to uphold these commitments. Educational standards in higher education must evolve to ensure the explicit inclusion of Indigenous knowledge and cultural safety within quality assurance frameworks. Reputable Indigenous knowledge repositories can offer guidance for educators to engage in self-directed learning and contribute to meaningful reform within their own academic context. Moving forward, integrating Indigenous perspectives into educational and professional structures is essential to achieving equity, respect, and better health outcomes for Indigenous Australians.

The next chapter highlights Indigenous leadership in nation-building and healthcare, upholding principles of self-determination to take hold of our inherent right to sovereignty.

Bunya tree, overlooking Bunya Mountains [photograph], by Danielle Manton

Chapter 3: Indigenous Leadership

This chapter is supported by the following two Croakey Health Media publications:

> Manton, D. (2023). *'We have the knowledge, the expertise and the solutions': International Indigenous Health and Wellbeing Conference*. Croakey Health Media. https://www.croakey.org/we-have-the-knowledge-the-expertise-and-the-solutions-international-indigenous-health-and-wellbeing-conference/

and

> Manton, D. (2023). *Leadership in the room: IAHA conference was a masterclass in Indigenous knowledges, practices and voices*. Croakey Health Media https://www.croakey.org/leadership-in-the-room-iaha-conference-was-a-masterclass-in-indigenous-knowledges-practices-and-voices/

These publications report on Indigenous leadership and are grounded in Indigenous epistemologies. The publications amplify community voices, highlighting Indigenous knowledges, experiences and aspirations in relation to healthcare.

Preface

As in the previous chapter, the essence of the Bunya Project echoes the enduring impact of colonisation and racism on the health and wellbeing of Indigenous communities, including my own family. Just as younger Bunya trees rely on the shelter and guidance of older trees until they mature, our communities lean on our Elders and leaders for protection, guidance and wisdom, nurturing us to become resilient leaders ourselves.

Despite facing adversity in an environment resistant to their growth, our Elders have persevered, paving the way for the reforms and policies that shape our present. True change can only be driven forward by Indigenous leadership, rooted in our terms and our ways. Like Bunya trees thriving in harsh conditions with the right support, Indigenous leadership holds the potential to flourish and drive positive transformation in our communities, in our families and in tertiary education.

3.1 Chapter overview

This chapter highlights the value Indigenous voices, perspectives and leadership can add to health professional education and curriculum. We must recognise and value the leadership of our ancestors and our Elders. We draw strength from our ancestors and Elders, from the sacrifices they have made to afford us the opportunities we have today, as both Indigenous peoples and non-Indigenous peoples.

Prior to colonisation our ancestors cared for us and nurtured us in the land, our Elders guided us through language, story and ceremony. We were taught through modelling, action and responsibility, we knew our place and our role in family and community.

Post colonisation this all changed; however, the principles and values remain. Our ancestors continue to guide and nurture us and our Elders teach us through advocacy, resistance, resilience and modelling. Our leaders are strong; we have ‘blakspertise’, especially in how to care for each other. This chapter highlights the leadership that has challenged systems, policies and processes of segregation and assimilation to get to where we are today. For the first time in Australian history the word ‘racism’ is written in legislation so that the systems and people who continue to perpetuate racism and undermine human rights can be held to account in their own system, using their own laws.

This chapter argues for the crucial role of Indigenous leadership in transforming health education and closing the health gap between Indigenous and non-Indigenous Australians. Drawing on historical context and contemporary challenges, the chapter highlights the enduring power and relevance of Indigenous healing practices and knowledges. It critiques current healthcare systems for silencing and excluding Indigenous voices, contributing to persistent health disparities. Moving beyond critique, the chapter proposes solutions rooted in Indigenous governance structures and culturally safe curriculum redesign, changing the healthcare system through education and a culturally safe workforce.

The key aims of this chapter are to:

1. Describe the importance of Indigenous knowledges and leadership in healthcare and healthcare education.
2. Discuss Indigenous and Western epistemologies through an equity lens.
3. Explain how current systems marginalise Indigenous knowledge and contribute to health inequities.
4. Highlight the need for immediate change and the role of academics as agents of change

The chapter concludes by urging immediate action and partnership with Indigenous communities to build a more equitable and effective healthcare system grounded in Indigenous wisdom and leadership.

3.2 'We have the knowledge, the expertise and the solutions': Leadership in Indigenous Healthcare

For millennia, Aboriginal and Torres Strait Islander peoples have held custodianship over vast knowledge systems encompassing health, land management and cultural practices (Matthews et al., 2023). Yet, despite this rich heritage, health disparities between Indigenous and non-Indigenous Australians persist (Productivity Commission, 2023b; Ring & Griffiths, 2022). This chapter argues that Indigenous leadership in health education offers a critical pathway towards closing the gap and achieving healthcare equity (Povey et al., 2022). By integrating Indigenous knowledges, values and perspectives into teaching and learning structures, we can not only improve healthcare outcomes for Indigenous communities but also enrich the medical education of all healthcare professionals (Manton et al., 2023).

3.2.1 Silencing/Exclusion of Indigenous knowledges

Australia is built on the silencing and exclusion of Indigenous knowledges through a longstanding history of oppression and control faced by Aboriginal and Torres Strait Islander peoples, impacting the passing down of knowledges, recognition of the value and utilisation of traditional knowledge systems, within a mainstream construct (Drummond, 2023). From colonisation to the present day, Indigenous healthcare practices have been regulated and controlled through non-Indigenous bureaucracies, and it is not working. Gaps remain across most Closing the Gap (Dreise et al., 2021) targets, and indicators are stagnant or going backwards (Ring & Griffiths, 2022). Colonial policies and attitudes were intended to suppress Indigenous knowledge systems and promote the dominance of the Western biomedical model. This legacy continues to influence current bureaucratic structures and decision-making processes (Dreise et al., 2021).

Culturally appropriate approaches incorporating Indigenous knowledges and practices are needed (Drummond, 2020; Manton & Williams, 2021). Recognising, respecting and valuing Indigenous leadership, expertise and contextual knowledge are crucial for addressing contemporary healthcare challenges (Kennedy et al., 2022). Aunty Professor Pat Anderson recognised the immense value of Indigenous knowledges and the opportunity that is being missed, saying 'We have over 120,000 years of knowledges, it is absurd not to be acknowledged and respected' (Anderson, 2023). According to Professor Lester-Irabinna Rigney, 'ignoring Indigenous knowledges has failed all Australians, identifying the gap between rich and poor as increasing' (Rigney, 2023).

Recent developments such as the inclusion of the term 'racism' in Australian legislation indicate growing awareness of and efforts towards addressing systemic inequities in healthcare (*Health Practitioner Regulation National Law 2009* (NSW)).

3.2.2 Power of the People

We stand on the shoulders of giants and can undertake the work we can because of those who have gone before us, creating this path of self-determination as well as instilling the cultural expectations and fire to achieve more for our people (Thurston, 2023).

Indigenous peoples and Elders continue to advocate and work tirelessly to break open the spaces where Indigenous practices, knowledges and voices need to be of benefit to Indigenous families, communities and peoples (Ullrich et al., 2022; Woodward et al., 2020). There are so many Aboriginal and Torres Strait Islander peoples who have been determined to improve policies, practices and approaches in Aboriginal healthcare for better health outcomes for Indigenous peoples (Pandey et al., 2023; Stajic, 2020).

Redfern Aboriginal Medical Service was the first Aboriginal medical service (AMS) in Australia, opening in 1971 (AMS Redfern, 2021). The medical service received very little funding and relied on volunteers and community goodwill to run. At the time access to healthcare treatment was limited due to extreme racism, to the point that it was psychologically and physically unsafe (AMS Redfern, 2021). Although the AMS was overwhelmed with patients and the healthcare was provided by voluntary healthcare practitioners, the AMS demonstrated how Aboriginal practices and principles are beneficial to all peoples (Foley, 1991). The current federal minister for Indigenous Australia, Linda Burney, has described Redfern as the birthplace of self-determination (Morgan, 2006).

Aunty Pamela Mam pioneered Aboriginal community-controlled healthcare in Queensland, opening the first AMS in that state in 1973 with no funding, only for it to be firebombed two weeks later, demonstrating the extreme racism at the time (Carson, 2023). According to Adrian Carson, '[s]he was driven by the principles of compassion, commitment, and dedication in what she termed proper

healthcare' (Carson, 2023; Institute for Urban Indigenous Health, 2022). We hold her teachings in the highest regard and 'honour her legacy in everything we strive to achieve' (Carson, 2023). The AMS that once delivered 'proper healthcare' from a small shop front has now grown to a large network servicing 40,000 Indigenous patients in Southeast Queensland (Carson, 2023; Institute for Urban Indigenous Health, 2021).

It is important to remember and make visible the stories of our ancestors, Elders and leaders highlighting the sacrifices, determination, resilience and resistance of individuals like Aunty Pamela Mam and organisations such as the Redfern AMS. This reminds us that we can influence change for a culturally safe and responsive healthcare system that will benefit all Australians (Crooks et al., 2020).

3.2.3 Leadership in Indigenous nation-building

Indigenous nation-building involves efforts by Indigenous communities to assert self-determination, preserve cultural identity and address socioeconomic challenges. It often includes initiatives related to self-governance across key areas such as healthcare, education, economic development and cultural revitalisation (Rigney et al., 2022).

In the context of health, Indigenous nation-building encompasses creating healthcare systems that align with cultural values, prioritise community needs and empower local governance (O'Neil et al., 2016). By integrating traditional healing practices, promoting wellbeing through connection to culture and addressing social determinants of health, Indigenous communities aim to achieve holistic wellbeing and reduce health disparities (McMillan et al., 2016).

Indigenous nation-building is demonstrated through community-led advocacy building community-controlled organisations. This started in the 1970s in Australia with Aboriginal medical services utilising a community-controlled governance structure (AMS Redfern, 2021). Australia has peak organisations that advocate and influence change at a government and policy level; however, although extremely respected in the sector they have no authoritative power in the decision-making process (Coalition of Peaks, 2023; IAHA, 2024; NACCHO, 2022). Globally, countries such as Canada have established a governing structure built on First Nations perspectives, values and principles (Gallagher, 2019), with a network consisting of the First Nations Health Authority (First Nations Health Authority, 2024) working collaboratively with the First Nations Health Directors Association (First Nations Health Directors Association, 2023) and First Nations Health Council (First Nations Health Council, 2023). This process of governance influences system transformation through action and modelling (Gallagher, 2019) and upholds articles 3, 5, 18 and 22 of the United Nations Declaration on the Rights of Indigenous Peoples (UN General Assembly, 2007).

3.2.4 Looking backwards to move forward

We must look backward to move forward. In Australia, false rhetoric has created and reinforced a false truth of colonisation and the atrocities that have and continue to occur based on this notion of ownership, superiority and privilege (Griffin & Trudgett, 2018). As a nation, all people must know the true history of Australia, learn from the truth and heal with the truth (Villanueva, 2021). Aboriginal and Torres Strait Islander peoples know the true history of this country, over 65,000 years of knowledge (Clarkson et al., 2017), with colonial atrocities over the more recent 250 years (Smallwood et al., 2021). Indigenous peoples in Australia need change and recognition, and education is an important conduit to facilitate the transfer of this knowledge, from community. This is supported by an international consensus statement made by globally leading academics in the field stating colonisation, privilege and racism are critical components of the healthcare education curriculum (Jones et al., 2019).

In Māori culture there is a proverb that translates to 'walking backwards into the future' (O'Sullivan, 2019), recognising the evolution of Indigenous wisdom through rebellious, resistant and resilient practices that maintain their relevance to the current context (O'Sullivan, 2019). Further, recognising Indigenous knowledges and ways of knowing offers solutions for several contemporary issues, such as relationality – how we work with each other, managing power differentials through processes such as collective governance and decision-making – as well as specific issues such as climate change, land management practices and pandemics (Manton, 2023; Woodward et al., 2020).

3.2.5 Equity and strength

Equity

Indigenous and Western worldviews and epistemologies are opposed (Martin et al., 2017; Nakata, 2007; Williams et al., 2023). This is specifically evident in understanding and approaches to healthcare, where the Aboriginal definition of health is holistic focusing on the physical, spiritual and cultural wellbeing of the whole community (National Aboriginal Health Strategy Working Party, 1989). Opposingly, Western biomedicine focuses on the body, the illness and the absence of disease (Cambrosio et al., 2003).

Equity is tenuous when the systems and structure continue to provide advantages to non-Indigenous peoples (Francis-Cracknell et al., 2023). Aspiring to 'equity' can be a form of subtle assimilation, as the goal is to be 'equal' to our non-Indigenous counterparts; however, due to the different worldviews and epistemologies involved the approaches, indicators and successes may be completely different from those of the mainstream approach (Watego, 2023). Comparing two completely different peoples using the same measurement tools, approaches and indicators of success all too often fails, with the blame

attributed to First Nations peoples' non-compliance or perceived inadequacies (Craven et al., 2016). Equity alone cannot meet the needs of Aboriginal and Torres Strait Islander peoples.

Programs, approaches, structures and funding models are designed in a way that can never truly know, understand or reflect Indigenous peoples, systems, structures, processes and governance. For example, advocating for equity involves demonstrating a problem or a solution to access resources, this is not a good use of time or resources: 'A lot of the work is in documenting the issues and the findings so that they will have uptake by non-Indigenous peoples – but it is what community already knows too well' (Reid, 2023).

Strength

The deficit approach required to access equity funding, to get attention from bureaucrats to act, in and of itself contradicts Indigenous principles, and ways of working.

> Unfortunately, governments continue to see Aboriginal and Torres Strait Islander disadvantage from a deficit-based approach – addressing the 'Indigenous problem'. Governments need to move to see us as capable and resilient. (Gooda, 2012, p. 6).

In contrast, a strengths-based approach focuses on what is present rather than what is absent. A strengths-based approach demonstrates Indigenous leadership and expertise as healthcare professionals. The strengths-based approach is pragmatic and cost-effective (Bullen et al., 2023; Fogarty et al., 2018) and focuses on solutions, building on what already exists and is already effective. One example of this was during the COVID-19 pandemic, when Aboriginal Community Controlled Health Organisations drew on their knowledges and expertise to keep community safe even when faced with limited access to public resources (Crooks et al., 2020; McCalman et al., 2021). Celebrating success is a critical strategy in challenging stereotypes by influencing change in public attitudes, perceptions and experiences regarding Indigenous peoples and events (Australian Human Rights Commission, 2019).

3.2.6 Taking hold of sovereignty

Indigenous sovereignty refers to the inherent right of Indigenous peoples to self-governance, to make decisions about their own affairs, and to control lands and resources. It recognises Indigenous peoples' unique political and cultural status, emphasising autonomy and the ability to determine our destinies while maintaining our connection to the land; a spiritual connection to Country, to ancestors and future generations (Referendum Council, 2017).

The UNDRIP (article 20) states that Indigenous peoples have a right to a self-governed economy, to be able to have resources available that can be used according to priorities determined by the community (UN General Assembly, 2007).

Economic independence is a key aspect of sovereignty and the ability of Indigenous peoples and communities to have self-determination. Financial control is one of the most effective tools of oppression (Villanueva, 2021) Indigenous peoples cannot generate an economy from poverty (Diver, 2023; Rigney, 2023). Economic safety and security are crucial for 'communities to have the opportunity for a safer, happier future' (Diver, 2023). Indigenous organisations such as the Kaiela Institute are building this future by establishing a prosperity plan, which aims to build a thriving First Nations economy and income to be invested in the region (Algabonyah Bussiness Development Unit, 2021; Briggs, 2023).

Sovereignty should also be present within governance structures to include Indigenous accountability – listening to Elders with the patience and humility to accept when you are not doing it right (Australian Physiotherapy Council, 2022; Bishop, 2023; Kennedy et al., 2022).

> One of the most glaring limitations of human rights protections in Australia is that the Australian system of government does not prevent the federal government from making laws that discriminate against Indigenous peoples on the basis of race. Recent examples include the federal government's 1998 amendments to the Native Title Act and the enactment of the 2007 Northern Territory Emergency Response legislation (which suspended the application of racial discrimination laws). (Australian Human Rights Commission, 2009, p. 3)

Indigenous governance structures contrast with the Western structure with differing values, and accountability systems reflective of those values (Jumbunna Institute Indigenous Policy Hub, 2020).

At present, governance and accountability are not reciprocal, shared or equal. Aboriginal Community Controlled Organisations are accountable to the government in order to receive funding. However, the government has no Indigenous governance structure with the influence or power to hold the government accountable. The NSW Closing the Gap implementation plan 2022-–2024 identified the NSW Government's 'commitment to be accountable to the community' through two-way dialogue and effective communication (Commonwealth Government, 2023).

3.2.7 The need to change practice

Aboriginal and Torres Strait Islander peoples are not having their needs met through the current health systems and structures (Jones et al., 2020). Despite a merry-go-round of policies and initiatives, this remains true. Healthcare practice one aspect of the systemic the problem; within a complexity of challenges healthcare practitioners on the frontline need to have the knowledge, skills and training to implement the professional capabilities required to work with Aboriginal and Torres Strait Islander peoples (Taylor et al., 2020). Therefore, healthcare practice needs to change (Aspin et al., 2012; Jennings et al., 2018; Manton et al., 2024) under the leadership of Indigenous and community experts.

Often the ‘standard’ response is to increase employment targets, which is a well-used strategy to deflect responsibility as an ‘Indigenous problem’, suggesting that it is an unskilled, underprepared total healthcare workforce that is the problem (Durey & Thompson, 2012; Harding, 2018). Current practice does not uphold our human rights to access healthcare free from racism, nor does it value Indigenous sovereignty or control over healthcare (Bradley, 2019; Parter et al., 2021).

Indigenous leadership in healthcare education is crucial (Bearskin, 2023). This does not mean an Indigenous community member or academic needs to teach every class with Indigenous content (Villanueva, 2021). Rather, it means Indigenous academics should have oversight over the curriculum; curriculum should be co-designed with Indigenous academics and community members to ensure what is taught reflects Indigenous values, experiences and aspirations for their healthcare (Kennedy et al., 2022; Manton et al., 2023).

3.2.8 Culturally underpinned Indigenous healthcare practice

Culture underpins all healthcare practice and healing. Culture is not limited to song, dance and ceremony; culture is in Indigenous values, Indigenous principles and interactions with each other (Manton & Ragg, 2023, p. 14). Culture is a determinant of wellness (Salmon et al., 2018) and can be a significant omission when not recognised and included in treatment as a core element of a patient’s or client’s treatment plan by the healthcare practitioner or team (Manton & Ragg, 2023).

Indigenous worldviews and values differ from Western worldviews and values when considering evidence-based practice. From an Indigenous perspective, in the community the evidence is in the result, in seeing people thriving (Kinchin et al., 2017; Manton & Ragg, 2023, p. 21) as opposed to evidence that is peer-reviewed and published.

The focus needs to be on wise practices for education, standards, partnership and research (Paul et al., 2010), where research and practice work collaboratively (NHMRC, 2018). If done well, upholding the ethical research principles (AIATSIS, 2020; NHMRC, 2018), researchers can work alongside the community. ‘We know the answer but have to bring our stories together as evidence to convince the powerful – here is the evidence’ (Smith, 2023). This could be an opportunity to ‘elevate Indigenous knowledges to change the world – provide a different imagery of what the world could be’ (Smith, 2023).

Indigenous peoples have the knowledge, expertise and solutions that can be beneficial and should be integral to healthcare education. It is time to create and hold the space in tertiary education for Indigenous peoples to lead the way for our peoples and all peoples to flourish in the future.

3.3 Summary

Embracing Indigenous leadership in health education is not simply an option, but a moral imperative. By recognising the intrinsic value of Indigenous knowledges, investing in culturally safe curriculum redesign and empowering Indigenous governance structures, we can create a culturally safe healthcare system that honours the past, heals the present and builds a future in which all peoples thrive.

The journey towards culturally safe healthcare requires a transformative shift in mindsets, a willingness to learn from and alongside Indigenous knowledge-keepers. The seeds of change have been sown, nurtured by the strength and resilience of Indigenous communities. It is our responsibility, as healthcare professionals, as educators, as citizens, to ensure these seeds blossom into a future in which health and healing weave a tapestry of inclusion, respect and shared prosperity.

The time for action is now. Let us rise to the challenge, guided by the wisdom and leadership of Indigenous communities, and forge a path towards a healthier future for all.

3.4 Croakey Health Media

Croakey Health Media is a not-for-profit public interest journalism organisation, established in 2018 with a mission to promote the health and wellbeing of individuals, families, communities, societies, and the environment.

The organisation's vision is to build a sustainable public interest journalism sector that contributes to the health and wellbeing of people and the environment at local, regional, national, and global levels. Its purpose is to provide social journalism and professional services that empower communities, policymakers, and civil society to improve health outcomes, focusing on health equity and inclusion.

Croakey Health Media is governed by a member-elected board, ensuring transparency, integrity, and alignment with its core values. These values include respect for Country and First Nations Peoples, independence, commitment, service, trust, and courage. The Croakey Health Media values are closely aligned with the aim and impact of the Bunya Project, publication below reflects the values of Croakey Media and the Bunya Projects commitment to privileging Indigenous voices and leadership in healthcare.

3.4.1 Croakey Article 1

This publication reports on Indigenous leadership and is grounded in Indigenous epistemologies. This publication relates to the broader Bunya Project as it demonstrates expertise within Indigenous communities, workforce and academia. This publication provides and holds space to amplify community voices, highlighting Indigenous knowledges, experiences and aspirations in relation to healthcare.

While the article has the same name as the content previously provided in this chapter, content is aligned through different public health readership.

> Manton, D. (2023). '*We have the knowledge, the expertise and the solutions': International Indigenous Health and Wellbeing Conference*. Croakey Health Media. https://www.croakey.org/we-have-the-knowledge-the-expertise-and-thesolutions-international-indigenous-health-and-wellbeing-conference/

"We have the knowledge, the expertise and the solutions": International Indigenous Health and Wellbeing Conference

Editor: Ruth Armstrong **Author:** Danielle Manton Thursday, June 22, 2023

In: #Lowitja2023, Racism, Indigenous health, Uluru Statement, The Voice, Cultural determinants of health, Lowitja Institute, Public health, Human rights, Health and medical research

Introduction by Croakey: If you had FOMO from all the tweetage that arose from the Lowitja Institute's conference on the lands of the Gimuy Walubara, Yidinji and Yirrganydi peoples in beautiful Cairns, strap yourself in.

The best conferences are the ones that not only inspire you, but leave you thinking and build on your thoughts and actions in some way.

In the report below for the Croakey Conference News Service, Danielle Manton, a Barunggam women, grown up on Dharug Country and Senior Lecturer in Indigenous Teaching and Learning at the University of Technology Sydney, reflects on, and responds to some of the conference highlights, around its themes of Truth, Rights and Response.

Danielle and Terry Manton, with son Levi

Danielle Manton writes:

The Lowitja Institute's Third International Indigenous Health and Wellbeing Conference started with force. In keeping with the theme for day one of **TRUTH**, the Welcome to Country set the tone with the truth of the Country we were gathered on, the unceded land of the Gimuy Walubara, Yidinji and Yirrganydi peoples.

Gudju Gudju Fourmile welcomed us to his Country, speaking of the truth of the land, and sharing the truth of the dispossession of land, separation from family and Country, the violence of colonial authorities and domination and control over the Gimuy Walubara, Yidinji and Yirrganydi peoples.

Gudju Gudju Fourmile sets the tone for the conference with his welcome.

Gudju Gudju Fourmile spoke of the ongoing impact of intergenerational trauma and poor health outcomes, sharing story of his family, his experiences and his own health challenges. He left the delegates with a clear call to action: "The truth telling has to start…our health is in your hands."

An audio-visual presentation featuring conference Patron Aunty Dr Lowitja O'Donoghue ignited the passion and motivation in the delegates with an inspirational directive, "I believe we have the solutions at hand, don't be afraid to take a risk."

Australian Minister for Health and Aged Care Mark Butler acknowledged in a pre-recorded message that the conference was a "showcase of the strengths of Indigenous knowledge and culture from all over the world".

A welcome also from DrBernie Singleton on behalf of the Yirrigandji clan

Power of Indigenous Truth

Truth incorporates our truth as Indigenous peoples and knowledge holders. Australia has a lot to learn from Indigenous peoples: "We have over 120,000 years of knowledges, it is absurd not to be acknowledged and respected," Aunty Professor Pat Anderson told the conference in a keynote address.

A truth that emerged from this presentation is that we have done it their way for long enough. It is definitely not working for our peoples, but as well as that, it doesn't seem to be working well for any people!

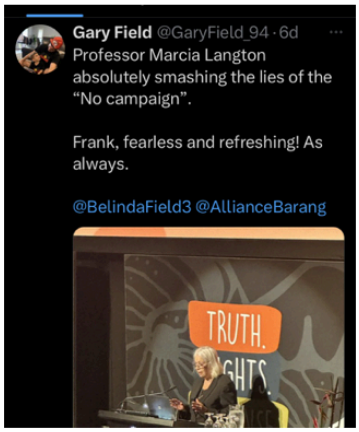
Later in the conference, Professor Lester-Irabinna Rigney reiterated how ignoring Indigenous knowledges has failed all Australians, identifying the gap between rich and poor as increasing as we make an authoritarian shift.

Truth about the constitution

Distinguished Professor Marcia Langton AO presented an authentic yarn with the audience, sharing her learnings and insights regarding the Voice process and the Australian constitution. Her presentation was personal and inspiring, she had no script or notes, speaking from her heart rather than as a professor of anthropology or geography, but as an Aunty. It felt as though we could've been sitting around the kitchen table.

The truth is the constitution was written in 1901 at a time when all government policies and documents were designed to oppress Aboriginal and Torres Strait Islander peoples. In another session, Aunty Professor Pat Dudgeon put it this way: "Colonisation is a takeover of what is considered truth and knowledge".

Langton went on to say that the social constructs of Australia have changed dramatically, and as a country we need a document that reflects the society we live in. Additionally, the Government has a responsibility to our peoples and the Voice to Parliament "is the most minimal of rights, it is a constitutional pathway to overcome racism," she stated.



International perspective on truth

Karen Diver followed Distinguished Professor Marcia Langton with practical and powerful insights from her experience in the United States. Diver served as Chairwoman of the Fond du Lac Band of Lake Superior Chippewa from 2007 -2015 and was also appointed by the Obama Administration as the Special Assistant to the President for Native American Affairs among other influential roles advocating for her peoples.

Diver reminded us that social change is a process of slow and steady growth, and our best offensive is to work from the inside, have representation in every agency, and have a voice at as many tables as possible.

"It makes you wonder why being in a conversation about our own future is scary for some people," she said.

It should be simple: #nothingaboutuswithoutus.

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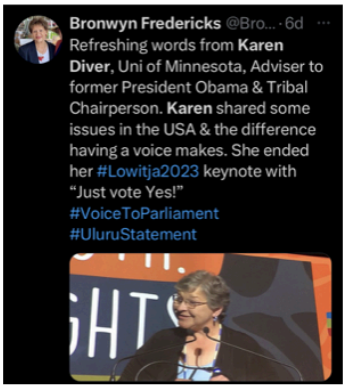


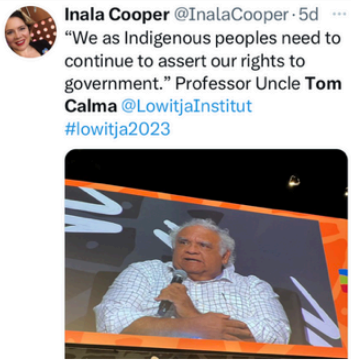
Healing power of truth

The message from these keynote speakers was clear and consistent: we must look backwards to move forward.

As a nation all people must know the truth, learn from the truth and heal with the truth. Aboriginal and Torres Strait Islander peoples know the true history of this Country, over 65,000 years of knowledge, with colonial atrocities the more recent 250 years. We need change and recognition. Isn't the definition of insanity to continue to do the same thing and expect a different outcome?

In the words of Aunty Professor Gracelyn Smallwood AO, we need to ask ourselves and those within our sphere of influence: "What did you do to leave a legacy for our children? We need to start with something."

Day 1 International panel on Voice, Treaty, Truth



Day 1 international panel on voice, treaty, truth

The plenary for Day two, with the theme of **RIGHTS** consisted of three formidable First Nations global leaders and changemakers: Munanjahli and South Sea Islander woman Professor Chelsea Watego, Professor Janet Smylie, a Métis Physician and health researcher from Canada, and Professor Papaarangi Reid, a distinguished public health practitioner who belongs to Te Rarawa iwi.

Rights and equity

Professor Chelsea Watgeo made many thought-provoking points; one that stuck with me was "equity is of service to white supremacy". In unpacking this I realised the truth of it. Although often well-intentioned, equity alone cannot meet the needs of Aboriginal and Torres Strait Islander peoples.

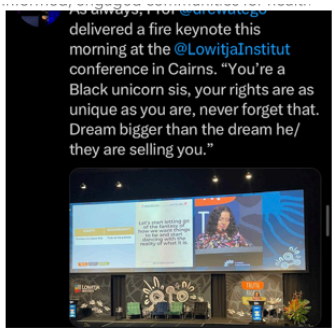
Our worldviews are opposing, and aspiring to "equity" can be a form of subtle assimilation, which all too often ends in failure, with the blame attributed to First Nations peoples' non-compliance or perceived inadequacies.

In reality, programs, approaches, structures and funding models are designed in a way that can never truly know and understand Aboriginal and Torres Strait Islander peoples, our systems, structures, processes and governance. Indeed, part of advocating for equity involves demonstrating a problem or a solution in order to access resources.

Another of the keynote speakers, Professor Papaarangi Reid, identified this, stating "a lot of the work is in documenting the issues and the findings so that they will have uptake by non-Indigenous peoples – but it is what community already knows too well".

Watego told the conference, "It's time we blackfellas break up with equity, it's a toxic relationship we've got to get out of. We have options, we have sovereignty!"

Sovereignty is also reflected in the Uluru Statement from the Heart as our connection to the land; a spiritual connection to Country, to our ancestors and our future generations.



Taking hold of Sovereignty

The panel discussion later in the day on the economic determinants of health supported the concept of sovereignty, with Yorta Yorta man and chair of the Kaiela Institute in Shepperton, Paul Briggs OAM, outlining in practical terms "we have rights to an economy, we need resources at our disposal to allocate to our own priorities".

Fellow panellist Karen Diver stated, "we cannot be passive and complacent and drive an economy off poverty". Diver went on to recognise "the ever-present need of our communities to have the opportunity for a safer, happier future".

Briggs said the Kaiela Institute was building this future by "establishing a rights-based platform that repositions the value of Indigenous peoples in the economy".

Sovereignty includes governance structures. Australia's inaugural Ambassador for First Nations People, Justin Mohamed, spoke to Indigenous accountability – listening to Elders with the patience and humility to accept when you are not doing it right.

Ambassador Mohamed added another layer into the conversation regarding First Nations foreign policy: to "have conversations with Indigenous peoples across the waters".

Rights through sovereignty was also a common focus in the concurrent sessions.

Aunty Dr Carmen Parter, a proud decendent of the Darumbal and Juru clans of the Birra Gubba Nation of Queensland, from the Djurali Centre, Macquarie University, presented on "Rightfully reclaiming our sovereignty in research data analysis: an Indigenous data analysis framework of practice through story telling," articulating, "My ancestral knowledges are critical in my research process."

Parter went on to say that "maintaining our sovereignty in data analysis is our inherent right".

Day three, with the theme **RESPONSE,** was a call to action. Lowitja lifetime award winner and first keynote speaker for the day three plenary was Professor Lester-Irabinna Rigney.

Rigney spoke with purpose, abandoning his pre-prepared presentation to gift both the Higher Degree and Early Career researchers with his insight gained through multiple decades in research and advocacy for our peoples, our communities and our children.

The need to change practice

Rigney was concise in stating what needs to change, to improve healthcare: "The basic move is about practice, what is the health workforce practice and who does it serve?" He went on to remind us, "Practice is the problem. Our people do not get their needs met if they go to the dominant healthcare service."

Rigny's comments interwove the themes from the previous days. Our people do not get their needs meet in colonial systems because the true history of the systems is not addressed. Aboriginal and Torres Strait Islander peoples experience racism, exclusion, and dismissal at alarming rates to the detriment of their own health and wellbeing.

Current practice does not uphold our human rights to access healthcare free from racism or value our sovereignty to have control over our healthcare.

Rigney left the delegates with the reflective challenge: "What is the purpose of your practice and who benefits?"

Culturally underpinned practice

The second speaker in the Day three plenary was Métis Registered Nurse leader, Dr Lisa Bearskin, from the University of Victoria in Canada. Dr Bearskin embraced the theme of response, recognising the response already occurring in our communities globally.

Bearskin acknowledged "the huge responsibilities we carry forward, protecting our culture, our knowledge and claiming our sovereignty".

In a similar vein to Professor Lester-Irabinna Rigney's focus on practice, Dr Bearskin said: "We are moving away from evidence-based practice and moving towards wise practices for education, standards, partnership and research."

In community we see our people thriving and that is evidence.

This was supported by the final speaker, Distinguished Professor Linda Tuhiwai Smith from the Ngāti Awa, Ngāti Porou and Tuhourangi tribes in Aotearoa New Zealand, who said: "We know the answer but have to bring our stories together as evidence to convince the powerful – here is the evidence."

Smith also told the conference, "research can lift the burden in service delivery". To work alongside community strengthens community and strengthens us as members of the community.

Smith used the opportunity to encourage, inspire and motivate the delegates to keep up the work to which she and her colleagues across the globe have dedicated their lives. She encouraged us to, "elevate Indigenous knowledges to change the world – provide a different imagery of what the world could be".

Future focus

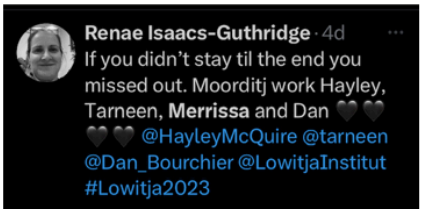
The final presentation of the conference, titled 'Honouring the future', was a panel presentation from three deadly innovators – disruptors refusing to accept the status quo of society.

All three panellist have taken the lead in amazing organisations, changing the lives of Indigenous young people and paving the way for a better future. Their work demonstrates what can be achieved when practice is done right!

Tarneen Onus-Williams, Australian Progress Fellow, told the conference that: "Revolution has always been in the hands of young people…make as much of an impact as you can."

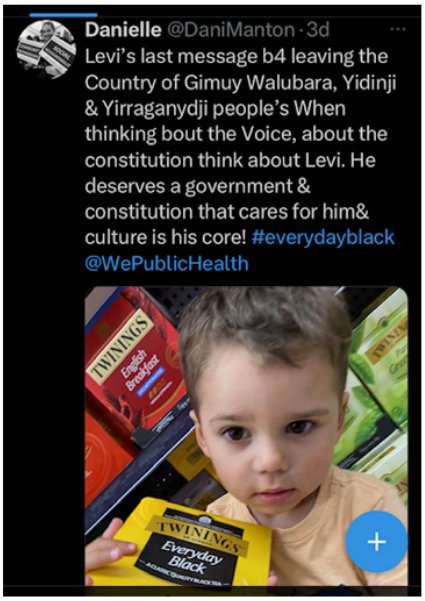
Speaking on the panel about her work as CEO and founder of the National Indigenous Youth Education Coalition, proud Darumbal and South Sea Islander woman Hayley Maguire added: "If you do it our way you can actually heal."

Another panellist, Merrissa Nona, "Chief of Good" (CEO) of Deadly Inspiring Youth Doing Good, was equally optimistic, stating: "It is fully engrained in the next generation: anything is possible!"



The Third Lowitja conference was refreshing, inspiring and motivating, it set the tone for a year of change, a year where anything is possible.

The conference reminded us through its themes of truth, rights and response, that we have the knowledge, the expertise and the solutions. It is time for us to lead the way for our peoples and all peoples to flourish in the future.



3.4.2 Croakey Article 2

This publication reports on Indigenous leadership and is grounded in Indigenous epistemologies. This publication relates to the broader Bunya Project as it demonstrates expertise within Indigenous communities, workforce and academia. This publication provides and holds space to amplify community voices, highlighting Indigenous knowledges, experiences and aspirations in relation to healthcare.

Manton, D. (2023). *Leadership in the room: IAHA conference was a masterclass in Indigenous knowledges, practices and voices*. Croakey Health Media

URL: https://www.croakey.org/leadership-in-the-room-iaha-conference-was-a-masterclass-in-indigenous-knowledges-practices-and-voices/

Uncle Lyndon Davis and his dancers from the Kabbi Kabbi People open IAHA 2023 with a Welcome to Country. Image Danielle Manton

Leadership in the room: IAHA conference was a masterclass in Indigenous knowledges, practices and voices

Editor: Ruth Armstrong **Author:** Danielle Manton **Wednesday, December 6, 2023**

In: Social determinants of health, Racism, Vaping, Donor-funded journalism – 2023, Indigenous health, Uluru Statement, Cultural determinants of health, Cultural safety, Indigenous education, Allied healthcare, Public health

Introduction by Croakey: Last week, the annual conference of Indigenous Allied Health Australia (IAHA) took place on the traditional lands of the Kabi Kabi peoples, on Queensland's Sunshine Coast.

In the post below, Danielle Manton, a Barunggam woman-grown on Dharug land and a Senior Lecturer in Indigenous Teaching and Learning, describes how delegates were taken on a journey of reflection on the "leadership, strength, resilience and courage of our ancestors, to honour and protect our ways, our knowledges, our voices and our practices."

It's a journey you won't want to miss, in very good company, so hop on. (And also check out the previous post of Snaps and Selfies from the conference).

Our Knowledges, Voices and Practices: conference themes. Image, IAHA

Danielle Manton writes:

The theme of leadership was clearly woven through the 2023 IAHA conference, starting with the Welcome from Uncle Lyndon Davis, Traditional Custodian of Kabi Kabi lands, waterways and skies.

In sharing the stories and songs of his ancestors and old people, Uncle Lyndon commenced a journey for us, the delegates, that was carried throughout the conference to reflect on the leadership, strength, resilience and courage of our ancestors to honour and protect our ways, our knowledges, our voices and our practices.

The welcome shared culture through song and dance, immersing us in the strong, powerful and rich history of Kabi Kabi culture.

IAHA CEO Donna Murray said "the welcome and the nourishment, love and strength our Kabi Kabi brothers and sisters have given us has been phenomenal."

She said:

> *It's about our ways of leadership, our ways of learning, our ways of working and our ways of transformation, collectively and individually."*

Leadership "in the room"

The leadership was in the room – Jayde Fuller, Gamilaroi woman and National Director of the Aboriginal and Torres Strait Islander Health Strategy in the Australian Health Practitioner Regulatory Agency (Ahpra), acknowledged the "staunch leadership" of Donna Murray in her opening remarks.

Fuller further recognised "the strength and the power of Indigenous ways of knowing, being and doing," as a "critical protective and enabling factor for combating racism in healthcare," and acknowledged the collective expertise of Aboriginal and Torres Strait Islander health practitioners.

She went on to discuss the important work she is leading at Ahpra, noting that racism is inextricably linked to healthcare outcomes, that the role of Ahpra is to protect the public, and that Aboriginal and Torres Strait Islander peoples are absolutely deserving of safe care.

Fuller recognised the important and central role of Aboriginal and Torres Strait Islander leadership in anti-racism and cultural safety reform stating,

> *reform requires blakspertise (a shorthand word for black expertise). We have Indigenous staff in Ahpra to lead and implement the cultural safety strategy."*

Through the leadership of Fuller and her team, October 2022 saw the introduction of a national legislative amendment prioritising cultural safety in healthcare provision – "the first time the word racism has been featured in healthcare legislation in Australia".

This legislative change provides a clear measure to hold all healthcare practitioners and healthcare education institutions to account.

Fuller highlighted a landmark anti-Indigenous racism tribunal decision earlier this year in which a non-Indigenous medical professional's behaviour was found to constitute medical misconduct, resulting in prohibition from providing any healthcare service and ineligibility to apply for medical registration for at least 12 months. (See also this Croakey report).

Uncle Professor Tom Calma AO, an Aboriginal Elder from the Kungarakan tribal group, member of the Iwaidja tribal group in the NT and co-patron of IAHA, demonstrated his leadership by igniting the fire in the delegates "Creating opportunities is one thing. Taking advantage of opportunities is the other – that's your job".

Uncle Tom acknowledged the year that has passed, saying "there is hope, there has to be hope".

"The referendum lost, we will look at other measures and work, and put pressure on government and the opposition, to make those changes. We still have truth-telling and treaty processes to come," he said.

Calma also reminded us that 6.2 million people that voted yes and over 60, 000 Australians walked with us as volunteers – "how do we capture and maintain the momentum? The younger voters were positive in voting yes," he added. "The future is looking bright!"

The co-design process of the Uluru Statement from the Heart modelled leadership through a process that was "validated by Community, demonstrating the inclusive nature of what a voice should look like – participation across the nation, capacity building. They [the principles of effective leadership] are all there, and they are sound," said Calma.

From this leadership and modelling, he said, "many Aboriginal organisations have started to take up these principles within their own Aboriginal Community Controlled organisations."

Professor Tom Calma AO addresses the conference. Image IAHA instagram

Dr Aunty Jackie Huggins AM, a Bidjara and Birri Gubba Juru woman, began her keynote address by recognising the leadership and expertise in the room, saying, "I salute all of you and the work that you do in terms of keeping our people healthy, alive, sustained and well."

Huggins invited us to listen to her journey and the leadership that has shaped her career. She said:

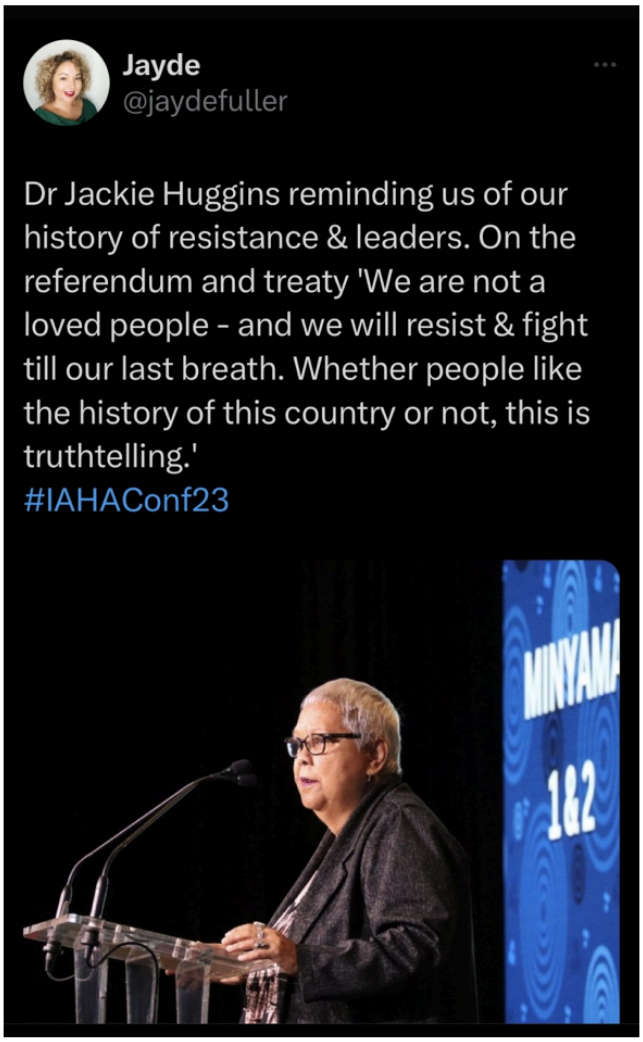
> *I walk in the giant footsteps of my ancestors, particularly my mother Rita who struggled and worked for our people to be treated equally and to be recognised as this Nation's First Peoples. I am reminded of her and so many other people, and it spurs me on, and it should spur you all on."*

Huggins, who has been a strong advocate for Treaty in Queensland, said "now is the time I really believe that we can correct all of the misinformation through treaties across the Country".

Further, she has been instrumental in establishing a staged approach to truth-telling and healing that honours the importance of the local context and experiences of Aboriginal and Torres Strait Islander peoples since colonisation in Queensland (more information can be found through the Interim Truth and Treaty Body.)

Huggins continued to remind us of the strength we draw from our ancestors, that they have prepared us to stand up, be strong, and do what is right for our people and Country. She told the conference,

> *You know we are a strong and resilient mob and how can we not be, since we have existed over 65 000 years in this place, cared for it, loved it, our links to nature and the environment will go unrivalled anywhere in the world.*
>
> *We are living treasures in our own land and our ancestors will not see us suffer too long. We carry all their legacies and will keep fighting to help justice and healing amongst others."*



Johnathan Thurston AM, Gunggari man, also opened his talk recognising the leadership and sacrifice of the Elders that have gone before him, saying he would like to "thank our Elders for the paths they have walked and the battles they have fought. Because of you, my generation are afforded the freedoms that you were not, so thank you."

Johnathan Thurston AM: a true leader and a conference favourite. Image IAHA Instagram

On Day two of the Conference, Uncle Dr Mick Adams spoke to the IAHA delegates about his journey into academia and the leader he was born to be. He said "I never took a backward step, never felt shame. If I wanted it, I tried to get it."

Adams, who is a descendent of the Yadhiagana/Wuthathi peoples and the Gurindji people with extended family relationships with the people of the Torres Straits, Warlpiri (Yuendumu), and East Arnhem Land (Gurrumaru) communities, spoke of a paper he wrote in 2004 documenting his journey titled "A journey through the academic mist."

In the paper he highlighted the leadership of those before him and those beside him. He said: "The journey of reconstruction for Aboriginal and Torres Strait Islander males has just begun. For some of us we have followed leaders and broken down the barriers to take our rightful positions within our communities and the family context."

Adams provided this advice for future leaders in the room:

> *Do what you want to do and make sure you do it right, that's when you become the expert and no one can fault you, but if you take shortcuts, they are going to catch you out".*

Dr Mick Adams, later in the conference, received the 2023 Craig Dukes Lifetime Achievement award

Adrian Carson, CEO of the Institute for Urban Indigenous Health (IUIH), shared the story of leadership from Aunty Pam Mam IUIH Patron who in 1973 opened the First Queensland Aboriginal Medical Service in Redhill, without any government funding. At the time, racism was overt and aggressive. Within the first two weeks of its opening, the Institute was firebombed! Aunty Pam said, "Nothing is to stop, everything must continue!"

Carson spoke of the organised approach of the IUIH network despite a health system that was designed to be convoluted and complex. The IUIH network is coordinated and integrated to be able to provide culturally safe healthcare access to up to 40,000 Indigenous patients in Southeast Queensland.

Carson's concluding slide read:

"IUIH continues to be guided by the experience and wisdom of our Elders, particularly our Patron Aunty Pamela Mam who pioneered Indigenous Health in Southeast Queensland. She was driven by the principles of compassion, commitment, and dedication in what she termed proper healthcare. We hold her teachings in the highest regard and honour her legacy in everything we strive to achieve."

Leadership in Our Practices

Throughout the conference, we saw many examples of leadership in practice. Beginning with Jayde Fuller who spoke about the importance of Indigenous leadership in regulating against racism.

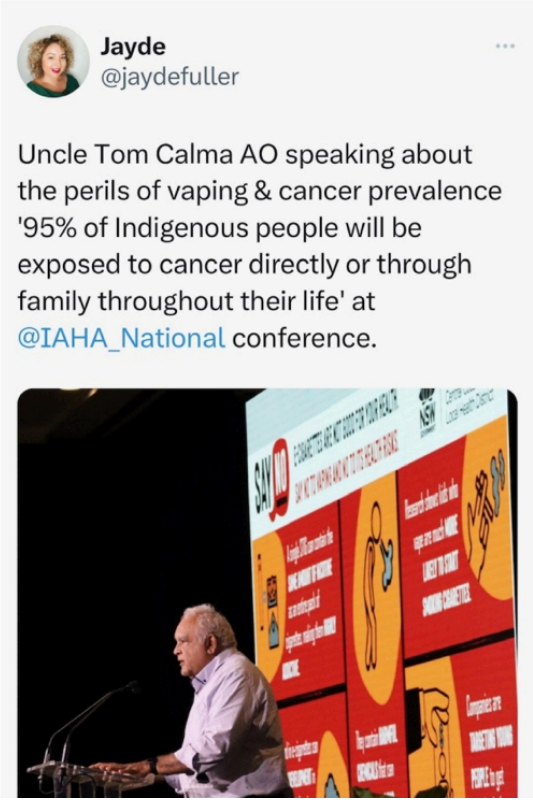
She said: "To work respectfully and safely with mob, the governance must be grounded in principles of self-determination, centring our leadership in defining and driving cultural safety. We (Ahpra) have the Aboriginal and Torres strait islander health strategy group, our most senior authorising body relating to cultural safety program."

Uncle Tom Calma, in acknowledging the Kabi Kabi peoples, recognised the leadership in practice of IAHA, stating:

> *Our youth are going to be the future custodians of our knowledge, stories and culture, history and languages. We demonstrate in practice the recognition of our youth here at IAHA, in the way we bring them through and take the opportunity to develop people."*

Calma demonstrated leadership in practice, speaking in his role as the National Coordinator for Tackling Indigenous Smoking.

He called on delegates to be active in tackling smoking and vaping, saying, "it's important we don't just rely on GPs … Each of you have a responsibility and capacity to do a brief intervention. If you come across a client… and can smell a cigarette or the flavour they are puffing on – the smell of the vape – just have a chat with them. It's not about telling people *don't do it*, it's about saying *if you need a hand to change your behaviour these are the referral pathways*. It's one of the biggest killers for our mob."



Johnathan Thurston talked about leadership in practice, through his own experience in Rugby League saying, "It's not luck, it's hard work, dedication and sacrifices."

Thurston has also demonstrated leadership in practice through the work of the Johnathan Thurston Academy. He said: "Our staff and myself want to be that support crew to help them start setting goals, wrap our arms around them and hopefully get them re-engaged back into schooling and create better behavioural changes."

Adrian Carson provided many examples of leadership in practice at IHUI, including IHUI's integrated system of care, growing from five services in 2009 to 19 in 2023!

IHUI is also implementing the First Specialist Mental Health Hub in Queensland.

Leadership in Our Voices

Jayde Fuller demonstrated the leadership in our voices, underpinned by principles of self-determination, whereby Aphra created a public consultation process, holding space primarily for Indigenous peoples, while also allowing space for allies to contribute to the "scheme-wide definition of cultural safety." The consultation led to, "one definition of cultural safety which helps to form a common understanding and shared language among all health practitioners".

Johnathan Thurston has used his Voice to create a platform for change for the next generation of Indigenous leaders. He said: "The Jonathan Thurston Academy has nothing to do with Rugby League. It is about education, employment and wellbeing."

In using his voice and platform, he reminds the young people he works with of their privilege to be able to self-determine their own future saying:

> *Don't be shame, if you knew what your Elders had done for you to be here, you'd walk with your head high, chest out. They fought those battles for you to be able to make the decisions you get to make. They didn't get to make those decisions when they were growing up because that was controlled by this nation."*

Leadership in Our Knowledges

Presenting the IAHA leadership program, Donna Murray said "leadership is identified as critical in every workforce strategy, however, it is invisible".

In 2022 IAHA welcomed their first leadership program cohort. The Program draws on the IAHA Cultural Responsiveness framework. Murray highlighted that IAHA members identified "our ways of knowing being and doing" are the critical success points: our knowledges.

Murray went on to say: "Working in mainstream spaces, I also use Aboriginal leadership, but that is on a professional level as well, and I'm always bringing my cultural self to these spaces. That is what we embed in our IAHA leadership program."

Leaders among leaders Uncle Tom Calma, IAHA patron and Donna Murray, IAHA ceo @IAHA_National

Huggins recognised the leadership demonstrated in our young people, drawing on Western education to advocate and influence change while being grounded and true to our own knowledges:

> *My great hope: I see many young people who are so grounded in their culture, they have Western education (not all of them) but they are so grounded and so fierce about asserting their rights as Aboriginal and Torres Strait Islander peoples of this Country and it makes me really proud."*

Kevin Yow Yeh, Wakka Wakka and South Sea Islander man and IAHA conference MC, recognised the importance of our voices, the contribution we make for our people, and the leadership of our knowledges, saying, "how important black researchers are in this place, given, historically, the production of knowledge in this place has been racist".

He took this further to highlight and literally call out the leadership of Narungga, kaurna, Ngarrindjeri educationalist, Uncle Professor Lester – Irabinna Rigney, saying: "A shout out to Uncle Professor Lester Rigney for the ground-breaking work in creating black research methodologies in the late 80s and 90's."

Our people and Elders continue to advocate and work tirelessly to break open the spaces where our practices, our knowledges and our voices need to be to benefit our families, communities and peoples, as well as all peoples.

Uncle Tom Calma has demonstrated this in the role of his advocacy and involvement in the development of the recently released first Australian Cancer Plan, where Indigenous peoples, knowledges and voices are woven throughout.

Mr Yunupingu, quoted by Jackie Huggins:

> *What Aboriginal people ask is that the modern world now makes the sacrifices necessary to give us a real future. To relax its grip on us. To let us breathe, to let us be free of the determined control exerted on us to make us like you. And you should take that a step further and recognise us for who we are, and not who you want us to be. Let us be who we are – Aboriginal people in a modern world – and be proud of us. Acknowledge that we have survived the worst that the past had thrown at us, and we are here with our songs, our ceremonies, our land, our language and our people – our full identity. What a gift this is that we can give you, if you choose to accept us in a meaningful way."*

The Monthly Essay, July 2016

3.6 Chapter conclusion

This chapter shows the richness and value of Indigenous leadership, knowledges and expertise in health and healing for tertiary healthcare education. Ongoing health inequities are perpetuated by a system built on a false notion of colonial superiority continues to marginalise Indigenous knowledges and perpetuate health inequities. Advocating for transformative change, this chapter highlights the potential of Indigenous leadership in healthcare education by collaborating with Indigenous community organisations and individuals to privilege Indigenous perspectives and practices into tertiary education curricula and governance structures. It elucidates how embracing Indigenous leadership not only benefits Indigenous communities but also enhances healthcare outcomes for all. Urging immediate action and partnership with Indigenous communities, grounded in Indigenous epistemologies and leadership.

The Croakey articles demonstrate Indigenous leadership in action. This is shown by the leadership of Indigenous peak organisations outlined in the previous chapter to create and hold space for Indigenous healthcare leaders, staff and students to gather in both an international and national context. The articles directly privilege Indigenous voices with quotes, images and posts (or Xeets).

This chapter frames the thesis, demonstrating Indigenous expertise and leadership in academic, clinical and community healthcare contexts. Despite expertise in both Indigenous and Western epistemologies and clinical practices, Indigenous peoples are almost invisible in the tertiary workforce and in curricula, which is explored in the next chapter.

Bunya tree, looking from the ground through the tree (photograph by Danielle Manton).

Chapter 4: Critical Reflection on Literature

This chapter incudes a paper that has been published as:

> Manton, D., & Williams, M. (2021). Strengthening Indigenous Australian perspectives in allied health education: A critical reflection. *International Journal of Indigenous Health, 16*(1), 223-242. https://doi.org/10.32799/ijih.v16i1.33218

Preface

The image above is a photo looking from the ground up through the Bunya tree. It is a reminder of the importance of looking at ourselves and the need to look at ourselves from a different angle or perspective.

The Bunya tree from this perspective looks full and luscious. From this perspective, you cannot see the unusual branching pattern, often with longer branches at the top and shorter branches below, with big gaps where branches have been broken from the tree and are yet to regrow.

The Bunya tree image above can be used to guide reflection: by looking at the tree from a different perspective, we notice elements we might not have noticed before. This is a prompt to reflect on your perspective – have you tried looking a different way?

The perspective of the image above is a metaphor with the gaps awaiting regrowth and the broken branches is a metaphor. The metaphor are prompts to guide your critical analysis, drawing on the

information from the previous chapters to recognise the complexities for Indigenous peoples to access healthcare that is free from racism, where are the gaps? What is breaking the branches from the tree? What is encouraging new growth? Did we even notice the gaps until we changed perspectives?

4.1 Chapter overview

This chapter explores 'what needs to change' in allied health education specifically – the context in which the Bunya Project began. While the context has changed since this paper was published, the sector recognises that ongoing complacency regarding accountability makes them complicit in perpetuating ill health through racism and culturally unsafe care. Since the following Bunya Project article was published, measures have been implemented to improve accountability and provide mechanisms to enable patients to call out their negative experiences through Ahpra health practitioner legislation, as described in Chapter 2.

Despite some positive changes, the gap remains regarding the practical and pragmatic strategies to prepare university students, staff and the workforce to understand the important role they play. The following material outlines, how their approaches need to change and how the information and knowledge gained translates into professional practice at an individual and team level right through to systemic and institutional change.

The key aims of this chapter are to:

1. Describe how Indigenous Australians are largely invisible in allied health professions in Australia.
2. Explain, that Indigenous Australians are underrepresented in tertiary education.
3. Outline actions that allied health and tertiary education professions can take to:
    a. promote cultural responsiveness, develop partnerships with Indigenous communities, and
    b. recruit and retain Indigenous staff and students.
4. Identify how Indigenous knowledges and practices contribute to achieving health equity among Indigenous peoples.

While this chapter is focused on allied healthcare, the content and learnings are applicable across the healthcare sector and potentially beyond.

4.2 Strengthening Indigenous Australian Perspectives in Allied Health Education: A Critical Reflection

INTERNATIONAL JOURNAL OF INDIGENOUS HEALTH

Research Trainee

Strengthening Indigenous Australian Perspectives in Allied Health Education: A Critical Reflection

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ARTICLE INFO

Keywords:
Indigenous Australians Allied Health Curriculum
Cultural safety
Cultural responsiveness

https://doi.org/10.32799/ijih.v16i1.33218

ABSTRACT

While professional education in medicine and nursing in Australia has been implementing strategies to increase accessibility for Indigenous Australians, allied health professions remain underdeveloped in this area. Failure to improve the engagement of allied health professions with Indigenous Australians, and failure to increase the numbers of Indigenous staff and students risks perpetuating health inequities, intergenerational disadvantage, and threatens the integrity of professions who have publicly committed to achieving cultural safety and health equity between Indigenous and non-Indigenous people. Knowing this, leaders in the allied health professions are asking 'What needs to change?' This paper presents a critical reflection on experiences of a university-based Indigenous Health Unit leading the embedding of Indigenous perspectives in allied health curriculum, informed by Indigenous community connections, literature reviews, and research in the context of an emerging community of practice on Indigenous health education. Key themes from reflections are presented in this paper, identifying barriers as well as enablers for change, which include Indigenous community relationship-building, education of staff and students, and collaborative research and teaching on Indigenous peoples' allied health needs and models of care. These enablers are inherently anti-racism strategies that redress negative stereotypes perpetuated about Indigenous Australians and encourage the promotion of valuable Indigenous knowledges, principles and practices as strategies that may also help meet the health needs of the general community.

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Glossary

Allied health*:* Includes health professionals who are not doctors, nurses, or dentists. Allied health professionals work to prevent, diagnose, treat and manage illness, disease, and chronic conditions.

Cultural safety: Development of an environment that is spiritually, socially, emotionally and physically supportive and safe for Indigenous people, and that respects their cultures and identities.

Wholistic health*:* The social, emotional, psychological, physical, environmental, spiritual and cultural wellbeing of the whole community, in which individuals are able to flourish across the lifespan and generations.

Indigenous Australians: Aboriginal and Torres Strait Islander peoples, the original inhabitants and sovereign owners of Australia.

Indigenous Graduate Attribute: University-level requirement for graduates to be responsive to needs and cultures of Indigenous people, relative to their profession.

Acknowledgements

Maridulu Budyari Gumal, Sydney Partnership for Health, Education, Research, and Enterprise Education Working Party, Liverpool, New South Wales, Australia

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Introduction

Because of their diversity and differing expertise, allied health services can offer much to meet the needs of Indigenous Australians, who currently experience among the worst health outcomes of any of the population groups across urban, regional and remote locations in Australia (Australian Bureau of Statistics [ABS], 2018) and the world (Anderson et al., 2016). Many of the health issues Indigenous Australians experience are those that are likely to greatly benefit from individual and interdisciplinary allied health care (Ewen et al., 2019). A person with Type 2 diabetes mellitus, for example, may benefit from allied health care such as podiatry, orthoptics, counselling and psychology, because of frequent co-morbidities of lower-limb infections and amputation, diabetic retinopathy and risks of poor mental health and social isolation (Australian Institute of Health and Welfare [AIHW], 2016; Cunningham, 2010; Deroy & Schütze, 2019).

However, data suggest Indigenous Australians access allied health services less than others in Australia. In 2016, claims made for specialist and allied health services to Australia's Medicare Benefits Scheme were 43 percent less for Indigenous Australians compared to others (AIHW, 2016). This is despite the fact that the allied health workforce in Australia is large, making up about a quarter of all health professionals (AIHW, 2014). Further, the workforce is steadily growing and is expected to continue to do so (Department of Health, 2019). However, the number of Indigenous Australians employed as allied health professionals is small and varies greatly across the professions (Williams et al., 2020). Government targets for an Indigenous workforce of 3 percent of the total workforce (NSW Public Service Commission, 2019) have rarely been met (Williams et al., 2020).

This 3 percent Indigenous workforce target reflects the percentage of Indigenous people in the general Australian population (ABS, 2017). This workforce target also acknowledges that allied health professions seek and require growth in the number of Indigenous professionals, and reinforces the role of allied health professions in treatment of health issues, prevention, early intervention and follow-up care, interdisciplinary referrals and promotion of self-management (Ah Kit et al., 2003; Bailie et al., 2016; Gibson et al., 2015; Philip, 2015). Allied health professions are known for being diverse, with 23

recognised by New South Wales (NSW) Health, the largest government health policy and service delivery organisation in Australia (Williams et al., 2020). There are many allied health education offerings around Australia, with coursework training accessible in face-to-face and mixed-mode delivery (Williams et al., 2019). Yet questions remain about why Indigenous Australians have such low levels of access to services and such low staff and student numbers.

Methods

This article is a critical reflection on the low numbers of Indigenous Australians working in, studying and accessing allied health, informed by the work of two Indigenous Australian university staff members with teaching and research experience in health. To inform the establishment of a new Indigenous Health Unit, woven among six allied health units but autonomous, we conducted a review of international literature pertaining to allied health, Indigenous peoples and workforce development. Community consultations were conducted in four regions of the Australian jurisdiction of New South Wales (NSW). NSW is home to the highest number of Indigenous Australians, with 33.3 percent of the Indigenous population of 798,400 people, yet they make up only 3.5 percent of the total NSW population (ABS, 2019). Meetings were held to ascertain Indigenous organisations' interest in collaborating to develop new allied health curriculum. Meetings occurred with Indigenous Elders, service providers and community members, and were followed by an Expression of Interest process inviting Indigenous community organisations to formally collaborate. Six Indigenous organisations self- nominated to be involved and to form the Indigenous Health Bunya Project (Manton, 2019), a mixed-methods action research project to develop and evaluate new curriculum from an Indigenous perspective.

For a separate government-funded research project we were concurrently undertaking to investigate barriers and enablers for building an Indigenous Australian allied health workforce, we conducted three literature reviews. These focused on 1) allied health service delivery related to Indigenous people; 2) Indigenous employment literature, policies, and workforce data; and 3) pathways into allied health education for Indigenous people. These three rounds of literature reviews are synthesised here, along with insights from the Indigenous community consultations.

Our Indigenous Health Unit's andragogy and the framework for adult learning, which was conceptualised to guide curriculum development, is also described. This framework incorporates the Cultural Responsiveness Framework of the national organisation Indigenous Allied Health Australia (IAHA, 2019a), the 8-Ways Aboriginal Pedagogical Framework (Yunkaporta, 2009), and the National Health and Medical Research Council's (NHMRC) ethics guidelines for Aboriginal and Torres Strait Islander health research (NHMRC, 2018) to provide an informed foundation for the Indigenous Health Unit's teaching and research. Our critical reflection on literature, consultations, frameworks, and

experiences has followed Kolb's learning cycle (Lisko & O'Dell, 2010), occurring in the context of an emerging community of practice, the Aboriginal Health and Wellbeing Education Working Party of Maridulu Budyari Gumal, a multi- institutional research translation collaboration (2020). Themes arising from our reflections are presented here to guide future allied health curriculum and workforce development strategies for Indigenous peoples and allied health professionals more broadly.

Results Invisibility of Indigenous Australians in Allied Health

Literature reviews and community consultations confirmed that Indigenous Australians are relatively invisible in the allied health professions in Australia. Aboriginal Community Controlled Health Organisations (ACCHOs) are the largest providers of health care to Indigenous peoples in Australia (Australian Institute of Health, 2016); however, allied health care in ACCHOs is minimal, with long waiting lists and limited availability due to funding restrictions, remoteness of service locations, and low number of staff willing to work remotely. Allied health staff in these services are rarely Indigenous people, and Indigenous Australians are seldom reflected in recruitment, advertising, or mentoring programs to grow the allied health workforce (Williams et al., 2019). The evidence base about Indigenous Australians and allied health is small, and that which exists positions Indigenous people as service users, with publications written 'about' rather than 'by' Indigenous people.

In research reviewing Australian allied health professions' commitments to Indigenous health, only minimal evidence of advocacy, partnerships, and professional development activities was found (Williams et al., 2020). This inactivity generally persists, even though the poor health of Indigenous Australians has been well-reported and responded to by other health disciplines, such as medicine and nursing, as well as by ACCHOs for at least three decades. Allied health professions have only minimal engagement in collective national-level advocacy to improve health equity between Indigenous peoples and other Australians, such as through the Close the Gap campaign. This campaign stimulated, and also annually independently reviews, the Australian Government's Closing the Gap framework, which has seven national targets for improvements in Indigenous health (Council of Australian Governments, 2008; Prime Minister and Cabinet, 2019). Few allied health professions have been involved in these national target developments. Further, few allied health professionals include information regarding Indigenous Australians on their websites, and few include Indigenous Australians in their leadership teams or on written communications available to members (Williams et al., 2019). Very little growth in numbers of Indigenous allied health professionals has occurred in the last decade for which NSW data are available. Only four out of 23 allied health professions counted met the 3 percent target, with seven having no Aboriginal and Torres Strait Islander staff (Williams et al., 2020). Overall, in Australia the Indigenous allied health workforce represents less than 0.5% of the Australian allied health workforce (IAHA, 2018).

Leadership of Allied Health Professionals: Accreditation and Indigenous Graduate Attributes

Indigenous Australians are also relatively invisible in the accreditation processes of allied health professions. Some professions have developed accreditation standards that incorporate Indigenous peoples' perspectives into tertiary curriculum and/or professional development (Australian Health Practitioner Regulation Agency, 2019; Australian Pharmacy Council, 2014; Australian Physiotherapy Council, 2017; Australian Psychology Accreditation Council, 2019; Human Genetics Society of Australasia, 2016; Speech Pathology Australia, 2018a, 2018b). These accreditation requirements go some way to recognising Indigenous people as non-Western cultures different from the mainstream Australian population, requiring culturally and socially relevant models of care based on Indigenous leaders' expertise and community need. However, some allied health professions do not require Indigenous perspectives for accreditation, nor do they provide a rationale for this or any other explicit sector, staff, or student development options (Williams et al., 2019).

On the other hand, most Australian tertiary education institutions have committed to including Indigenous peoples' perspectives or other diverse cultural perspectives in their curriculum (Universities Australia [UA], 2020). University of Technology Sydney, the tertiary institution that is home to this Indigenous allied health project, requires that all graduating students meet an Indigenous Graduate Attribute (IGA). An IGA in this Australian tertiary education context is a short, aspirational statement added to all coursework descriptors and course outlines which indicates that as a result of completing the course, all students will have an improved awareness of Australia's Indigenous cultures (Behrendt et al., 2012; Bodkin-Andrews et al., 2018; Bosanquet et al., 2012; Bullen & Roberts, 2018; UA, 2011). IGAs are not compulsory for Australian universities to implement (NHMRC, 2018), but of Australia's 40 tertiary institutions, 31 have committed to developing cultural capability among students generally, and 14 routinely report on progress towards meeting an IGA (UA, 2020). Universities with an IGA require coursework-teaching staff to audit their curriculum and identify content and assessment items that could be added to meet the IGA. Usually an IGA requires that all students become culturally aware of and responsive to the needs of communities with whom they may be in contact as professionals (Bath et al., 2004; Bovill, 2017; Durey et al., 2017; Graduate School of Health, 2018). IGAs may enable students to develop cross-cultural skills relevant to succeeding in future careers and complementary to knowledge gained throughout their education (Hunt et al., 2015; Page, 2014). Embedding an IGA may facilitate students and staff transferring, adapting, and developing knowledge and skills to engage with diverse Indigenous communities across Australia (Goerke & Kickett, 2014), using higher education to stimulate positive change in Australian culture and workplaces (Behrendt et al., 2012; Krakouer, 2015; Page et al., 2018; Power et al., 2016; Ryan & Ryan, 2013).

However, inclusion of Indigenous content in the curriculum is not enough (Fredericks, 2008). The extant literature on transformational learning theory and practice asserts that critical self-reflection, immersion in settings to apply knowledge and practice skills, and feedback from mentors are essential (Huria et al., 2017). In the Australian Indigenous health education context, these types of opportunities for students have rarely been achieved, particularly not in such a way as to support students becoming culturally safe health service providers, nor to improve accessibility of health services (Fitzpatrick et al., 2019). Such immersion opportunities are urgently required, with a concerted and coordinated effort to ensure staff and students are supported in real-world contexts to develop knowledge and skills, and, most importantly, to be supporting and serving community needs and priorities.

Tertiary Aboriginal and Torres Strait Islander Teaching Staff

In allied health, Indigenous staff are vital to gather, critique, and convey evidence and practice wisdom from culturally relevant perspectives, as well as to make connections to ACCHOs for student placements and provide support for staff and students throughout studies and placement (Lucas et al., 2018; Thackrah et al., 2017). Indigenous peoples' experiences in Australia, including segregation, assimilation, ongoing social exclusion, and frequent experiences of racism, are sensitive and nuanced issues, and it takes expertise and resources to teach students and health professionals about them. Further, health policy and models of health are complex and require teaching expertise. Models of health require Indigenous Australian perspectives, given that concepts of health are culturally determined and are wholistic (Prime Minister and Cabinet, 2019).

At the same time that students are grappling with new information such as this wholistic health definition, they are often also dealing with concerns about how much they have not known about the poor treatment of Indigenous Australians (Gerrett-Magee, 2006; O'Dowd, 2012; Reynolds, 2000), and questions about their place in perpetuating inequality (Fitzpatrick et al., 2019). These can be considerable blocks to learning that must also be sensitively addressed (Fitzpatrick et al., 2019). However, one shortfall in achieving such sensitive education and in meeting embeddedness of an IGA is that tertiary institutions generally do not meet their targets for Indigenous Australian staff numbers, who are best placed to deliver culturally informed course content and guide curriculum (UA, 2011, 2017).

This is despite Australian Government funding for tertiary instructions that requires them to have Indigenous employment strategies, appoint senior Indigenous leaders, and implement annual reporting mechanisms to stimulate necessary changes. These requirements have been devised to both increase staff numbers and ensure accountability and sustainability of improvements over time (UA, 2017). Other supports for Indigenous staff include mentoring; academic development programs; flexible arrangements such as supporting staff to work from the traditional Country and/or community to which

they and their ancestors belong; paid leave to honour culturally significant events such as funerals, ceremonies, and days of observance; and network meetings (Behrendt et al., 2012; Onnis, 2019; Roche et al., 2013).

Upskilling Mainstream Allied Health Professionals

The low number of Indigenous tertiary education staff puts the onus on the general body of allied health professions' teaching staff to upskill themselves, become confident in conveying quality information about Indigenous Australians' health needs and issues, and adequately address student learning needs. Knowledgeable allied health practitioners are vital – for promoting health, preventing disease, and providing diagnosis, treatment, and management (Gibson et al., 2015). Further, as IAHA (2015) advocates, 'It is the responsibility of health service providers to demonstrate culturally responsive leadership, and build governance structures and environments that ensure health professionals are encouraged, expected and able to respond' respectfully to the needs of Indigenous people (p. 8) and the needs of people from a range of cultures (Hawala-Druy & Hill, 2012).

However, histories of massacres and poisonings of Indigenous Australians, and of land theft by colonisers, can render academic staff and students uncomfortable, as can Indigenous peoples' cultural practices and assertions for land and human rights. For these reasons, education about the history and culture of Indigenous Australians is often avoided (Yunkaporta & McGinty, 2009). This risks perpetuating stereotypes and misinformation, and limits progress for Indigenous peoples (Nakata, 2007). Further, without professional development and training, academics are likely to fear incorporating Indigenous perspectives in their curriculum. Although most academics are experts in their field and may teach with excellence, this expertise does not inherently transfer to the teaching of Indigenous perspectives and knowledge (Nakata, 2007). Learning critical self-reflection is therefore essential, as are developing and adapting critical reflection tools (Jackson Pulver et al., 2019; Lucas et al., 2018), and evaluating teaching and learning strategies to develop the cultural responsiveness of the health workforce (Fitzpatrick et al., 2019).

Terminology Troubles: Is it Cultural Awareness, Competence, Safety, or Other?

Education about Indigenous Australian cultures suffers from confusion about terminology, and competition between education providers erodes the trust and motivation that organisations might have for accessing training (SPHERE Network, 2019). Some start with 'cultural awareness' – basic information-giving that is foundational to further steps (Power et al., 2016; Russell-Mundine, 2017; West et al., 2017). However, this is heavily critiqued as not being robust enough, particularly because it does not require improvements in how people behave or relate (Fredericks & Thompson, 2010). Frequently the term 'cultural safety' is named as the ideal (Bin-Sallik, 2003; IAHA, 2019a; Williams,

1999), partly because 'safety' is decided by service users (Papps & Ramsden, 1996) and because it reflects a wholistic definition of health. Cultural safety aims to provide:

> An environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge, or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge, and experience of learning together. (Williams, 1999, p. 213)

Further, cultural safety training has been described as being about empathy, ensuring service providers reflect on their own attitudes and practices to balance power in client– service provider relationships (Hughes, 2018).

These elements of cultural safety are difficult to make a reality. Cultural safety training has also been criticised for focusing on service delivery, rather than on systemic change required to bring about health equity (IAHA, 2019a).

Others instead assert that cultural responsiveness should be the goal because it includes cultural safety but also addresses broader socio-cultural needs of populations (Carteret, 2010; IAHA, 2019a). Working in a culturally responsive way includes strengths- based and action-oriented approaches for achieving cultural safety, and also action to increase accessibility of health care, through leadership and good governance. As IAHA (2015) asserts, with cultural responsiveness, 'the processes and supportive structures around health service delivery are equally as important as actual health outcome measures when determining the overall effectiveness of health service delivery' (p. 8).

This positions cultural responsiveness as requiring that the social determinants of health be addressed – an action some health service providers argue is not their role, however, given their focus on individual-level clinical care (Jackson Pulver et al., 2019).

Knowledge Hierarchies and Their Limits

As a result of perceived complexities in developing cultural responsiveness, tertiary teaching staff may choose to meet minimum requirements of university and accreditation mandates (Hennig & Paetkau, 2018), despite these seldom being developed by Indigenous peoples nor with cultural responsiveness in mind. Indigenous Australians are relatively powerless; it is tertiary institutions that have the history and power to define adequate learning and knowledge (Pease, 2013), asserting a generalised set of facts, which overwhelmingly reflects and reinforces Western science (Pease, 2013), as if it were applicable to all (Greenhalgh et al., 2016). Universities in Australia have existed for no longer than 160 years (UA, 2017), a fraction of the 60,000 years of Indigenous Australian cultural continuity, which is too often overlooked (Dudgeon & Bray, 2018; Sherwood, 2013).

In the past, perspectives of Indigenous Australians across most levels of education have focused on deficits (Bodkin-Andrews et al., 2018; Hogarth, 2018), with reliance on statistics to convey health inequity, mortality rates, and comparisons to other Australians (Brough, 2001). While a realistic picture is required, biomedical and epidemiological data gathered by non- Indigenous people overlook contextual information that would provide a wholistic understanding (Tsey et al., 2019).

Through a deficit lens, negative statistics and problems perpetuate stereotypes and oppressive actions, without commitment to Indigenous Australians' community-driven change (Page et al., 2018). This reinforces the notion that Indigenous Australians as a population all have the same problems and are in need of help from outsiders (Fredericks, 2008). Tertiary students have most often been learning 'about' Indigenous communities and culture from an outsider position (Norman, 2014) – which is also likely to reinforce deficit discourse (Nakata, 2007; Norman, 2014) – rather than through authentic voices and connections. The result is a discriminatory system that silences Indigenous Australians' ways of knowing, being, and doing (Hogarth, 2018), minimises opportunities for self-determination to be progressed, and risks assimilation of Indigenous Australian students into the dominant mainstream culture rather than strengthening Indigenous solutions. Invisibility of Indigenous perspectives in allied health curriculum specifically, and in the allied health professions generally, is likely to persist because of the minuscule number of Indigenous allied health professionals. There are still too few Indigenous allied health professionals, or other Indigenous health professionals, with experience, time, or support of supervisors to influence curriculum, development of models of care, and the non-Indigenous staff training required to bring about change (Bailey et al., 2020; Williams et al., 2020).

Community Connections to Bring About Change

Some tertiary institutions do, however, state that they aim to reflect the communities they are located in (University of Technology Sydney, 2019), and occasionally tertiary staff embedding an IGA have developed local community relationships to enrich student learning and professional practice (Bodkin-Andrews et al., 2018). This is beneficial to Indigenous Australians, who are diverse and have more than 250 nations across Australia (Guilfoyle et al., 2010). Consequently, it is inappropriate for one person or group to represent all communities (Carroll et al., 2015). Through strategic local community connections, relationships can develop, with the value of personal connections role-modelled to staff and students (Gibson et al., 2015).

Research and reflections from medicine and from nursing education highlight that developing cultural responsiveness best occurs as a shared process with Indigenous communities, and that it draws on diverse inputs and voices of community members (Carroll et al., 2015). This shared process is asserted in the United Nations Declaration on the Rights of Indigenous Peoples, which states that communities have the expertise and right to meet their social, cultural, and economic needs (Bretag, 2013; United

Nations, 2012; Wiessner, 2009). Self-determination is reinforced by Australian national and state government frameworks that recognise the inherent right of Indigenous peoples to self-determine health care (Ah Kit et al., 2003; Hunt, 2017). Community engagement is also an ethical principle that shapes decision-making among Indigenous Australians (West et al., 2017; Biles et al., 2022) and promotes self-determination (Carroll et al., 2015; Hunt, 2017). In self-determining strategies for future health education and care, Indigenous voices carry within them the experience of families and communities over generations, pre- and post-colonisation (Geia et al., 2013). They provide students and staff with an authenticity that is difficult to dismiss (Mills et al., 2018; Norman, 2014). When they are included in teaching and learning, Indigenous voices are to be privileged and central (Fredericks, 2008), not an add-on to dominant Western paradigms (Durey et al., 2017; Fredericks, 2008; Hogarth, 2018; West et al., 2017). This in turn requires Indigenous teaching staff, working in partnership with local communities to promote their realities, needs, and aspirations.

Limitations

This article is a critical reflection of two Indigenous Australian academics. While reflection followed a process and incorporated three rounds of literature reviews and community consultations, there was a dearth of research-based literature on Indigenous peoples and allied health to draw on. This article, however, offers an informed perspective, well positioned from within allied health tertiary education and constantly engaging with allied health professionals about overcoming barriers to engaging with Indigenous peoples.

Discussion

The longstanding rhetoric that Indigenous Australians' poor health is an intractable problem (Hogarth, 2018; Jackson Pulver et al., 2019) is slowly changing. One challenge for the future, however, is ensuring Indigenous voices are embedded in health curriculum, including allied health, which is profoundly underdeveloped compared to other health disciplines. This is arguably more possible now than ever before in Australia, enabled by tertiary institutions' commitments to students achieving IGAs. Speaking with authority to allied health students and helping them achieve IGAs requires knowledge, experience, and authenticity (Bodkin-Andrews et al., 2018). Promoting Indigenous ways of knowing, being, and doing by including Indigenous voices in curriculum provides this authenticity with a relevance that is hard to dismiss (Mills et al., 2018; Norman, 2014).

There are, however, many challenges when working at the 'cultural interface' – the space between Indigenous and Western knowledge systems (Nakata, 2007). Navigating these knowledges and worldviews requires advanced skills of Indigenous teaching staff to not only interpret the wide range of information and convey it sensitively to a novice audience of students, but also cope with deficit discourse about Indigenous peoples.

Unfortunately, there are few Indigenous allied health professionals in Australia, and tertiary institutions rarely meet their Indigenous staff target numbers. However, there are a number of important developments, including an Australian tertiary sector-wide strategy for increasing Indigenous staff and student numbers (UA, 2020), and IAHA's Indigenous allied health workforce development strategy (IAHA, 2018). IAHA's workforce surveys and reflections show improvements among its Indigenous allied health student and professional membership in access to supportive networks and mentoring, development of cultural responsiveness of their contexts more generally, and some influence as leaders (IAHA, 2019b, 2019c). Until such time as Indigenous allied health student, professional and academic staff numbers grow, the onus must be on the general body of allied health and teaching staff to be critically reflective and contribute to conveying good information about culturally responsive models of allied health care for Indigenous Australians. However, while tertiary educators may have extensive experience with clinical care, this has generally not rendered them confident with Indigenous Australians. The issue is circular: tertiary education institutions suffer from not being able to employ more Indigenous Australian staff to develop and deliver allied health curriculum given there is a shortage of Indigenous allied health staff, and it is difficult to recruit and retain Indigenous Australians in allied health coursework if the curriculum or institution does not represent their needs, cultures, and aspirations.

One potential circuit breaker is genuine partnerships with Indigenous organisations. This could be achieved through partnerships between Indigenous organisations, Elders, experts, and tertiary institutions, which tertiary institutions are supporting now more than ever through their strategic plans. There is a growing conviction, too, that conveying Indigenous knowledges in allied health curriculum, workforce development, and service delivery has much to offer all communities (IAHA, 2015), because Indigenous health is wholistic and draws on fundamental interpersonal skills such as respect, engagement, and shared responsibility for making progress (Berglund & McNeill, 1989; NHMRC, 2018) – all of which align with the aspirations of the allied health professions.

Conclusion

It is perhaps only when Indigenous Australians' ways of knowing, being, and doing are recognised for their intrinsic value that they may inform and influence mainstream teaching and service delivery, thereby contributing to achieving health equity. Until then, concerted effort is required to bring the current and next generations of allied health professionals to a standard at which they are confident engaging with Indigenous Australians. One strategy for this is developing partnerships between tertiary institutions and Indigenous organisations that are mutually beneficial: identifying needs of local Indigenous communities and designing curriculum that develops service providers of the future who are able to assist in meeting these needs. An extension of that is advocating for Indigenous peoples' health rights within curriculum, and providing evidence about Indigenous people's self-determined

models of health care. These are inherently anti-racism strategies that redress negative stereotypes perpetuated about Indigenous Australians and enable the promotion of valuable Indigenous knowledges, principles, and practices as strategies to meet community care priorities and standards. These connected health service provider actions will contribute to transformational change required to improve health equity, because it is intergenerational change – tertiary-level training strategies will result in the next generations of health service providers being arguably more prepared than current and previous generations.

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4.3 Chapter conclusion

The perspective shifts needed for change outlined in this chapter have been about 'looking back to move forward' – which is partly what Indigenous knowledge systems that have been teaching Indigenous peoples healing and caring strategies since time immemorial. The ongoing impact of colonisation is present in tertiary and healthcare systems and structures, accompanied by layers of trauma and racism that hinder the nourishment and safety of Indigenous peoples. We need to look back, heal and change the system's structures and expectations, emphasising the necessity of culturally strong, locally driven solutions led by Aboriginal and Torres Strait Islander communities.

Despite Aboriginal Community Controlled Health Organisations (ACCHOs) serving as primary healthcare providers for Indigenous peoples in Australia, the allied health professions remain largely invisible within these organisations due to funding restrictions, remote service locations and a scarcity of willing staff, exacerbating the already limited representation of Indigenous people among allied health professionals. This systemic failure to address Indigenous health equity within the allied health workforce is made worse by minimal engagement in advocacy or professional development activities.

Historical power dynamics and systemic biases within tertiary education can reinforce stereotypes and be a barrier for Indigenous peoples, voices and perspectives to be involved in curriculum and professional development in allied health, as it is culturally unsafe and the institution is not ready to hear what needs to be said. Recognising the diversity of Indigenous Australians and the necessity of strategic local community connections is vital for fostering cultural safety and promoting authenticity and self-determination in teaching and learning, outlined by the United Nations Declaration on the Rights of Indigenous Peoples and Australian national and state government frameworks that recognise the inherent right of Indigenous peoples to self-determine health care, reinforcing the importance of privileging and centralising Indigenous voices in teaching and learning to promote authenticity and self-determination.

Indigenous staff play a crucial role in providing culturally relevant perspectives and addressing sensitive issues, tertiary institutions frequently fall short in meeting targets for Indigenous staff numbers, despite government funding and support mechanisms aimed at increasing representation and accountability.

In conclusion, the chapter emphasises the importance of acknowledging and addressing the ongoing impact of colonisation within tertiary education and healthcare systems. To move forward, it is essential to look back and heal, creating structures that support culturally strong, locally driven solutions led by Aboriginal and Torres Strait Islander communities. Despite the vital role of Aboriginal Community Controlled Health Organisations (ACCHOs). For genuine change, institutions must foster cultural safety, engage with diverse local communities, and prioritise Indigenous voices and leadership in education and workforce development.

The next chapter outlines how the Bunya Project seeks to improve healthcare for Indigenous Australians by integrating Indigenous perspectives and knowledge into university-level allied health education. Led by Aboriginal researchers in collaboration with Aboriginal Community Controlled Health Organisations, the project uses storytelling to create culturally informed curriculum and assessments. The Bunya Research Protocol, developed through community-led focus group discussions and interviews, emphasises the importance of academic reflexivity and fostering strong relationships between universities and Indigenous communities. The chapter's key aims are to highlight the importance of preparation, community engagement, ethical project methodology, and the use of Participatory Action Research (PAR) to amplify Indigenous voices and support self-determination.

Applying, skills and knowledge to prepare the soil.

Chapter 5: Methods

This chapter incudes a paper that has been published as:

> Manton, D., Williams, M., & Hayen, A. (2023). The Bunya Project: Protocol for a Mixed-Methods Approach to Developing a Culturally Informed Curriculum. *JMIR Research Protocols*, *12*(1), e39864.

Preface

Expanding on the themes of perspective, experience and reflection discussed in the previous chapter, this chapter presents the methods of the Bunya Project. It highlights how critical self-reflection has led to clear guiding principles governing the Project's conduct. These principles align with broader cultural expectations and Bunya Project serves as a framework for Indigenous community engagement, Indigenous leadership in teaching and learning, and Indigenous research cultural protocols.

Similarly to the critical role of proper soil preparation in fostering the growth of a Bunya tree, creating conducive cultural frameworks is essential when collaborating with Aboriginal and Torres Strait Islander peoples. This involves cultivating cultural ways of working alongside community protocols and expectations – a process of 'preparing the soil' for the Bunya Project's initiatives to be successful, to grow, to produce nourishing seeds for the community and to repopulate Bunya trees.

5.1 Chapter overview

The Bunya Project aims to improve healthcare for Indigenous Australians by embedding Indigenous perspectives and knowledge into allied health education in universities. It is led by Aboriginal researchers in collaboration with Aboriginal Community Controlled Health Organisations, using storytelling to influence culturally informed curriculum and assessment design in tertiary health education. The Bunya Research Protocol was community led with 6 focus group discussions developing and guiding the questions for the 24 interviews conducted, drawing on the expertise of those most involved in all aspects of healthcare as practitioners, consumers and community (Crane & O'Regan, 2010).

The protocol outlined in this chapter guides academics to understand the importance of their reflexivity to improve their knowledge, skills and mutually beneficial opportunities in working with Indigenous communities. This approach will build stronger relationships and trust between universities and Indigenous communities and enhance the preparedness of non-Indigenous academic staff to support Indigenous-led education.

The key aims of this chapter are to:

1. Describe the importance of preparation, engaging with Indigenous community organisations and reflecting on personal perspectives.
2. Explain how to implement guiding ethical principles with project methodology.
3. Provide an overview of how to apply reflective and ethical principles to critically reflect on the protocol, centring Indigenous community needs and aspirations throughout the project.
4. Describe the use of a Participatory Action Research (PAR) approach to centre and amplify Indigenous voices and self-determination.

Covid-19 Impact statement:

> COVID-19 impacted this project, requiring the project to adapt research methods and participant engagement, resulting in fewer participants. Four organisations instead of the expected six were involved in interviews, and there were delayed timelines for all data collection. COVID-19 created, difficulties in maintaining quantitative data collection integrity as the method changed from face-to-face collection to an online survey format.

5.2 Methodology and methods paper

JMIR RESEARCH PROTOCOLS Manton et al

Protocol

The Bunya Project: Protocol for a Mixed-Methods Approach to Developing a Culturally Informed Curriculum

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Abstract

Background: Indigenous peoples live across all continents, representing approximately 90 nations and cultures and 476 million people. There have long been clear statements about the rights of Indigenous peoples to self-determine services, policies, and resource allocations that affect our lives, particularly via the United Nations Declaration on the Rights of Indigenous Peoples. An area for urgent improvement is curricula that train the predominantly non-Indigenous health workforce about their responsibilities and that offer practical strategies to use when engaging with Indigenous peoples and issues.

Objective: The Bunya Project is designed to advance Indigenous community-led teaching and evaluation of the embeddedness of strategies to achieve an Indigenous Graduate Attribute in Australia. The project centres the relationships with Aboriginal community services to lead education design relating to Indigenous peoples. The project aims to articulate community recommendations for

university education in allied health in the usable format of digital stories to create culturally informed andragogy, curriculum, and assessment measures for use in teaching. It also aims to understand the impact of this work on student attitudes and knowledge about Indigenous peoples' allied health needs.

Methods: Multilayered project governance was established, along with a two-stage process using mixed-methods participatory action research and critical reflection, using the reflective cycle by Gibbs. The first stage, *preparing the soil*, used community engagement, drew on lived experience, encouraged critical self-reflection, embodied reciprocity, and demanded working collectively. The second stage, *planting the seed*, requires more critical self-reflection, the development of community data through interviews and focus group discussions, the development of resources with an academic working group and community participants, the implementation of those resources with student feedback, the analysis of the feedback from students and community members, and reflection.

Results: The protocol for the first stage, *preparing the soil*, is complete. The results of the first stage are the relationships built and the trust earned and gained, and it has resulted in the development of the *planting the seed protocol*. As of February 2023, we have recruited 24 participants. We will analyse data shortly and expect to publish the results in 2024.

Conclusions: The readiness of non-Indigenous staff to engage with Indigenous communities has not been ascertained by Universities Australia, nor can it be assured. Staff preparation and skills to support the curriculum, create a safe learning environment, and develop teaching and learning strategies to guide academics to recognise that how students learn is as important as the content students learn. This learning has broad implications and benefits for staff and students within their professional practice and for lifelong learning.

International Registered Report Identifier (IRRID): DERR1-10.2196/39864 *(JMIR Res Protoc 2023;12:e39864)* doi: 10.2196/39864

KEYWORDS

Indigenous; university; curriculum; leadership; cocreation; self-determination

INTRODUCTION

Overview

There are 476 million Indigenous peoples worldwide, who belong to the world's oldest continuing cultures and who have the right to self-determine health services to meet needs [1]. Health services are built upon and use the services of a predominantly tertiary-educated workforce. However, university health education contains little about Indigenous rights or knowledge [2]. Although immersion in cultural settings is recommended to stimulate transformation in knowledge and skills, current health curricula in Australia offer little towards this [3]. With few Indigenous staff at universities, responsibility lies with non-Indigenous staff, who are often underconfident in selecting and conveying information about Indigenous peoples [3]. Partnerships with Indigenous health organisations as experts in cultural models of care are essential; however, there are few examples in the literature to guide this [3]. An area for urgent improvement is curricula that train the predominantly non-Indigenous health workforce about their responsibilities and practical strategies they must use when engaging with Indigenous peoples and issues.

The Bunya Project is part of a participatory action research (PAR) project that aims to develop the skills and capabilities of academic staff to understand the principles and processes required to develop and embed Indigenous perspectives into the health care curriculum, ultimately influencing systemic change within the health care workforce.

This paper outlines a process for Indigenous community participation, showing how it is possible and important in developing culturally respectful engaging resources for students learning at university, across disciplines. The Bunya Project models processes and protocols for working with Indigenous peoples and community organisations that honour diverse Indigenous peoples' knowledge with authenticity, humility, and reciprocity, as per cultural and ethical protocols. This paper contributes to the narrative as to how and why universities should partner with Indigenous communities and organisations; the value of the Bunya Project lies not only in sharing important knowledge held by Indigenous community organisations and members but also in demonstrating how to bring community into university life. This Bunya Project protocol may be useful for Indigenous peoples around the world, to adapt to local circumstances in partnership with community organisations and local teaching institutions.

The Bunya Project protocol outlined in this paper provides the principles and strategic knowledge used by a university education health faculty in Australia, driven by the Indigenous health team. The early stages of the protocol describe what could be called the 'pre-research' stage – much of this preliminary work is taken for granted by the authors as 'proper ways' or a respectful process, knowledge of which is gained through lived experiences and social expectations in a community context. However, what is

obvious to us may not be obvious to non-Indigenous academics. Therefore, this paper outlines the principles and processes required to implement this protocol, based on the authors' insider knowledge and lived experience as Indigenous peoples.

The Bunya Project is inspired by the tall Bunya tree of eastern Australia – *Araucaria bidwillii* – which grows slowly and, through its development, produces large pinecones that separate into edible nuts for current generations to be nourished by. It also spreads seeds for future generations to cultivate and grow. This Bunya Project provides a long-term, intergenerational, and unifying process for the voices of Indigenous peoples to be heard and shared in the allied health curriculum.

Background

Aboriginal and Torres Strait Islander peoples are the Indigenous populations of the continent referred to as Australia. Aboriginal peoples are heterogenous, with >250 different language groups [4], each with their own protocols and ceremonies. The Torres Strait Islands comprise five island clusters, consisting of 38 inhabited islands and 113 islands in total. The islands lie between the tip of Queensland on the Australian continent and Papua New Guinea. Acknowledging this diversity is foundational to understanding and approaching teaching and learning within Indigenous contexts.

Government Policy Context

In Australia, all national and state-based policies indicate that Aboriginal and Torres Strait Islander peoples have the right to cultures being at the centre of decisions made, with full participation in decision-making [5,6] and its evaluation [7]. However, many of those currently in decision-making positions have had little education or support in understanding Australia's history, cultures, or rights [8]. There are limited representative mechanisms for Aboriginal and Torres Strait Islander peoples to formally be included in decision-making, as there is an inherent power imbalance [9,10]. Those agreements made between governments and peak Aboriginal and Torres Strait Islander organisational bodies often have little resourcing and no evaluation, which limits both their ability to act and accountability [11].

University Responsibilities and Realities

Current university education curricula produce graduates who often enter positions of power relevant to Indigenous peoples' realisation of rights. However, their education is severely lacking and does not produce graduates who are sufficiently well developed to bring about the types of urgent health system or health workforce changes needed to influence the drastic improvements required [3,12]. This is a common issue for Indigenous peoples globally [13].

The embedding of Indigenous peoples' perspectives into mainstream university curriculum has been named for at least two decades in Australia [14,15] but only recently have structures been put in place by some universities [16,17] that help produce conditions for clear, evaluable actions. The peak body for Australian universities, Universities Australia, produced a strategy for 2017 to 2020 [18] and an Indigenous strategy for 2022 to 2025 [19], both of which make leadership statements but have not been wholly evaluated or updated for future developments.

Nonetheless, most Australian universities have committed to embedding Indigenous perspectives into their curriculum [20] and are seeking Indigenous peoples' leadership [21]. A specific strategy has been introduction of an 'Indigenous Graduate Attribute' (IGA), a statement of attainment that is expected of all graduates in relation to Indigenous peoples [22]. In the health context, the IGA aims to improve graduates' knowledge about Indigenous peoples and issues and, where possible, provide experiences with Indigenous peoples, with the expectation that this will improve professional practice [23] and, ultimately, improve health outcomes for Indigenous peoples.

Unfortunately, there are few examples for universities about how to achieve the IGA. Universities have rarely met Indigenous staff targets [24], meaning that non-Indigenous people are largely responsible for developing and delivering curricula about Indigenous peoples and for driving the implementation and evaluation of the IGA. Perhaps in some recognition of this, Universities Australia recommends that tertiary institutions 'build robust, respectful and collaborative partnerships between themselves and the Aboriginal and Torres Strait Islander communities that they serve' [14]. There are few practical strategies, scaffolding, or implementation guidance for university staff to create Indigenous community collaborations.

As an example of uninformed curriculum content, information about Indigenous peoples' health and wellbeing often begins with a focus on the most easily available information in the public domain – the Australian Government's Closing the Gap framework [25]. This framework has been designed to highlight inequity – the gap in processes and outcomes that Indigenous Australian peoples experience across many life domains compared with others in Australia [26]. In so doing, Closing the Gap powerfully reinforces negative stereotypes and assumptions about Indigenous Australian peoples, with no focus on strengths, local cultures, or worldviews about health. In the curriculum and in the classroom, this perpetuates stereotypes with a deficit lens [27] that is neither community-driven nor reflective, entrenching in students' minds the notion that Indigenous peoples do not have the expertise to enhance mainstream learning or contribute to developing their professional practice in providing health care.

The holistic collectivist notion of Indigenous Australian peoples' health has much to offer to Western biomedicine in recognising the whole person and their context: 'Not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total

wellbeing of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life' [28].

To health educators who are versed in Western biomedicine, this holistic health concept seems complex and 'too hard' [29]. Statistics used to measure and teach about health reinforce a power imbalance and dominance of the medical model [30]. With skilled, confident, and supported staff, more complex underlying contextual and environmental factors in health, including ongoing processes of colonisation, systemic bias and racism, are minimised [31]. Furthermore, the focus on Indigenous peoples' ill health does nothing to challenge students to understand the influence of their own cultural lens [32] or the future risks of continuing to render invisible and devalue Indigenous models of health care.

Challenges in Allied Health Education

Allied health care professions are recognisably underdeveloped, particularly in relation to Indigenous peoples' ways of knowing, being, and doing in the curriculum and clinical practice [3]. Allied health education has a long history of excluding Indigenous knowledge [3,33]. The Indigenous allied health workforce and student cohorts are small; there is an assumption that more Indigenous allied health practitioners and students are required, but there is little critical thought in supporting Indigenous holistic health care and how that might shape the future health workforce [34]. There are clear gaps in research about allied health care needs of Indigenous peoples, and there is no attention to minority populations of Indigenous peoples such as those in prisons and those with disability or multiple, compounding issues. This limits the scope of exemplars available to inform curriculum. These gaps persist despite allied health professional education having specific accreditation requirements, often specific to the discipline and with mandatory renewal [35]. Furthermore, for example, the Australian Physiotherapy Council has strengthened its accreditation requirements to achieve more Indigenous student enrolments and include cultural safety in the curriculum [36], reinforced by changes to the National Safety and Quality Health Service Standards [37]. The Indigenous Allied Health Association provides some resources to guide health professionals and support students [38]; however, the implementation and use of available resources vary across institutions [39].

Expertise About Indigenous Health Does Not Lie in Universities

Statements implicating universities in perpetuating the disadvantage of Indigenous peoples' experience have recently been met with mixed responses in Australia, including denial and confusion [39,40]. The cultural load that Indigenous Australian staff experience in mainstream organisations – the additional expectations on Indigenous staff to fulfil tasks in accordance with position descriptions and educate others about Indigenous cultures [41] – is beginning to be aired. However, the experience of the relatively small number of Indigenous staff at universities is seldom acknowledged – having to both cope with stereotypes and exclusion of Indigenous knowledge and having to rectify the curriculum to

meet accreditation while being understaffed [42]. University employment is not sustainable for Indigenous staff without the support of Indigenous community – personally or to help shape curriculum. Expertise about Indigenous health does not lie in universities. It is in the Indigenous community, which generally has few university graduates but has valuable expertise, cultural protocols, and appropriate positioning to identify and discuss key issues affecting their community and successful solutions.

Expertise of Indigenous Communities and Organisations

In contrast, mounting evidence exists for the success of Aboriginal community-controlled health organisations. The networked organisations (>140) across Australia have demonstrated leadership since the 1970s in effective and efficient holistic health care [43]. They address the social determinants of health [31] and recognise their successes emanating from continued cultural connections within Indigenous communities [44]. They carry across generations the Indigenous knowledge that has 'multiple and interconnected discourses, social practices and knowledge technologies' [45] and they showcase Indigenous voices that carry within them the shared and lived experience of families and communities, beyond individuals [46]. Aboriginal community-controlled health organisations are now one of the largest workforces of Indigenous Australian peoples [47]; they demonstrate many strengths in models of care, staff, support, retention, and career progression [48] and are important leaders for any new curriculum development.

Project Context

Bunya has been designed as a central strategy for a university faculty (the University of Technology Sydney [UTS] Faculty of Health) and a graduate health school (the UTS Graduate School of Health) to support students to achieve IGA and to deliver curriculum for students embarking on a career in allied health care, specifically pharmacy, physiotherapy, clinical psychology, orthoptics, genetic counselling, and speech pathology. Bunya explores both how curriculum development processes can include Indigenous communities and Indigenous community members' experiences of allied health care.

The idea of seeking to connect a university health faculty with Indigenous communities to develop curriculum and to research the process and outcomes is very well supported by Australia's peak body for health and medical research, the National Health and Medical Research Council (NHMRC). The NHMRC guidelines, *Ethical conduct in research with Aboriginal and Torres Strait Islander peoples and communities* and *Keeping research on track II*, were developed to promote health, prevent harm, and encourage best practice [49,50]. The NHMRC has also developed these specific guiding principles for conducting studies with Aboriginal and Torres Strait Islander peoples [49,50]. Historically, studies conducted in Aboriginal and Torres Strait Islander communities were extremely negative [50]. Previous studies conducted in Indigenous communities were, in some cases, physically barbaric [51]. Studies were designed to disempower, oppress, and silence Aboriginal and Torres Strait Islander peoples [52].

It is only in recent years that studies have been designed to be of benefit to Aboriginal and Torres Strait Islander peoples [53]. Aboriginal and Torres Strait Islander peoples are described as the most over researched population in the world [54]. Processes have been put in place by governing research bodies such as the NHMRC and the Aboriginal Health and Medical Research Council of New South Wales. Both guidelines, *Ethical conduct in research with Aboriginal and Torres Strait Islander peoples and communities* and *Keeping research on track II* [49,50], have been instrumental in the design and development of the Bunya Project and this protocol.

We have divided the Bunya Project into two stages – preparing the soil and planting the seed. Owing to the nature of PAR, it is impossible to separate protocols and learnings as clearly as in papers describing other forms of research, such as a clinical trial. The learnings from the *preparing the soil* stage influence the protocol developed in the *planting the seed* stage. As such, this paper will present some of the findings from the first stage, and a subsequent paper will elucidate them more clearly. The paper was written at the time of the transition from the first stage to the second stage.

Theoretical Frameworks

We have taken a PAR approach [55]. PAR is a qualitative research methodology that relies on the participation of the researcher and the participants to collaboratively gather and interpret data and findings throughout the project. The process of PAR is flexible and responsive to be able to adapt to the direction of the project, rather than being dictated or set from the beginning. PAR is a recognised Indigenous research methodology [56] designed to centre and amplify Indigenous voices and self-determination [57], which is an underpinning value of the Bunya Project. PAR reduces power inequity and helps to ensure reciprocity.

PAR also reflects the authors' lived experiences of working with the community and as educators in the university context.

PAR prioritises researchers and participants forming partnerships to identify issues of local importance and determine ways to understand the issues and strategies for action [58,59]. Furthermore, PAR methodology is used to understand complexities and influence change [55]. This resonates with the research team, given that Indigenous peoples have always implemented participatory principles within community governance through collective consultation and collective action [57]. PAR celebrates the complexity related to multiple contexts, including unique community settings and university education settings [59], with the ability to be agile to adapt to changing settings, participants, and ways of understanding [59].

In developing and articulating the preliminary process and protocol, the reflective cycle principles by Gibbs [60] were applied in a critical self-reflection context. The reflective framework principles by

Gibbs also guided the authors to unpack informal conversations within the community engagement process, ensuring that the community remained central to the process and principles articulated [61]. Therefore, no data have been collected from student participants or will be reported here from external research associated with the Bunya Project. This paper presents critical reflection data from the research team to inform the project and its stakeholders. In evaluating Bunya, these are the foundational aspects required to build and replicate the project.

METHODS

Ethics Approval

The Bunya Project has been designed in accordance with NHMRC ethics guidelines regarding studies being conducted with Aboriginal and Torres Strait Islander peoples [49,50].

The Bunya Project has been approved by both the University of Technology Sydney Human Research Ethics Committee (ETH18-2618) and the Aboriginal Health and Medical Research Council of New South Wales Human Research Ethics Committee (1451/18).

Preparing the Soil

Overview

To develop the Bunya Project and method, the authors took into account cultural ways of working, along with community protocols and expectations. Overall, five steps were necessary to 'prepare the soil' for the Bunya Project process. The five steps are as follows:

1. Community engagement – developing relationships to ensure that the project is of benefit to the community and responsive to the community objectives

2. Lived experience – humility in recognising the influence of our own lived experience on our worldviews and interactions

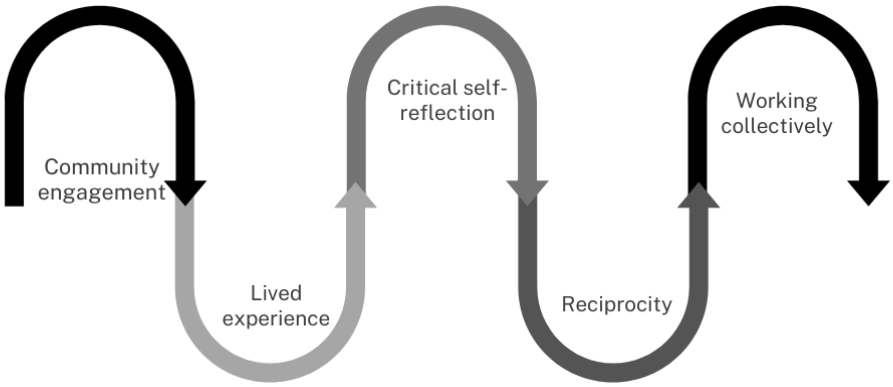
3. Critical self-reflection – about our own perspectives and the influence these perspectives and experiences have on the formulation of ideas, conduct, and expectations

4. Reciprocity – which ensures that the benefit is mutual and the communities are meeting their objectives, not what the researcher thinks is of benefit to them

5. Working collectively – which creates the space for all participants to belong and feel empowered as an important part of the team, process, and outcomes achieved

Figure 5.1 shows these steps but note that they are fluid and may be repeated in part or whole throughout the process.

Figure 5.1. Preparing the soil in the Bunya Project.



Community Engagement

We identified four priority groups to engage with:

1. Indigenous community organisations
2. Indigenous community members and healthcare service users
3. University staff
4. University students

Invitations for group 1, Indigenous community organisations, to participate in the Bunya Project were circulated through networks and social media to encourage self-nomination. The research team visited community organisations and attended community events, circulating information and responding to queries. In total, six organisations signed up as Bunya Project collaborators. During the COVID-19 pandemic, this was reduced to five owing to travel distance restrictions and then to four because one organisation ceased operating. A formal agreement was negotiated with each organisation about their participation, including supporting curriculum development, assisting with the recruitment of Indigenous individuals who are willing to participate in data collection, and providing mentoring and peer support during the Bunya Project.

The Indigenous community organisations invited community members and health care service users (group-2 participants) to participate either directly or through social media. Information about the Bunya Project was circulated within each organisation. Participants then self-nominated to participate.

Participation includes interviews to collect data pertaining to insight into their own health care needs and strengths within their community influencing educational opportunities for allied health education. A total of 24 Indigenous community members and health care users were recruited to be interviewed.

Group-3 participants, university staff, were recruited through self-nomination.

University students (group-4 participants) will be invited to participate in the Bunya Project via the unit coordinator or class tutors. Participation is voluntary. Students who self-nominate will be required to complete premethod and postmethod surveys; we are aiming to survey most participants (n=169, 75.1%), with the total being 225 students.

The Bunya Project encourages connectedness wherever possible among project participant groups.

Lived Experience

Lived experience recognises the cultural, spiritual, physical, emotional, and mental experiences; circumstances; beliefs; and worldviews of a person, including the wellbeing of the individual, family, or community. A lived experience recognises the ongoing impact of colonisation experienced by Aboriginal and Torres Strait Islander individuals, families, and communities. Lived experience also recognises specific events that have an impact on the social, emotional, and cultural wellbeing of Aboriginal and Torres Strait Islander peoples [62]. Lived experience as an Aboriginal person is complex, with many layers; is difficult to define but understood and recognised within the community and shared commonality; and does not need to be defined but is reflected through respecting protocols within the community [63]. Lived experience is an extremely valuable teaching tool, as students connect with shared lived experiences and the opportunity to learn from experiences that differ from their own. Lived experience also ensures that the teaching is authentic and relevant in a real-world context [64].

Critical Self-reflection

Critical self-reflection resulted in the identification of clear guiding principles for the conduct of the project. These guiding principles also reflect general cultural expectations when working with community and Indigenous knowledge. These principles are a guide for consideration in best practices for community engagement and leadership in teaching and learning and Indigenous research cultural protocols. As an Indigenous peoples-led research team, we cannot differentiate cultural protocols from research protocols; Indigenous culture informs knowledge production and the use of knowledge in research and practice.

Reciprocity

The research team actively participates in the Indigenous community organisations' business, supporting initiatives and events; contributing to committees; contributing skills, knowledge, and expertise; and providing access to university resources and networks.

The project continues to progress with mutual understanding of and agreement on key activities.

Working Collectively

Although the leadership of the Bunya Project rests with the Indigenous health academic unit within the faculty, the leadership has a clear desire to work collectively. The heads of each of the six postgraduate health disciplines were invited to nominate a staff member to join an academic working group fondly termed 'the Bunya Nuts.' These representatives provide discipline-specific expertise and guide curriculum development to ensure academic rigour and alignment with the curriculum that is already established.

The Bunya Nuts developed the terms of reference collectively; members are responsible for liaising within their discipline, inviting feedback, distributing community-developed video teaching resources, and facilitating student survey participation.

Objectives

The Bunya Nuts also selected the following objectives for its mixed-methods PAR project:

1. Develop relationships with Aboriginal community services to support the project and understand community recommendations for university education in allied health

2. Conduct interviews and collect digital stories from Aboriginal and Torres Strait Islander peoples, to understand 'what are their experiences, perspectives, knowledges and aspirations for their own health and wellbeing and in relation to allied healthcare?'

3. Create culturally informed andragogy, curriculum, and assessment measures for use among teaching staff and students

4. Implement an evaluation framework to understand the effects on student attitudes and knowledge about Indigenous peoples' allied health needs and aspirations and the authenticity, relevance, and accessibility of the curriculum for staff

5. Continue to develop culturally informed teaching and learning strategies

RESULTS

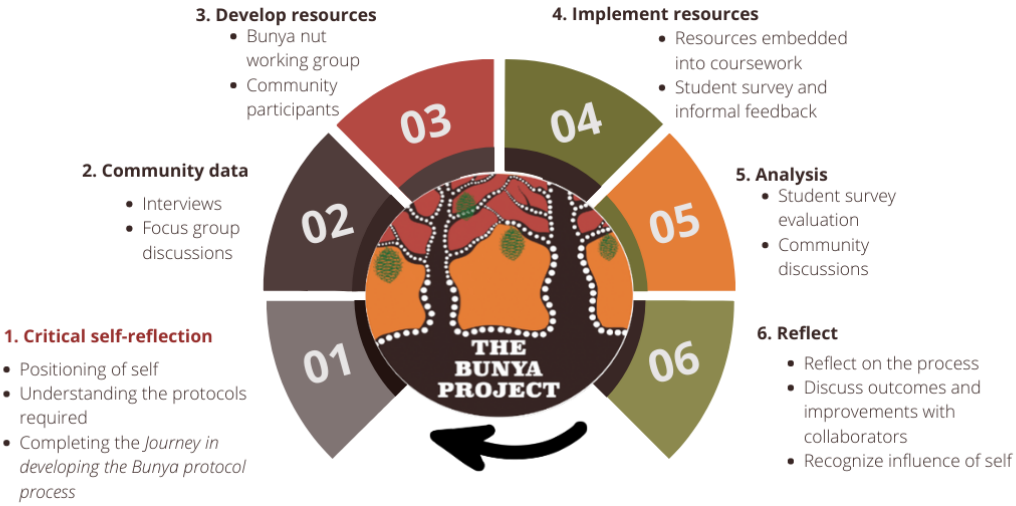
Planting the Seed

Overview

This section discusses the results of the 'preparing the soil' process of the Bunya Project. The 'preparing the soil' process resulted in key insights for the 'planting the seed' stage including how future data are to be collected and the process and methodology for replication within the reader's own context.

As outlined in this paper, the Bunya Project uses PAR cycles to gather information, develop curriculum, use it, and evaluate it from multiple perspectives. As a PAR project, the 'planting the seed' stage of Bunya itself has six stages, each stage influencing the next in a continuous cycle, as illustrated in Figure 5.2.

Figure 5.2. Planting the seed – Bunya Project protocol phases.



The 'planting the seed' process begins with critical self-reflection positioning by those guiding the project, their bias and influence, and ensuring that they have undertaken deliberate preparation to uphold the authenticity of the project. Phase 1 also incorporates the process in 'preparing the soil' illustrated in Figure 5.1 previously. This involves recognising their position, influence, and power and identifying the strategies and protocols required to privilege Indigenous voices and leadership and honour local protocols and expectations. Following this is community engagement and data collection; the data collected in each phase influence the following phases. Community data generate the content for the development and embedding of resources, and the resources activate thinking for the collaborative analysis of the survey and discussion. This is followed by a collaborative reflection about the process, improvements, and adjustments, and the cycle then commences again, with critical self-reflection of the person guiding the project.

As Figure 5.2 shows, Bunya is a PAR project because the overall community participation is central to all elements of the project. Phase 2 involves qualitative data collection, and phase 3 involves filming and editing the new teaching and learning resources and planning where in the curriculum they will be

most effectively used, in collaboration with Bunya Nuts and community participants. Phase 4 involves using the resources and collecting a baseline survey from students and staff, and phase 5 involves the follow-up survey to help understand change and analysis of data. Phase 6 involves reflection with Bunya Nuts and community participants. PAR defines Bunya because it relies on community engagement throughout [55,58,61,65].

Critical Self-reflection

Critical self-reflection is again consciously used in the 'planting the seed' stage of the Bunya Project, using the reflective cycle by Gibbs [60] to understand the experience, identify thoughts and feelings through the process, and recognise the importance of continuous improvement and the role of the researcher in modelling those processes as best practice. Undertaking this process at this point in the protocol provides the opportunity to highlight areas that may need to be revisited or unpacked further, in collaboration with the community involved.

Community Data

Focus Group Discussions

In the future, focus group discussions will be conducted with Indigenous organisation representatives. Focus group discussions encourage knowledge-producing dialogue in a group context. They allow the researcher to be part of the discussion [66]. This aligns with Indigenous ways of yarning and kapati, which encourages Indigenous peoples to talk freely about their experiences, thoughts, and ideas [67]. Furthermore, focus group discussions allow for broad discussion and framing and focusing questions and concepts to inform subsequent research phases, in this case, to inform semistructured interviews.

Focus group discussions will be semistructured, with guiding questions developed by the Bunya Nuts, and will be 30 to 60 minutes in duration.

The groups will have approximately six participants. Topics will range from health care knowledge and experiences to identifying needs and strengths within their community to influence the educational opportunities for tertiary education.

The focus group discussions will be audio recorded with written consent from all participants. Focus group participants will receive light refreshments in reciprocity of their time. All data collected during the focus groups will be deidentified.

Interviews

Interviews are designed to occur as a social interaction while sharing a cup of tea, known as kapati time, and create a safe space that facilitates yarning and storytelling [67]. Interviews stimulate knowledge

sharing through storytelling and yarning [68]; storytelling is an important way of sharing information in Aboriginal and Torres Strait Islander cultures [66]. The interview structure will follow a line of questioning arising from the Bunya Nuts and the focus group discussions; however, this structure is intertwined with the informality of conversation and storytelling about experiences pertaining to the question.

The interviews will be video recorded, with individual consent obtained from each participant before participation. Videos – digital stories – are a way of clearly displaying that the individual holds ownership over their knowledge, culture, and experiences and tells their story themselves, rather than having someone interpret their experience. Videos will then be edited for use, and written final approval will be obtained from the participant before the videos are implemented as internal teaching resources. Videos remain as the property of the participant and are not permitted to be changed or altered in any way unless additional consent is sought from the participant. The 24 interview participants will receive a gift card worth A$20 (US$13.23) as compensation for their participation.

Overall, six interviews will be conducted at each of the four locations.

Premethod and Postmethod Surveys for Staff and Students

The survey chosen to be used for the Bunya Project was designed as a university-wide instrument by the Centre for the Advancement of Indigenous Knowledges [8]. It measures students' attitudes, knowledge, and learning experiences pertaining to Indigenous ways of knowing, being, and doing. The premethod and postmethod survey measures whether the teaching and learning resources and strategies influenced change in staff and students' attitudes.

The survey assessment framework is based on five overarching themes that are aimed to critically engage with teaching and learning content related to the university's IGA. The overarching themes are as follows:

1. Knowledge
2. Critical reflectivity
3. Indigenous voice
4. Indigenous community engagement
5. Applied Indigenous knowledge [70]

The students will be provided with the survey through the survey platform. The Bunya Nuts representative for the discipline will upload the link to the learning management system for the subject.

The link will be accompanied by an announcement to encourage student participation. The survey will remain open for at least three weeks, and students will be encouraged to complete it.

Develop Resources

The development of the resources begins with the Bunya Nuts working group to identify topics within the curriculum for each discipline. These topics will be discussed in focus group discussions with Aboriginal Community Controlled Health Services, identifying the specific learning or information that the group determines as important for the students to know, understand, and apply within their professional practice. On the basis of the results of the discussions, one-on-one interviews will be conducted and video or audio recorded (according to participant preference). The interview questions and topics will be directly linked to the outcome of the focus group discussion, ensuring Indigenous self-determination throughout the process. The clips will be edited into short clips and reviewed by the participants to ensure that the message remained as intended.

Implement Resources

The resources developed will be made available to the school teaching staff within the various disciplines. The resources will be uploaded to the learning management system. Staff will be invited by the project team to access the resources. The project team will have control over who can access the resources and analytics to track where the resources are implemented within the learning management system, to ensure that the resources are only implemented in accordance with the ethical guidelines. The teaching staff will copy the resources into various points within their subjects to ensure that an Indigenous voice is present. The implementation of the resources will be accompanied by support processes outside this project, including teaching principles, an andragogy framework, and professional development opportunities for the staff. The project team recognises the importance of not only what is taught (the content) but also how it is taught (the andragogy).

Analysis

The analysis of the data will be undertaken by the research team, in collaboration with the community partners and the Bunya Nuts. The andragogy framework guides the analysis, centring Indigenous knowledge and learning methodology within the context of adult education. Specific analysis will be conducted for each data set – the focus group discussions, interviews, and surveys.

Interviews will be transcribed and entered into NVivo (QSR International) [70] to be coded, with themes arising from the data. Codes will be compared, condensed, and organised into high-level themes to be communicated [71]. Focus group discussions will be managed similar to interviews, with the inclusion of group analysis [72]. Drafts and ideas about the data will be shared with the participating community organisations for their feedback. Furthermore, the qualitative interviews will be transformed and edited

into digital stories, to be given to each participant and produce teaching resources for the disciplines. We will also draw on facilitator's written notes made during the focus group discussions.

The Centre for the Advancement of Indigenous Knowledges' processes for the analysis of data will be followed. The results of the validated survey will be analysed to measure the impact of the authentic community-controlled teaching resources on the staff and students' attitudes, knowledge, and learning experiences in relation to Indigenous perspectives within their professional learnings. The quantitative data will be carefully cleaned, with frequencies identified using SPSS [73] to identify overall patterns, including across the five basic themes the instrument focuses on. Other basic statistical data analysis will occur including averages and partial correlation for associations with student outcomes.

Drafts and initial thoughts will again be shared with the community organisations to provide feedback regarding the progress and impact of the resources developed. The community guidance will influence modifications in the teaching resources for future implementation, beyond the scope of this project.

Current Status

The protocol for the first stage, *preparing the soil*, is complete. The results of the first stage are the relationships built and the trust earned and gained, and it has resulted in the development of the *planting the seed protocol*. As of February 2023, we have recruited 24 participants. We will analyse data shortly and expect to publish the results in 2024.

DISCUSSION

Summary

Through the 'preparing the soil' stage of the PAR, the 'planting the seed' Bunya Project protocol emerged, as depicted in Figure 5.2. This represents key findings, the importance of critical self-reflections in Indigenous health education and PAR, the importance of holding space in curriculum development and design to privilege Indigenous voices through the engagement of community data, collective development of resources, implementing resources in a culturally safe learning space, the analysis of the learning content and process, and reflection to ensure continuous improvement of the process and educators.

PAR is an empowering methodology that privileges local knowledge and lived experiences throughout every facet of the project [56,57] – the direction, implementation, analyses, and outcome. The Indigenous perspectives embedded within the curriculum are based on establishing relationships with the local community that are reciprocal and collaborative with Indigenous leadership and the university through the Bunya Nuts academic working group. The collaboration between the Bunya Nuts and the community is instrumental in the creation of new knowledge as this collaboration develops the capacity

of both parties learning from each other through action [57,59,68]. The collective action involves creating videos and resources that honour and reflect the intended meaning and context from community to academia and from academia to community. This action extends to influence change in allied health care through educating and building a culturally responsive workforce. Bunya's andragogic framework is designed to reinforce the content, collaboration, and leadership of the community as the authoritative voice and knowledge holders [66].

This study encourages universities to develop partnerships with Indigenous community organisations in curriculum development. Establishing and maintaining authentic partnerships with Indigenous community organisations is important for the development of the future workforce and provides essential knowledge and skills for all graduates. Academic staff and institutions must move past an 'othering' mindset, including the notion that developing relationships with Indigenous community organisations and including Indigenous perspectives in the curriculum is the sole responsibility of Indigenous academic staff. The reality is that Indigenous staff numbers in universities are low, globally. Embedding Indigenous perspectives into the curriculum is the responsibility and privilege of all the academic staff. It is not possible to create a checklist or a descriptive 'how to' guide, as teaching and learning must be grounded and relevant to the local context. This paper outlines the guiding principles developed from the lived experience and reflectivity of the authors as community members and educators.

In Australia, government policy and legislative requirements have been introduced to ensure that curricula and workplaces implement training and professional development opportunities for students and staff, so that they can develop and apply knowledge and skills that create conditions for cultural safety and culturally responsive health care. Authentic partnerships with community organisations are an obvious place to start. Students can then commence their career with a strong foundation by understanding how to work authentically with Indigenous organisations and peoples. This paper outlines how to approach and achieve this outcome.

As this paper also shows, partnerships require reciprocal benefit and authenticity, creating the opportunity for universities to positively and authentically work with Indigenous community organisations to share knowledge skills and resources that will benefit not only the university and the students but also the community organisations and their staff and clients.

Comparisons With Previous Studies

The Bunya Project protocol unifies elements identified by past studies to form a comprehensive approach to embedding Indigenous perspectives within higher education with community engagement and leaders, andragogical framework, staff accountability, and student evaluation.

The growing momentum to include Indigenous perspectives into higher education and preparing graduates to work effectively with Indigenous populations is positive. However, current implementation processes in Australia lack accountability [63], evidence, and evaluation [8].

It has also been identified that Indigenous peoples cannot be solely responsible for all learning and teaching in academia. Indigenous and non-Indigenous academic staff must work together to implement the curriculum, using culturally safe [74] and relevant teaching and learning strategies [67,75,76,77]. This extends to the professional context whereby previous studies identified the importance of Aboriginal health workers and mainstream allied health workers working together within their professional context [74].

In accordance with United Nations Declaration on the Rights of Indigenous Peoples, Indigenous peoples have the right to self-determine health care and education [78]; therefore, they must be leaders in designing and informing curriculum, ensuring that learning is *with* Indigenous peoples and not *about* Indigenous peoples. This is demonstrated in various ways through previous studies, by applying and building on knowledge and experience with Indigenous peoples [79] to inform curriculum, through local Indigenous ways of knowing and learning in the classroom, and through community-engaged learning.

Previous studies in the area have identified the importance of the local context, of working with a single community – this does not reflect the diversity within Indigenous populations in Australia. The Bunya Project protocol extends this to include leadership from a diversity of communities.

The Bunya Project protocol also challenges educators to push past the concept of pedagogy to ensure that teaching and learning are receptive to the adult learner [80].

Transformational learning is central to this space and was identified throughout previous studies [32]. The San'yas Indigenous Cultural Safety Training in Canada is implemented as an educational intervention to promote transformational change in health systems, policies, and practice [81]. The Bunya Project protocol incorporates and builds on the importance of transformational learning and recognising the position of self by all involved, including community participants, academic staff, and students.

Limitations

COVID-19 affected the project, as lockdowns restrict interactions. Even during times of eased restrictions, communities were very cautious to engage owing to the risk posed by COVID-19 and have cancelled events or adapted to web-based events. However, the pandemic provided another opportunity to highlight Indigenous excellence as the overall response to the pandemic, including public health messaging and responses, and the rapid adaptability to web-based connectedness has been exemplary.

The Bunya Project was developed in one university and six communities, which does not reflect the diversity of Aboriginal peoples or Indigenous peoples globally.

CONCLUSIONS

This study reinforces the necessity for universities to be active in engaging with Indigenous communities to influence education content and, consequently, outcomes. It is not the responsibility of the few Indigenous staff to champion this; the implication is that the majority must authentically engage with the community and privilege their leadership and expertise within teaching and learning design, delivery, and evaluation.

The value and implication of the Bunya Project lies in its demonstration of how universities resource staff to engage with community organisations and members within the university setting. If working well with Indigenous peoples requires the readiness of non-Indigenous staff and students, universities need to provide staff with cultural capability training, facilitating opportunities to learn. This Bunya Project protocol and its 'preparing the soil' and 'planting the seeds' stages model a process for best practice and authentic engagement that creates space, respect, and recognition of the value and privilege to learn from Indigenous leadership and expertise.

PAR of the Bunya Project is working to evolve university education through the quality delivery of an IGA that prepares students to be informed professionals throughout their careers and to contribute to creating conditions for Indigenous peoples to experience cultural safety; this is a lifelong learning journey. The intended learnings from the Bunya Project are expected to extend beyond university through continuing personal and professional development and application throughout the individual's career.

Acknowledgments

The authors thank Dr Mark Ragg of Ragg & Co for the contribution to the development of the protocol. The study received funding from the University of Technology Sydney Graduate School of Health seed grant program.

Data Availability

Data will be made available; however, they have not been collected yet.

Conflicts of Interest

None declared.

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Abbreviations

IGA: Indigenous Graduate Attribute

NHMRC: National Health and Medical Research Council

PAR: participatory action research

UTS: University of Technology Sydney

5.3 Chapter conclusion

In this chapter, a description of the Bunya Project has outlined an ethical and culturally appropriate process for preparation, engagement with Indigenous community organisations 'preparing the soil' and planting the seed'. The process includes reflection on personal perspectives, and a commitment to ethical research practices with active Indigenous community participation through a participatory action research framework resulting in knowledge translation and action in practice. Aligning with NHMRC guidelines, the project prioritises promoting health, preventing harm and encouraging best practices, shaping its methodology to reflect participatory action research principles that prioritise Indigenous voices and self-determination. The Focus group discussion provided the platform for Indigenous community members from participating organisations to uphold principles of self-determination in the design and structure if the subsequent interview questions outlined in the next chapter.

Recent criticisms of universities' impact on Indigenous disadvantage have prompted introspection within the project, utilising the Gibbs reflective cycle to recognise the leadership and expertise of Indigenous staff in mainstream institutions while acknowledging the success of Aboriginal community-controlled health organisations in building the Indigenous healthcare workforce.

This chapter demonstrates how the Bunya Project centres Indigenous cultural ways of working and community engagement through lived experience, critical self-reflection, reciprocity, and collective work, establishing an environment based on authenticity and relevance to grow teaching and research practices in Indigenous healthcare.

Following this protocol with authenticity and humility in the spirit of reciprocity led to many opportunities to collaborate and celebrate with community. This reciprocity has been reflected in additional projects outside the scope of this thesis listed in other publications. Through this process the research team have been able to participate in cultural celebrations with the partner organisations such as Reconciliation Week cruises and NAIDOC celebrations. The reciprocal relationship also provided an opportunity for the University to practically contribute to the community by hosting events, and workforce development opportunities leading to honorary appointments and enrolments.

Other acts of reciprocity included:

- Committee membership for the planning and advisory of The Glen for Women residential rehabilitation centre
- Discussion and leadership within the Aboriginal Community Controlled AOD sector regarding research and evaluation opportunities to gather quality evidence of service delivery and client outcomes
- Advising and facilitating research decision-making with The Glen Group including responding to others' requests and ensuring ethical principles were adhered to

- UTS hosting the Aboriginal Drug and Alcohol Residential Rehabilitation Network symposium, breaking down barriers to university as a place beneficial for Aboriginal and Torres Strait Islander people and communities
- Students attending Aboriginal and Torres Strait Islander community events providing authentic community engagement opportunities that are beneficial to the community
- Facilitating ACCHO staff enrolment and success in university.

This project has significant potential to improve healthcare for Indigenous Australians by creating and holding space for Indigenous leaders and experts in healthcare curricula to influence systemic change through increasing the skills, knowledges and attitudes of the healthcare workforce.

The next chapter presents the qualitative findings, sharing Indigenous community voices regarding their healthcare needs, experiences, knowledges and aspirations and providing insight into what they recommend for tertiary education to improve health equity.

Bunya nut cut to display seeds (Oak Tree Designs, 2020)[1]

Chapter 6: Findings Part 1 – It's About Rights

This chapter incudes a paper that has been published:

> Manton, D., Williams, M., & Hayen, A. (2024) 'It's about rights': The Bunya Project's Indigenous Australian voices on Health Care Curricula and Practice. *Health and Human Rights Journal 26*(1), 87-99.

Preface

The Bunya Seeds symbolise a valuable yet often underestimated food source. Likewise, Indigenous knowledge and leadership in healthcare education hold the promise of fostering a healthcare system that respects Indigenous voices, acknowledges lived experiences and actively promotes cultural safety. Initiating transformation in healthcare education is crucial to drive change. This begins with listening to the Indigenous healthcare workforce community, understanding their aspirations for the Australian healthcare curriculum, and identifying the necessary knowledge, skills, and attitudes to improve healthcare practices and outcomes for Indigenous peoples.

Each Bunya seed is enclosed by a thin covering of tissue, or husk, which can be easily removed. Once this is done, the seed coat or shell of the nut must be opened with a nutcracker or hammer to reveal the large and very tasty seed inside. However, cooking these seeds correctly can be challenging. Merely

[1] Oak Tree Designs. (2020). *Bunya Bunya Tree*. Retrieved 8 April from https://oaktreedesigns.com.au/bunya-pine/

following a recipe is not enough, as the seeds can be flavoursome and nutritious if prepared and cooked correctly or, if the time hasn't been taken to prepare, extremely difficult to eat and bland.

Working with community is not an 'easy nut to crack', but it is essential researchers do all possible to support community to drive research and its interpretation (Biles et al., 2022). As with to the Bunya seed there is a protective layer that requires a relationship to be developed and requires humility and self-reflection; and just like the seed, it is not communities' responsibility to make sure the process is done correctly.

6.1 Chapter overview

This chapter highlights the possibility of a healthcare system that respects Indigenous voices, understands lived experiences, and actively fosters cultural safety. Transforming healthcare education is crucial to influence change. First, we must listen to the voices of our Indigenous healthcare workforce community and what they want to see in the Australian healthcare curriculum. Second we must identify what knowledges, skills and attitudes need to be reflected in healthcare professional practice to improve health access and outcomes for Indigenous peoples in Australia.

This is not just about improving healthcare – it is about upholding human rights principles. This chapter encourages stakeholders to work together with university communities Indigenous leaders and ACCHOs, to build a healthcare system that serves all Australians with respect, safety, and dignity at its core.

This chapter is a call to action that prioritises collaboration, respect, and a commitment to addressing past and present injustices. It empowers Indigenous communities and promotes positive change within the healthcare system.

The key aims of this chapter are to:

1. Outline the human rights and cultural safety principles expected in healthcare
2. Convey Indigenous peoples' voices and experiences in accessing healthcare
3. Consider implications for healthcare education outlining the importance of self-determination and cultural safety
4. Inform the development of the Bunya andragogy framework presented in the next chapter

The chapter emphasises the importance of upholding basic human rights principles such as collaboration and respect, while amplifying the voices of our Indigenous community in healthcare curricula and academic publications to recognise historical and ongoing injustices to improve access to culturally safe healthcare in Australia.

6.2 Qualitative interview findings

‘It’s about rights’: The Bunya Project’s Indigenous Australian voices on Health Care curricula and practice

Vol 26/1, 2024, pp. 87-99

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Abstract

Indigenous community-controlled healthcare organisations provide timely, sustained and culturally safe care. However, their expertise is often excluded from health professional education. This limits the transfer of knowledges and protocols to future practitioners – those positioned to shape healthcare systems and practices that would achieve health rights of Indigenous people and reduce health and social inequities. In Australia, despite national government commitments to transform Indigenous health curriculum, services, and systems, healthcare training organisations such as universities generally have low numbers of Indigenous staff and few strategies to engage Indigenous experts. The Bunya Project is an Indigenous-led participatory action research designed to support non-Indigenous university staff and curriculum development through partnerships with Indigenous community-controlled organisations. Twenty-four interviews were conducted with Indigenous peoples ascertaining recommendations for healthcare curriculum. Three themes emerged: (1) role-modelling and leadership of Indigenous-controlled health organisations; (2) specific learnings for health professionals; and (3) achieving human rights in practice. Each theme includes first-person accounts, strategies for improvement, and affirmations of effectiveness. Interviews also highlighted the need for health professionals’ extension beyond clinical caregiving; staff and students’ development of knowledge, skills, and actions about client self-determination to ensure clients can implement these rights across all aspects of their healthcare in the context of their life circumstances. Critical self-reflection by health professionals that identifies actions and resistance to these is a foundational individual-level skill to invest in for cultural safety.

INTRODUCTION

Right to health, and Indigenous rights

Indigenous peoples’ right to health is affirmed in international conventions and declarations – those pertaining to health, human rights, and to the specific rights of Indigenous peoples. The United Nations Declaration on the Rights of Indigenous People identifies conditions necessary to achieve the right to health and social justice, including self-determination, maintaining traditional health practices,

protection from vulnerabilities, and improving social conditions and determinants of health.[2] The right to culturally appropriate care is affirmed in the United Nations Committee on Economic, Social and Cultural Rights in General Comment 14, and cultural dimensions of health are also recognisable in articles about the right to control resources, lands and territories that Indigenous peoples and cultures are traditionally related to (UNDRIP article 31).[3]

Indigenous peoples' right to health is affirmed in legal and policy documents in the local jurisdictions of Indigenous peoples across the world.[4] These highlight the key principles of cultural safety in healthcare, access to land and resources, and accountability through legal recourse when right to health violations occur.

Statements in rights, legislation and policy documents frequently reflect the holistic worldview of Indigenous people – that health is more than just physical wellbeing, but is also social, emotional, spiritual, mental and environmental wellbeing.[5] These dimensions of health are affected and influenced by experiences across generations, particularly the influences of colonisation, colonialism, racism, and multitudinous forms of social exclusion.

Self-determination

Self-determination in healthcare is articulated in human rights instruments.[6] Indigenous peoples have the right to self-determination, including in healthcare (UNDRIP Articles 3 and 24).[7] Despite this, many healthcare systems have been named as structurally racist, with clear examples of interpersonal racism in healthcare settings.[8] In Australia, the system and processes are seen as an instrument of colonisation

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[2] United Nations Declaration on the Rights of Indigenous Peoples, GA Res 61/295 (2007) (UNDRIP); J. Gilbert and C. Lennox, ;Towards new development paradigms: the United Nations Declaration on the Rights of Indigenous Peoples as a tool to support self-determined development', *The International Journal of Human Rights* 231-2 (2019).
[3] Office of the High Commissioner for Human Rights Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health (Art. 12).* UN Doc E/C.12/2000/4 (August 2000); UNDRIP (see note 2)
[4] A. Moscoso, C. Pinones-Rivera, R. Arancibia and B. Quenaya, 'The right to health care viewed from the Indigenous research paradigm: Violations of the rights of an Aymara Warimi in Chile's Tarapaca region', *Health and Human Rights* 25/1 (2023).
[5] L. Jackson Pulver, M. Williams and S. Fitzpatrick, 'Social determinants of Australia's First Peoples' health: A multi-level empowerment perspective', in In P. Liamputtong (Ed.), *Social Determinants of Dealth* (Oxford University Press, 2019), 175-214.
[6] J. Gilbert and C. Lennox, 'Towards new development paradigms: The United Nations Declaration on the Rights of Indigenous Peoples as a tool to support self-determined development', *The International Journal of Human Rights* 23/1-2 (2019).
[7] Committee on Economic, Social and Cultural Rights (2000, see note 2).
[8] C. Watego, D. Singh and A. Macoun, *Partnership for Justice in Health: Scoping paper on race, racism and the Australian health system* (The Lowitja Institute, 2021); C. Parter et al., 'Talking about the "r" word: A right to a health system that is free of racism', *Public Health Research and Practice* 31/1 (2021); Y. Paradies and J. Cunningham, 'Experiences of racism among urban Indigenous Australians: Findings from the DRUID study', *Ethnic and Racial Studies* 32/3 (2009).

continuing to suppress Aboriginal and Torres Strait Islander peoples.[9] The recent framework to address health inequity in Australia, 'Closing the Gap', involves federal, state and local governments. The framework was first developed in 2008 with minimal consultation with Indigenous peoples or organisations; a majority of the inequities to be addressed worsened over the following decade.[10] A policy refresh occurred in 2018 with input from Aboriginal and Torres Strait Islander peoples and organisations, and in 2020 the Australian Government formed a partnership with Aboriginal and Torres Strait Islander organisations' Council of Peaks to shift the approach of Closing the Gap to include self-determination.[11]

Working in partnership with Indigenous communities is a key strategy to improve self-determination, healthcare quality, and the potential for cultural safety. [12] Health professionals receive little training on how to work in partnership with Indigenous communities, nor on key concepts of cultural safety, Indigenous rights, and specific Indigenous content underlying general evidence-based practices.[13] Overwhelmingly, healthcare education focuses on the ill health of Indigenous peoples with limited exposure to Indigenous perspectives on holistic healthcare models.[14] Without this knowledge healthcare providers risk continuing to devalue Indigenous models of healthcare by rendering them invisible.[15]

Cultural Safety

Culturally safe practice is defined by the Australia Health Practitioner Regulation Agency (Ahpra) and National Boards as 'the ongoing critical reflection of health practitioner knowledge, skills, attitudes,

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[9] W. M. Foucault, *Archaeology of Knowledge and the Discourse on Language* (Pantheon Books, 1972, trans. A. M. Sheridan Smith), p. 49; P. Wolfe, 'Settler Colonialism and the Elimination of the Native', *Journal of Genocide Research* 8/4 (2006); Parter (see note 8).
[10] C. Holland, *A ten-year review: The Closing the Gap Strategy and recommendations for reset* (Close the Gap Campaign Steering Committee, 2018).
[11] Council of Australian Governments, *COAG statement on the Closing the Gap refresh* (COAG, 2018); Coalition of Peaks and Australian Governments, *National Agreement on Closing the Gap* (2020), https://www.coalitionofpeaks.org.au/national-agreement-on-closing-the-gap
[12] C. Sheila, B.J. Smith, A. Possamai-Inesedy and A.M.N. Renzaho, 'Exploring the role of community engagement in improving the health of disadvantaged populations: A systematic review', *Global Health Action* 8/1 (2015); M. Wright et al., 'Co-designing health service evaluation tools that foreground First Nation worldviews for better mental health and wellbeing outcome', *International Journal of Environmental Research and Public Health* 18/16 (2021).
[13] D. Manton and M. Williams, 'Strengthening Indigenous Australian perspectives in allied health education: A critical reflection', *International Journal of Indigenous Health* 16/1 (2021).
[14] Jackson Pulver (see note 5); National Aboriginal Health Strategy Working Party (Australia), *A national Aboriginal health strategy* (1989); D. Manton, M. Williams and A. Hayen, 'The Bunya Project: Protocol for a Mixed-Methods Approach to Developing a Culturally Informed Curriculum', *JMIR Research Protocols* 12/1 (2023)
[15] D. Manton, M. Williams and A. Hayen, 'The Bunya Project: Protocol for a Mixed-Methods Approach to Developing a Culturally Informed Curriculum', *JMIR Research Protocols* 12/1 (2023)

practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free from racism'.[16]

There is growing pressure in the Australian health sector to demonstrate culturally safe practice. Cultural safety is a legislative requirement in Australian health practitioner regulation law with the objective to develop the capability of the Australian healthcare workforce to be culturally safe practitioners.[17]

There have been too few strategies to teach cultural safety in practice.[18] The Australian Government developed the Health Curriculum Framework consisting of nine capabilities, including respect, relationships, and partnerships. [19] These capabilities are often not well modelled at a university level.[20] Additionally, capabilities valued by Indigenous peoples such as respect, communication, advocacy, and reflection are rarely explicitly developed or measured.

Aboriginal Community Controlled Health Organisations Workforce and Leadership

The 145-plus Aboriginal Community Controlled Health Organisations (ACCHOs) in Australia demonstrate leadership in delivering culturally safe holistic healthcare.[21] ACCHOs are the largest employers of the Indigenous workforce in Australia.[22] ACCHOs' staff enter a healthcare career wanting to achieve systemic change and positive outcomes for their families and communities.[23] ACCHOs are well placed to facilitate partnerships with universities to build the Indigenous workforce.[24]

Education

Universities play a key role in perpetuating and reinforcing structures of inequality and oppression. They have very few partnerships with ACCHOs to develop curriculum nor strategies to work with Indigenous peoples.[25]

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[16] Ahpra, *The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025* (2020), p. 9.
[17] Ibid.; National Boards and Ahpra, *Regulatory guide* (2022).
[18] Manton and Williams (see note 13).
[19] Department of Health, *Aboriginal and Torres Strait Islander Health Curriculum framework* (2014).
[20] R. Delbridge et al., 'Working at a cultural interface: Co-creating Aboriginal health curriculum for health professions', *Higher Education Research & Development* 41/5 (2022).
[21] Manton and Williams (see note 14).
[22] National Aboriginal Community Controlled Health Organisation, *NACCHO Members* (11 August, 2023) https://www.naccho.org.au/naccho-members/
[23] J. Bailey et al., *We are working for our people: Growing and strengthening the Aboriginal and Torres Strait Islander health workforce: Career Pathways project report* (2020).
[24] M. Davis, 'Community control and the work of the national Aboriginal community controlled health organisation: Putting meat on the bones of the UNDRIP', *Indigenous Law Bulletin* 8/11 (2013).
[25] D. Saxe and J. Gale, 'Unsettling the "white university" – Undermining color-blindness through critical race theory and testimonio', *Journal for Critical Education Policy Studies* 19/3 (2022); B.M. Brayboy, H.R. Gough, B. Leonard, R.F Roehl and J.A. Solyom, 'Reclaiming scholarship: Critical Indigenous research methodologies',

Graduates are typically underprepared to work with Indigenous peoples, and have little understanding of the burden of colonial contexts, histories, and ongoing trauma.[26] Coupled with assumptions, stereotyping, and lack of reflective insight, this perpetuates an inequitable power dynamic.[27]

Inclusion in healthcare education is limited to observation *about* Indigenous peoples rather than *with* Indigenous peoples. Indigenous Australians frequently and recently report experiences of racism as part of daily life and in the health system.[28]

Universities produce graduates who immediately have positions of power in relation to Indigenous peoples.[29] Recent graduates play an important role in how Indigenous patients engage within healthcare.[30] If recent graduates were equipped with appropriate knowledge, skills, and strategies they could become proactive in promoting and providing space for Indigenous leadership, and in identifying and addressing racism.

Health curricula often includes first-person accounts of lived experience to bridge theory and practice in healthcare.[31] The Indigenous-led participatory action research, the Bunya Project, was designed to support non-Indigenous university staff and curriculum development through partnerships with Indigenous community-controlled organisations and strategic opportunities to hear firsthand accounts of health needs and recommendations.[32]

METHODOLOGY

The Bunya Project research is centred in an Aboriginal worldview, recognising the value of the knowledge held with Indigenous peoples for millennia and its importance and relevance in the current context. This project is grounded in the centring and privileging of Indigenous ways of knowing (epistemologies) being (ontology) and doing (axiology).[33] The design of the Bunya Project has elsewhere been described in full,[34] with only a short overview provided here, and a focus on the qualitative research component pertaining to this paper.

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in S.D. Lapan, M.T. Quartaroli and F.J. Riemer (Eds.), *Qualitative research: An introduction to methods and designs* (Wiley, 2012).

[26] Manton and Williams (see note 14).

[27] J. Marcelin, S. Dawd, R. Siraj, S. Kotadia and Y. Maldonado, 'The impact of unconscious bias in healthcare: How to recognize and mitigate it', *The Journal of Infectious Diseases* 220/2 (2019).

[28] Parter (see note 8); Reconciliation Australia, *2020 Australian reconciliation barometer* (2020).

[29] Manton and Williams (see note 14); Manton, Williams and Hayen (see note 15).

[30] Y.S. Poon et al., 'A global overview of healthcare workers' turnover intention amid COVID-19 pandemic: A systematic review with future directions', *Human Resources for Health* 20/1 (2022).

[31] T. Parnell et al., 'Lived experience narratives in health professional education: Educators' perspectives of a co-designed, online mental health education resource', *BMC Medical Education* 23/1 (2023).

[32] K. Harrington, A. Flint and M. Healey, *Engagement through partnership: Students as partners in learning and teaching in higher education* (Higher Education Academy, 2014).

[33] S. Wilson, 'What is Indigenous research methodology?', *Canadian Journal of Native Education* 25/2 (2001).

[34] Manton and Wiilliams (see note 14).

Methods

The qualitative research conducted as part of the Bunya Project aimed to develop, implement, and evaluate Indigenous health curriculum and resources in New South Wales, Australia, from 2019 to 2023. Data collection involved focus group discussions.[35] The FGD were followed by interviews, with the interviews exploring concepts raised in the FGD.[36]

Interviews, conducted in a relaxed setting known as kapati time, emphasised storytelling and knowledge sharing, reflecting the project's centrality of Indigenous expertise and methodologies.[37]

The structured interviews focused on Indigenous self-determination in healthcare education and what mainstream health students should incorporate into their professional practice.[38]

While the interviews were semistructured, based on kapati time and yarning principles, guiding questions were provided to all invited participants. The interview duration ranged from 15 to 60 minutes, and was determined by the participants and the conversation.

Ethical Approval

The Bunya Project adhered to Australia's National Health and Medical Research Council's ethical guidelines, ensuring free and informed consent from participants and respecting their ownership of all collected data, including videos, audio recordings, and transcripts. The project was approved by the University of Technology Sydney Human Research Ethics Committee (ETH18-2618) and the Aboriginal Health and Medical Research Council of New South Wales Human Research Ethics Committee (1451/18). We used participant-selected pseudonyms to maintain confidentiality while honouring their Indigenous identities and roles within the community.

Recruitment

The first author recruited the convenience sample for the study, which primarily consisted of Indigenous staff and community members from the four partner organisations, with a total of 24 participants evenly distributed across genders and age groups. All participants identified as Aboriginal peoples and resided in New South Wales, with interviews conducted between 2019 and 2022, mostly in person but some via Zoom due to the COVID-19 pandemic.

Analysis

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[35] J. Creswell, *Research design: Qualitative, quantitative, and mixed methods approach* (Sage, 2018).
[36] K. Charmaz, *Constructing grounded theory* (Sage, 2014).
[37] R. Ober, 'Kapati time: Storytelling as a data collection method in Indigenous research', *International Journal of Learning in Social Contexts* 22/1 (2017).
[38] Ibid.

The first author conducted all interviews, collecting firsthand data including context, non-verbal behaviours, and participants' voices.[39] After reading all transcripts without annotation, codes were created from emerging themes through active coding, leading to the identification of overarching themes.[40] These themes, emphasising rights as a driver of analysis, were refined through focused coding, resulting in three key findings with 12 subthemes.[41] Feedback from participating organisations and individuals ensured the reflective nature of the findings, with participants quoted using chosen pseudonyms.

FINDINGS

How the Methodology Influenced the Findings

Accessing Indigenous voices is crucial for integrating Indigenous perspectives into curriculum. The diverse stories gathered in the Bunya Project, while varied, share common themes, such as Indigenous people feeling unsafe in health services, being blamed, and feeling responsible for accessing services rather than services prioritising accessibility for them.[42] The common message is the aspiration that healthcare practices in Australia will meet their basic human rights.

'What We Show You': Self- determination of Indigenous-controlled Health Organisations to Create Culturally Safe Healthcare

The participants conveyed that there is immense expertise and experience that mainstream health services could learn from Aboriginal peoples not only about cultural knowledge, but about flexible and multifaceted ways to make healthcare accessible. Access to the highest attainable level of health care is a fundamental human right, as is Indigenous people self-determining programs and services that affect wellbeing.[43] For Aunty Ivy, a respected Gamillaroi Elder, culturally safe access to healthcare service, meant an understanding of Indigeneity:

> *I use an Aboriginal medical service because I don't have to explain.*

Aboriginal people using Aboriginal services or seeing Aboriginal health care providers often do not have to explain experiences Aboriginal people have with, for example, colonisation, racism and

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[39] Charmaz (see note 36), p. 111.
[40] Ibid., p. 115
[41] Ibid.
[42] G. Bodkin-Andrews, S. Page and M. Trudgett, 'Shaming the silences: Indigenous graduate attributes and the privileging of Aboriginal and Torres Strait Islander voices', *Critical Studies in Education* 63/1 (2022); S. Topp, A. Edelman and S. Taylor, '"We are everything to everyone": A systematic review of factors influencing the accountability relationships of Aboriginal and Torres Strait Islander health workers (AHWs) in the Australian health system', *International Journal for Equity in Health* 17/1 (2018).
[43] International Covenant on Economic, Social and Cultural Rights, GA Res. 2200A (XXI) (1966); UNDRIP (see note 2)

complex family and community relationships, which non-Indigenous people tend not to know about.[44] The following participant, Kaurna Elder Aunty Lily-Jo, outlined the benefit of removing barriers such as anxiety related to attending appointments with set times.[45] In her words:

> *At the Aboriginal medical service, I just did a walk-in, they have that on Mondays and Tuesdays where you can just get a quick script and go. So that was accessible, and I found that really helpful.*

Unlike mainstream health organisations and hospitals, ACCHOs can achieve preventative healthcare.[46] They also address the needs of the whole community across the lifespan and proactively develop relationships within the community.[47] Aunty Lily-Jo continued:

> *So, I think they work. I've seen it in early years, high school and then the Aboriginal health days for community are really good.*

The approaches implemented by ACCHOs demonstrate leadership in understanding the needs within the local context.

Advocacy and Empowerment

Alinta, a Biripi woman in her mid-20s spoke of the importance of advocacy based on feeling safe within the healthcare, empowering her not only for herself but to the benefit of her community. Indigenous people globally have connected individual and community empowerment to both the experience emanating from human rights, but also to become active in advocating for human rights.[48] As Alinta explains:

> *Being able to stand up and actually have a voice for them within their health is something that has made me stronger and being able to help myself but also be able to stand up and be a voice for the ladies that we help as well.*

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[44] S. Fitzpatrick, *Inner qualities versus inequalities: A case study of student change learning about Aboriginal health using sequential, explanatory mixed methods*, PhD thesis (UNSW, 2023).
[45] S. Avery, *Culture is inclusion: A narrative of Aboriginal and Torres Strait Islander people with disability*. (FPDN, 2018).
[46] D. Coombs, 'Future-proofing Indigenous self-determination in health: Goals, tactics, and achievements of Aboriginal Community Controlled Health Organisations in New South Wales, Australia', in N. Moodie and S. Maddison (Eds.), *Public policy and Indigenous futures* (Wiley, 2023), pp. 73-93.
[47] S. C. Thompson et al., 'Shedding light or fanning flames? A consideration of the challenges in exploring the relative effectiveness of Aboriginal Community Controlled Health Services', *Quality in Primary Care* 23/3 (2015).
[48] T. Calma and D. Dick, 'Social determinants and the health of Indigenous peoples in Australia – A human rights-based approach', International symposium on the social determinants of Indigenous health, April 29-30, 2007, https://humanrights.gov.au/about/news/speeches/social-determinants-and-health-indigenous-peoples-australia-human-rights-based

Kahi, a Saltwater man in his early 30s, spoke of the confidence he has when accessing eye healthcare, self-advocating:

> *I don't know if it's me as a person who establishes those boundaries and I have that willpower and I guess that confidence to say, 'This is where I'm at. You need to tell me the point of difference. You need to tell me what I need to do.' But they were willing to listen and learn from what I needed for my eyecare.*

2) 'What you need to know': Healthcare free from discrimination, learnings for health professionals

Mainstream healthcare professionals and education providers have much to learn about how to work with Indigenous peoples.[49] In Australia polices and regulations are beginning to hold healthcare practitioners and education providers accountable to this learning but there is still much ambiguity about how to approach learning and what curriculum content should be.[50] The participants in this study identified points they felt important for healthcare practitioners to know and understand when working with Aboriginal peoples. These reflect the United Nations' work on health professional education with a human rights-based approach, that includes providing information and skills to address and prevent bias and discrimination.[51]

Legacy of Colonisation

The interviews suggest the importance of understanding the ongoing legacy of colonisation, how past policies and power continue to impact Aboriginal peoples. Exclusion practices, especially, assumptions, stereotyping, and oppression are in the fabric and culture of Australian healthcare systems and structures.[52]

Gandangara man Uncle Rex reflects on this through his own experiences and journey:

> *something that I'm working now to find out, about the history and everything of my culture, and especially my history of my family. Aboriginal people don't have a great history in the past, especially medical influences, because they haven't been able to get the access that everyone else has had.*

Alinta recognising the ongoing impact of colonisation and the continued negative impact of introduced food sources:

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[49] Manton and Williams (see note 14).
[50] Manton, Williams and Hayen (see note 15).
[51] *Report on a human rights-based approach to health workforce education*, UN Doc. A/74/174 (2019)
[52] Parter (see note 8).

> *I know the high risk that is involved with my people and culturally, health wise, what we've been through with colonisation and things like sugar, how much it's affected our diet and diabetes.*

Health practitioners play a vital role in recognising the ongoing impact of colonisation on health and healthcare. Aunty Joy, Kuku Yalanji and Kuku Thaypan Elder, shares her story interacting with health professionals:

> *If you don't really know who your parents are. See, that's what happened in my case because I thought somebody else was my father and I didn't know the history of the other side.*

Riley speaks of a similar experience, where there is a constant expectation and pressure to know ancestorial medical details:

> *Yeah. Just not assuming that everyone has just that nuclear family structure. I know, even just going back to mum, because she was adopted, she used to get a lot of questions when she was pregnant with my brothers and I, from the doctors of what's her medical history and everything. She couldn't provide that, at that time.*

The ongoing legacy of colonisation is extremely personal for many people and traumatic. This legacy effects how Aboriginal peoples engage in the health system and often how the health system engages with Aboriginal peoples.

Racism and Distrust

Many Indigenous peoples face racism as a daily reality.[53] Despite racism being illegal in many nations including Australia and a breach of human rights.[54] Aboriginal peoples especially experience frequent racism in health settings, leading to a profound distrust of the system.[55] Nulla, a Gamilaraay woman in her early 30s, spoke of her experience with interpersonal racism, being told that:

> *You don't look Aboriginal. You're white.' And I was like, I am, but I am also Aboriginal.*

Uncle Jim, a respected Wiradjuri Elder spoke of his experience with his daughter, firstly to justify her Aboriginality based on her appearance like Nulla, and then an additional layer whereby he had to challenge stereotyping and assumptions based on her cultural identity without any clinical reasoning. Uncle Jim describes the experience:

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[53] Ibid.
[54] *Racial Discrimination Act 1975* (Cth); Human Rights Watch, *An approach to reparations* (July 19, 2001), https://www.hrw.org/legacy/campaigns/race/reparations.pdf
[55] Parter (see note 8).

> *And all along that way I had to justify her Aboriginality and them saying, well she's not really Aboriginal, she doesn't look Aboriginal. But because her Aboriginality, she had these medical histories, and they weren't listened to. And that's happened to me as well in emergency situations where they stereotype Aboriginal people and they don't relate that to our medical histories.*

Aunty Ivy, a respected Gamillaroi Elder, shared a similar experience where conclusions were drawn without any clinical diagnostics:

> *So that convinced them that I was a drug addict. They did no obs [clinical observation] on me in triage in the casualty.*

As a result of these experiences participants identified their distrust and apprehension to access health services and work with non-Indigenous health professionals.

Tidam, an Aboriginal man from the east coast of Australia in his mid-30s, spoke of wanting to know specific information about the healthcare professional:

> *I'd want to know about their history and how long they've been in the profession, success rate and things like that.*

Jarrah, Aboriginal and Māori man in his mid-20s spoke of the legacy of the past and how it continues to influence attitudes and approaches to healthcare, manifesting fear:

> *I think a lot of us are scared to go to the doctor's, I think that's been passed down. You only sort of go to the doctor's if you're going to die if something bad used to happen.*

A health system that is responsive to the healthcare of all Australians should not rely on the ability of the parent to navigate the system to have a positive outcome for their child. Aunty Ivy recalled:

> *that could have been a very different pathway for her if her parents didn't have the skills to be able to navigate through that system.*

Cultural load

Cultural load refers to the extra responsibility placed on Indigenous individuals in both personal and professional settings, with the expectation to educate, provide insight, and offer support on topics perceived as 'Indigenous'.[56] In Australia, it is against the law to discriminate against someone based on

[56] M. Gooda, *Social Justice and Aboriginal and Torres Strait Islander peoples access to services*, address to QCOSS Regional Conference: Building a Better Future – themed around improving service delivery for regional and remote communities (2011).

race or culture, and operating in ways that results in culture incurring any differential practices is discriminatory.[57]

Nulla, a Gamilaraay woman in her early 30s, described an example where she was required to explain a federal pharmaceutical benefits scheme (related to Closing the Gap (CTG)) to a pharmacist. This knowledge should be foundational among pharmacists in Australia. Nulla describes the encounter:

> *'Oh, what's CTG?' then you are the one who has got to educate them.*

Nulla continues:

> *I've never hated being Aboriginal, but I hate having to educate and inform people.*

Stereotypes and assumptions

Stereotyping and assumptions relate to power, race and positionality.

Monti, a Noongar man in his mid-40s, warned:

> *[J]ust because someone's from that community, you don't want to label them as everyone's got the same problem, as well.*

Nulla reflected in her experiences where health professionals assumed based on stereotyping rather than clinical reasoning and diagnostic testing:

> *Are you Indigenous? Do you have diabetes?*

Aunty Tahnee respected Wonnarua Elder speaks of a similar experience where the assumption without clinical reasoning or diagnostic testing:

> *But because I've got that tick of being Aboriginal, they assumed I'd come in there to get drugs off them.*

Interview participants noted that some healthcare professionals believe that all Aboriginal patients should primarily be attended to by Indigenous staff members, such as the Aboriginal Liaison Officer. However, often these staff members cannot see patients without the clinical input of a healthcare professional.

The reality of this was described by Nulla and her experience:

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[57] Diversity Council of Australia, *First Nations facing increased discrimination and cultural load* (July 20, 2023), https://www.dca.org.au/news/media-releases/first-nations-facing-increased-discrimination#:~:text=Findings%20summary%3A,and%2For%20harassment%20at%20work

And it's like, oh, okay. There, if they're Aboriginal or Torres Strait Islander, they will just like, oh, Aboriginal liaison Officer. But that Aboriginal liaison Officer doesn't necessarily have any healthcare experience, so it's not like they're putting a nurse in there or a psychologist or a speech [pathologist]. That's just what I see.

Uncle Jim identified the potent influence of bias and assumptions about Indigeneity, and the importance of critical self-reflection to challenge these:

And of course, they come with preconceived notions of what an Aboriginal person is, have sort of stereotypical ideas and they never question those ideas, so they don't question themselves, they're always right. So they need to understand that they cannot always be right, they can be wrong sometimes.

Ed emphasised the significance of critical self-reflection, urging health practitioners to engage in community-centred work, understand the issues affecting all community members, recognising their strengths, to challenge preconceived assumptions.

Ed, a Noongar man in his 40s, has provided very clear advice:

I think knowing that community and knowing the problems in the community. I think also people in general, especially non-Aboriginal people, they paint a picture of Aboriginal people are very sick people. And I know a lot of Aboriginal people are very, very much switched on into their health and looking after themselves quite well. I think just knowing the problems in the community maybe and trying to change that, it can help, but if you going for work research, I think it's a good idea, to know what those problems are, as well.

Assumptions can lead to fatal outcomes in the immediate future and long term; this fear was reflected in many participants' comments above, and further below.

3) 'What you need to show us': Quality health services, human rights in practice

The interview participants described many foundational skills and concepts that all healthcare practitioners should demonstrate when working with Indigenous peoples. Cultural safety is now legislated for in Australia, as discussed further below.

Cultural safety

The participants were able to remember health practitioners who had demonstrated culturally safe practice.

Sarah, a Worimi and Kuku Yalanji woman in her late 30s, appreciated the opportunity to self-determine and direct her own healthcare:

> *She respected what I wanted to do, I asked for it. She followed through with what I wanted to do.*

Kahi shared an experience of working with a family where a child required healthcare treatment, highlighting the practitioner's skill in fostering a culturally safe environment by involving his family:

> *I was just so, I guess, relieved and elated at the same time that she was able to consider the implications of this young kid's issues within the family setting and the role that each and everyone in that family had to play to support this young person's motor skills and their movement so they could eat, so they could communicate. It was a really great experience.*

Jiemba, an Aboriginal, Irish and Scottish man in his mid-40s, identified how the people and the culture at the service he attended created a safe space where he was comfortable to stay longer. As a result, they were able to do thorough diagnostics and diagnosis:

> *[T]hey found a lot of things that were underlying with me. And they were very good with our people and culture and that there. They've got a good understanding. They were actually pretty good there*.

The participants' comments generally demonstrated that cultural safety principles do occur in practice and can be replicated.

Security of person and relationships

When Indigenous peoples require healthcare, they often find themselves in vulnerable positions, for several reasons outlined above as well as navigating uneven power dynamics that can compromise the rights to physical and mental integrity, as well as security of person.[58] Establishing relationships is crucial in addressing these power dynamics and fostering feelings of safety, which are core components

[58] UNDRIP (see note 2).

of cultural safety. This involves practitioners prioritising communication, respect, and the creation of safe relationships that value each client as a person.[59]

This was explained through Kahi's words:

> *[R]elationships are key. It's not always about the service that you can provide to make someone feel better through their medical concerns. It's really about grounding yourself in understanding their walk of life, understanding where they've come from to get to where they are when you first meet them. And sustaining those relationships with either them, themselves, their family, or even their community that matters.*

Aunty Lily-Jo added to this concept through aspirations for her own healthcare:

> *I would like to ensure that I have an accessible, trusting, respectful relationship, especially with our non-Aboriginal staff health staff.*

Uncle Jim provides insight and direction about how to begin forming relationships:

> *[F]orming that relationship, the same as what we do, who we are, where we're from, which breaks down a lot of barriers. I think, those first initial barriers…*

Aunty Ivy provided an example from her own experience when a health practitioner understood the importance of relationships:

> *And he was excellent and very much wanting to know more about Aboriginal culture and he actually had a lot of Aboriginal clients and they were being referred to him from the Aboriginal medical service. So it was very good relationship.*

Developing relationships does take time, however they are an investment in the ongoing care of the patient.

Communication

Communication in healthcare is a fundamental quality standard in patient and workforce safety[60] and is a fundamental human right, to be able to seek, receive and impart information.[61] Uncle Rex identified the importance of communication to establish relationships and trust:

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[59] L. Tynan, 'What is relationality? Indigenous knowledges, practices and responsibilities with kin', *Cultural Geographies* 28/4 (2021).
[60] Australian Commission on Safety and Quality in Healthcare, *Communicating for safety standard* (11 August, 2023), https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard
[61] S. McLeod, 'Communication rights: Fundamental human rights for all', *International Journal of Speech-Language Pathology* 20/1 (2018).

I believe that if you communicate well and show that we've got an open mind when it comes down to meeting different people even the first time. I think it's important.

Yindi, a Wiradjuri woman in her early 30s, discussed how the language used by health practitioners can create distance between them and the patient. While acknowledging the importance of understanding clinical language, Yindi emphasised the need for practitioners to scaffold this process and recognise that each person's story is unique:

I think language is a really big thing. The first thing that I can think of is, I don't know, the more clinical you are, the more detached I feel from a health worker. If you can speak to me like a human and try to have that connection, I think is really important. So language and the way that you're speaking to Aboriginal peoples

Monti provided an example of when he felt the practitioner implemented communication skills to work with him, and together they were able to challenge him to achieve a better outcome:

They were great in the way that they worked with me, understood my limitations physically and then even pushed the boundary to where mentally I was like, 'Oh, I can't do this, I can't do this.' But they knew better than I did in terms of my physical. So they really supported me physically and mentally through that.

Ed pointed out that communication is more than what is said; it includes the importance of listening:

But I think it's important, to know that you're there even just to listen to what they are saying

Sarah developed this point further, recognising that communication includes a non-verbal dimension:

I think it's their body language, their tone in their voice. You could be like talking nicely, at the same you can feel they're not really interested. Acknowledging in just a handshake or whatever, all those things. Don't rush it.

Steven, a Noongar, Worimi and Kuku Yalanji man in his early 20s, identified the broader implications of communication:

Because I believe everyone should have the chance to be part of community and communication is an important part of developing relationships and belonging in community.

Steven's broader reflections also explain his perspective of communication being foundational to relationships in communities, and that because services are in communities, the healthcare providers' willingness and ability to develop relationships in the community is part of feeling safe to access and comply with healthcare.

Personal skills

Personal skills such as communication style are often subjective, hard to articulate and difficult to teach and assess.[62] Personal skills, however, fundamentally relate to interpersonal practice that has a positive impact on patients, often leading to a positive experience, improved adherence and patient outcomes.[63] The personal skills of a health professional supports all peoples right to access the highest attainable standard of care.

Monti, who lives in regional NSW, spoke fondly of the personal skills of a local pharmacist:

> *He always remembers my name. We have a yarn. He doesn't – probably seen me kids once or twice, but, how's the wife and kids? What grade are they in school now? Talks about [Town] – what's the weather like in [town]? Because he knows I live here now, and yeah.*

The ongoing impact of colonisation, oppression and racism has honed these skills as a protective armour. Uncle Warrin, a Worimi man, issued a warning for current and future healthcare practitioners working with Aboriginal people:

> *I think Kooris are very good at reading people. And if there's bullshit in the health professional, the Kooris would react with a wall. Or just be nice, but wary.*

Annabelle, a Worimi, Kuku Yalanji woman in her mid-30s, builds on this, explaining:

> *Learn a person's story, not just treat a symptom. Find out more about the person as much as you can in the small timeframe you have. Listen, don't just go and judge. Understand cultural and historical traumas as well as the strength that that culture has, because the white way isn't always the right way. There is always a different side and a different lens and a different view that you could explore. But that takes time, practice, and patience on your behalf to do that. And you're going to want to have to learn it.*

Riley spoke about the difference between community experiences and expectations compared to practitioners' experiences and expectations. He reflected that it is important for health practitioners to know that difference is not wrong.[64] Riley confirms the importance of respect as a demonstration of authenticity, and for practitioners to understand the complexities of the local context and be respectful. Riley said:

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[62] Ibid.
[63] V. Rosequist, *Mind your manners: An investigation on patient perception of bedside manner and its effect on their visit,* Masters capstone project (The University of Tampa, 2023).
[64] M. Wright et al., 'Understanding and working with different worldviews to co-design cultural security in clinical mental health settings to engage with Aboriginal and Torres Strait Islander clients', *Primary Health Care Research & Development* 22 (2021).

Not to judge people, they look to understand the area you live in and to also show that you are respectful to them.

When considering what is important for health practitioners to know when working with Aboriginal peoples Jarli (Aboriginal ancestry unknown, late 30s*)* clearly named salient points:

[I]t's just having respect. Respect and education.

DISCUSSION

This research among 24 Aboriginal people explored their healthcare experiences, with positive and negative examples provided by mainstream and Indigenous-led services. Participants provided recommendations for university healthcare curriculum development, in keeping with the Bunya Project's purpose to positively influence staff, support them to transform and evaluate their curricula, and in training health students to be more culturally appropriate and respect the rights of Indigenous people. The healthcare curriculum is only a starting point, and as participants explained, practitioners also benefit from learning within and from Aboriginal communities during and after graduation. Participants emphasised the importance for educators to equip future health professionals with practical skills and knowledge to promote human rights, emphasising active listening, respect, trust-based relationships, and empowering Indigenous people to self-determine solutions to complex health issues.[65] The participants asked for the social context, particularly of the local Aboriginal communities, to be known and understood because it influences health and wellbeing and rights; Aboriginal community life is a cultural determinant of health.[66]

Participants in the Bunya Project consistently emphasised the importance of human rights and Indigenous rights in healthcare practices and curriculum development. However, there is a notable lack of professional development opportunities for academic staff, many of whom lack experience in engaging with Indigenous communities.

Subjugation embedded in the healthcare system perpetuates systemic racism, necessitating critical reflection to shift the narrative from blaming Indigenous peoples to recognising systemic issues. By equipping students with skills to become culturally capable clinicians, the burden on Indigenous peoples as educators can be reduced. Partnering with Aboriginal Community Controlled Health Organisations offers universities opportunities to improve health curriculum and practices collaboratively and

[65] Australian Commission on Safety and Quality in Healthcare (see note 66)
[66] Lowitja Institute, *Culture is key: Towards cultural determinants-driven health policy* (2020).

respectfully.[67] Partnering with ACCHOs offers universities opportunities to improve health curriculum and practices collaboratively and respectfully, improve health curriculum, and on their own terms.[68]

CONCLUSION

The health sector has the largest Indigenous workforce in Australia, largely because this is a priority area where people feel they can make the most impact, to the benefit of their communities.[69] Curriculum that involves Indigenous healthcare providers and users can feasibly be developed if universities do so in partnership with Indigenous community-controlled organisations. Through partnerships, universities can also feasibly and valuably contribute to Indigenous communities and engage more deeply with local cultures, and self-determined events and solutions to complex health. Including Indigenous knowledges and community members in the teaching of healthcare practice creates potential for intergenerational change – not only among Indigenous people but among healthcare providers and educators, and to support human rights to be realised.

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[67] S. Page, M. Trudgett and G. Bodkin-Andrews, 'Creating a degree-focused pedagogical framework to guide Indigenous graduate attribute curriculum development', *Higher Education* 78 (2019); J. Cranney et al., 'Graduate attributes of the 4-year Australian undergraduate psychology program', *Australian Psychologist* 44/4 (2009); O. Humberto, L. Konjarski and S. Howe, 'Does university prepare students for employment? Alignment between graduate attributes, accreditation requirements and industry employability criteria', *Journal of Teaching and Learning for Graduate Employability* 10/1 (2019).

[68] L. Matson et al., 'Transforming research and relationships through collaborative tribal-university partnerships on Manoomin (wild rice)', *Environmental Science & Policy* 115 (2021); H.J. Mackey et al., 'Partnership through story: Promising practices for meaningful research', *Tribal College Journal of American Indian Higher Education* 33/2 (2021); V. Hiratsuka et al., '"You actually view us as the experts in our own system": Indigenous–academic community partnership', *Progress in Community Health Partnerships: Research, Education, and Action* 14/2 (2020).

[69] Bailey (see note 23).

6.3 Chapter conclusion

The chapter has addressed the intersection of human rights principles and cultural safety in healthcare, highlighting persistent challenges such as structural racism and distrust in healthcare settings faced by Indigenous peoples in Australia. Despite legislative mandates for culturally safe practice, strategies to teach cultural safety in healthcare education remain limited, with key capabilities often inadequately addressed in university curricula, hindering efforts to provide culturally safe care.

Advocacy and empowerment within healthcare are crucial for achieving stronger community health outcomes, while amplifying Indigenous voices and experiences in curricula and academic publications is essential for recognising historical and ongoing injustices, as mentioned in Chapter 4, and for improving access to culturally safe healthcare.

Through participant narratives, this chapter has highlighted the importance of demonstrating culturally safe practice and inclusivity of Indigenous knowledges, experiences and perspectives, informing the development of frameworks like the Bunya andragogy framework presented in the next chapter, with the ultimate aspiration that healthcare practices in Australia will align with basic human rights principles and meet the needs of Indigenous peoples, as defined and directed by Indigenous peoples.

Chapter 7: Findings Part 2 - Bunya Andragogy Framework

This chapter includes a paper that has been submitted as:

> Manton, D., Williams, M., & Hayen, A. (submitted 10/04/24, under review). The Bunya Project andragogy framework for healthcare education. *Australian Journal of Clinical Education.*

Preface

The cone of a Bunya pine, with its distinctive structure and potential danger, symbolises the resilience and influence of Aboriginal leaders and scholars working together within tertiary education systems. Just as the seeds within the nut draw nourishment from the soil and flow through the tree's veins, Indigenous community-controlled healthcare organisations offer guidance for tertiary education to embrace holistic, culturally safe healthcare practices. However, their expertise is often disregarded in health professional education.

Similarly, fear surrounds the Bunya nut due to its weight, posing significant risks to people and property as when it is ready it falls from the tree, falling up to 50 metres with a weight of up to 10 kg. While some local councils take measures to mitigate these risks, such as erecting warning signs or cordoning off hazardous areas during cone season, others resort to removing the cones or cutting down the trees entirely. This parallels the dynamics in tertiary education; where some academics and educators collaborate with Indigenous organisations and communities, others impose measures to maintain power and control or exclude Indigenous voices, leadership and perspectives altogether.

The Bunya Project showcases the potential for the seeds of Indigenous leadership to nourish all students and staff, fostering learning that is holistic, culturally respectful and anti-racist. By learning from Indigenous ways of working, healthcare practices can evolve into more comprehensive and inclusive approaches, that will ensure students become proficient healthcare professionals to benefit all peoples that access their care.

7.1 Chapter overview

A range of recent data highlight the need to both prevent and address racism in the Australian healthcare system, and to bring about cultural safety and accountability among health professionals and educational institutions. This chapter presents the Aboriginal-led Bunya Project andragogy framework, which offers a guide for tertiary and health professional education informed by theories of perspective transformation and derived from participatory action research outlined in the previous chapter. Grounded theory principles were applied in the research analysis process.

The andragogy was informed by the process outlined in Chapter 5, including the critical reflections and experiences of the research team (Crane, 2010). The andragogy was also heavily influenced and directed

by the data collected in the previous chapter (Chapter 6), highlighting what the Aboriginal participants want to see in healthcare education, related to Aboriginal peoples, experiences, histories and capabilities.

The key aims of this chapter are to:

1. Explain why and how to centre Indigenous epistemologies, resulting in thematic domains and teaching principles aligned with Indigenous ways of knowing, being and doing.
2. Present a culturally informed andragogy demonstrating interconnectedness grounded in cultural responsiveness, while also aligning with human rights policies and principles, and government standards and legislation.
3. Explain the framework and its five interrelated domains: Self, Sovereignty, Family, Environment, and Systems and structures.
4. Provide examples for flexible adaptation to specific local contexts.
5. Describe how the framework supports professional capability development.

While the Bunya framework informs tertiary Indigenous health education and professional development, the challenge remains about how to evaluate the impact of such learning over the long term. The Bunya Project also provides some insights, and highlights what is required of teaching academics and future healthcare workers in anti-racism and to improve healthcare provision for all, transcending its initial university-focused design to broader applications.

7.2 Informing Healthcare Education: The Bunya andragogy Framework

The BUNYA PROJECT ANDRAGOGY FRAMEWORK FOR HEALTHCARE EDUCATION*

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Competing interests: None declared.

*(manuscript is currently under review, November 2024)

ABSTRACT

There is an urgent need to address racism within Australia's healthcare system, including by improving cultural safety and accountability among healthcare professionals and education institutions. The Bunya Project framework proposes a solution that integrates andragogy and perspective transformation theories to guide educators in cultivating culturally safe health professionals and is informed by grounded theory and participatory action research that centres Indigenous epistemologies. The framework emphasises the interconnectedness of cultural safety, with five interrelated domains: Self, Sovereignty, Family, Environment, and Systems and Structures. These domains are adaptable to local contexts to nurture culturally safe teaching and learning environments, supporting professional capability development, including cultural reflexivity. While primarily tailored for Indigenous health education in tertiary settings, the framework extends to broader professional development. However, as discussed, challenges persist in assessing long-term impacts and transformative potential of education on professional practice. The Bunya Project framework's aim, ultimately, is to enhance healthcare provision transcending its initial university-centric focus.

INTRODUCTION

Indigenous peoples globally have expertise in holistic healthcare practices and education (Rogers et al., 2020) spanning hundreds of thousands of years. This paper demonstrates how healthcare education can be enhanced by drawing on a small number of key concepts as foundations and frameworks for action. Frameworks are essential to organise concepts into a meaningful structure, to help grapple with complexity and to facilitate communication involving multiple groups and stakeholders (Craven et al., 2016; Minnican & O'Toole, 2020). Frameworks are often used to guide Indigenous curriculum development (Department of Health, 2021a), health workforce training (Corporal et al., 2020; Williams et al., 2020) and also health professionals' critical self-reflection and lifelong learning journeys (Gibbs, 1988), and each contributes to promoting culturally safe practice (Ahpra, 2020). Frameworks also support monitoring and accountability, essential given Indigenous peoples globally experience systemic discrimination and disadvantage negatively impacting their health (Abubakar et al., 2022). Changing this is the responsibility of the entire health workforce (Parter et al., 2021), and education is a logical and pragmatic place to begin to influence systemic, institutional and cultural change.

This paper presents a framework to guide healthcare educators in the engagement of planning and delivery of coursework materials about, by and with Aboriginal and Torres Strait Islander peoples. Its development has occurred in the context of the Bunya Project, which explores healthcare needs, experiences, knowledges and aspirations that Aboriginal and Torres Strait Islander peoples have for their own healthcare that they believe are relevant to healthcare education (Manton & Williams, 2021; Manton et al., 2023, 2024). The Bunya framework provides an essential starting point for curriculum development, outlining key foundations to complement and support locally relevant teaching and learning, including engaging people with firsthand experiences, as well as teaching and learning principles already used by Indigenous educators, plus benchmarks of success recognised by Elders, leaders and Aboriginal community-controlled health workforces.

This is especially important given that design of new health and wellbeing programs, and the success of existing ones, requires well-coordinated and culturally responsive processes and practices (IAHA, 2019; McMillan, 2022). Health educators and health professionals alike must understand the ripple effect of their actions at a systemic level and locally, by appreciating local context and demographics, the resources and aspirations of local Elders and leaders, and locally relevant evidence for success (Manton et al., 2023). Achieving this is ideally informed through relationships with local community experts and following rights and cultural protocols including self-determination (Manton et al., 2023). Key values of this work include holistic approaches that seek to both educate and empower (Cajete, 1994, p. 208), as critical consciousness is developed through reflection on lived experience (Four Arrows, 2013). While this paper is specific to health and the health context in so-called Australia,

Indigenous peoples globally will see similarities and elements that resonate with them (Manton et al., 2023).

BACKGROUND

After decades of tireless advocacy by Indigenous community leaders, academics, professional associations and allies, addressing racism has now been named as being central to reforming the Australian health care system (Ahpra, 2020; Department of Health, 2021a; Pacey et al., 2017; Williams et al., 2020). More than mere aspiration, these reforms include amendments to the national legislation governing health professional registration (Parliament of Queensland, 2022), whereby health professionals and education institutions must now meet new levels of accountability in areas where they have been implicated in creating, reinforcing and perpetuating racism within the Australian healthcare system and its structures. This commitment involves ensuring that cultural safety is prioritised in healthcare provision, emphasising not only the nature of care but also how it is delivered. Practitioners are tasked with delivering care that is safe, accessible and responsive, devoid of any traces of racism (Williams & Marlin, 2022). As authors, and from our multiple perspectives as educators, service providers and community members, we have seen over the last three decades increasing workforce measures to 'prepare' staff for working with Indigenous peoples, including through tertiary education, and the importance of respecting the holistic Aboriginal definition of health, and social determinants of health. Further, there is increasing recognition that a holistic understanding of health and its determinants has implications for improving health care and healthcare education, and this has potential benefits for all peoples (Jackson Pulver et al., 2019).

This paper reports on efforts within a university health faculty to transform health professional education, based on the Bunya Project's action research with Indigenous community organisations (for full information see Manton & Williams, 2021; Manton et al., 2023, 2024). In Part I, we outline the challenge facing university educators to better prepare health professionals to work safely with Indigenous peoples. In Part II, we appraise the wider policy context surrounding the delivery of Indigenous healthcare learning and teaching. In Part III, we discuss methodology and methods informing our Indigenous healthcare learning and teaching and framework development. Part IV presents the evidence-informed andragogy and framework for action reporting doctoral research by Author A.

Achieving a healthcare system free of racism

Racism

Racism is recognised globally as a social determinant of health (Johnson, 2020), occurring within an eco-system of oppressive structures that thrive on the actions and inactions of the individuals that

comprise the system (Paradies, 2018; Phillips & Schrempf-Stirling, 2022). Racism is recognised as endemic in Australia (Dudgeon & Walker, 2022). A recent failed referendum for constitutional change in Australia to ensure Aboriginal and Torres Strait Islander people have a voice in federal parliament highlighted the racism entrenched in Australian society (Anderson et al., 2023; Foley, 2023; McKenna, 2022).

Aboriginal and Torres Strait Islander peoples report experiencing interpersonal racism at an increasing rate (Reconciliation Australia, 2020) which directly impacts how and when they choose to access healthcare (Gatwiri et al., 2021; Parter et al., 2021). The most recent report by the *Call It Out* register of racism against Aboriginal and Torres Strait Islander people found that health service employees 'were more frequently identified as perpetrators' and 'stood out as a group' compared to others such as police, education and non-government organisations (Allison et al., 2023, p. 51). Fear of experiencing racism (Avery, 2018) often leads to the delaying of much-needed medical attention for Indigenous Australians, which exacerbates conditions that may have been minor if treated immediately, and increases complexity when treatment is delayed for multiple co-morbidities.

Reducing experiences of racism could influence healthcare outcomes for Aboriginal and Torres Strait Islander peoples (Durey & Thompson, 2012), but health professionals often ask 'Where do we start?' (Norman, 2014; Trueland, 2004). Within universities, the impact of this lack of knowledge is reinforced by the small number and relative invisibility of Indigenous peoples in mainstream education (Behrendt et al., 2012), and by simplistic and often negative portrayals and false narratives about Indigenous peoples and their health in curriculum (Manton & Williams, 2021), society (Fogarty et al., 2018) and the media (Anderson et al., 2023; Stoneham et al., 2014).

Racism also persists in the way health professionals are educated (Ahuriri-Driscoll et al., 2021) and requires leadership and resources to implement anti-racism strategies across higher education, as envisioned by the Indigenous leadership behind the Ahpra cultural safety strategy (Ahpra, 2020). This requires a systematic approach that targets racism in all its forms. Without addressing racism in teaching, learning and assessment, universities will remain complicit in perpetuating systemic racism (Manton et al., 2023). Universities are well placed to influence change by graduating students with a strong introduction to Indigenous Australia grounded in self-determination (Fitzpatrick, 2023). The impact of racism can be lessened by universities embedding Indigenous leadership, voices and perspectives within all layers of their educative offering (Fredericks et al., 2023). This will go some way to ensuring that the conceptualisations of health and health care students learn about include alternative systems of knowledge and worldviews (Manton et al., 2023, 2024). It means an ongoing commitment to systemic reform and universities paying more than lip service to self-determination through embracing Indigenous-led solutions and ensuring Indigenous people's participation in decisions that affect them and their communities.

Cultural Safety

To improve healthcare quality and access and reduce racism, cultural safety is now a central focus of the Australian healthcare system (AHMAC, 2016; Department of Health, 2021b). A key driver is new cultural safety objectives in the national law pertaining to registered health professions (NSW Legislation, 2022), with the aim being to improve health service accessibility by ensuring health professionals have the skills, knowledge and attitudes to contribute to conditions for cultural safety (Ahpra joint statement). Despite confusion around what cultural safety means and what it looks like in practice (Lock et al., 2021; Manton & Williams, 2021), Australia's national health professional regulation body states:

> Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families, and communities. Culturally safe practise [sic] is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism. (Ahpra, 2020, p. 9)

Importantly, cultural safety can only be determined by the individual receiving care or education – not by the person providing the care or education (Ahpra, 2020), and as such reflects Indigenous peoples' right to self-determination (UN General Assembly, 2007). From the university's point of view, it means that health professionals and educators must graduate with the knowledge and skills to examine themselves and the potential impacts of their own cultures – personal and professional – on their interactions with Indigenous peoples (Fredericks et al., 2023).

To empower them in these respects, graduates require the lifelong learning skills, knowledge, and awareness to identify their own unchecked biases and assumptions and those of their disciplines (Jackson Pulver et al., 2019). Key to this is supporting students, academics, health professionals and their support teams to build skills in critical self-reflection. Continuously engaging in critical self-reflection is a lifelong journey of self-examination, skill development and the constant refinement of the ability to critically reflect on real-life situations (Jackson Pulver et al., 2019). Even as cultural humility becomes ingrained over time, it entails a cyclical process of self-exploration and critique intertwined with a readiness to gain insights and understanding from others, based on each person's life contexts.

This calls for learning opportunities that support both students and academics to articulate their positionality and apply their new skills in working well with Aboriginal and Torres Strait Islander community members. Cultural humility involves lifelong learning that includes students entering professional healthcare relationships to continuously grow and improve (Bishop, 2023). It also requires ongoing learning as qualified professionals, through opportunities such as professional development, (re)accreditation and quality assurance processes.

Also flowing from the national law, as it is embedded in each state or territory, is the provision for a complaints process; if a complaint is upheld, a professional's registration can be suspended or revoked. The first such registration suspension has already occurred, due to culturally unsafe communication by a medical professional (Ahpra, 2023).

Accordingly, the legislation has mobilised tertiary external accreditation bodies for Ahpra-registered professions to improve and assure their standards and verify education facilities are preparing graduates to be culturally safe practitioners (Clubb, 2022). In addition, educators must show evidence of how students achieve this. With the current, limited implementation of University Australia's university- and sector-wide strategies for Indigenous perspectives to be embedded in the curriculum (Anderson et al., 2023; Hammer et al., 2021), the pressure is on individual university staff, who will generally have had little formal training in Indigenous health or cultural safety (Manton & Williams, 2021). That is, each educator must do the work to increase their personal knowledge and skills, so that they can sustainably contribute to teaching and learning design as well as delivery of culturally safe learning and teaching experiences for their students.

We recognised there are few strategies to support staff to teach content about other cultures or Indigenous peoples, nor of crucial but complex issues such as the ongoing impacts of colonisation, or even the acknowledgement and celebration of Indigenous leadership, expertise and approaches. Nor is there recognition of the enormous influence on the student of the educator themself, and their responsibility to identify and be transparent about their own positionality, involving ongoing critical self-reflection on often privileged standpoints (Manton & Williams, 2021).

Concepts and theories informing Indigenous health learning and teaching

This section of the paper introduces three concepts that have informed our practice in Indigenous health learning and teaching, that has in turn informed the andragogical framework presented later. Firstly, andragogy is the practice of teaching adult learners (Knowles, 1977). Secondly, perspective transformation involves processes such as disorientation, critical reflection, dialogue, and a commitment to act (Mezirow, 2007). Thirdly, the core concept of the cultural interface, whereby two opposing knowledge systems meet, as articulated by Torres Strait Islander academic Professor Martin Nakata (2007).

Andragogy

Pedagogy and andragogy refer to the action of teaching – not only the content, but how the messages are conveyed to the students. Pedagogy is focused on young learners, specifically school-aged learning, where the child is dependent on the teacher to be engaged and motivated to learn (Clipa, 2014) and has less conscious lived experience, initiative or resources to enhance their learning.

Andragogy, on the other hand, encapsulates the adult learning experience. It focuses on the intrinsic qualities of adults undertaking new learning (Hamlin, 2022). Malcolm Knowles (1978, 1980) was among the first to model andragogy, which, according to Hamlin, includes six characteristics (2022, p. 211): 1) a need-to-know, 2) self-concept, 3) personal experience, 4) readiness to learn, 5) a unique orientation to learning, and 6) an intrinsic motivation to learn. Adult learners are seen as being self-motivated, and as drawing from a diversity of lived experiences, including previous education, for their learning (Knowles, 1978; Machynska & Boiko, 2020). An adult's choice to undertake formal learning is also a deliberate decision, and the student is personally, physically, and often, financially invested in study. The outcome of the study is a key focus – which may include a qualification – but students will also have a general interest in the learning journey (Leberman & McDonald, 2016).

Creating a learning environment characterised by respect, mutuality and care is emphasised (Knowles, 1977), as is encouraging engagement in the learning process, and allowing, and supporting students to be in control of their learning. This includes ensuring the learning design has enough flexibility, so that students can be involved in the implementation and application of learning processes and materials (Evans et al., 2020; Houde, 2006; Knowles, 1980).

Knowles also contends that students are more focused on the various ways their learning can be applied (Hamlin, 2022), including in their workplace (Fitzpatrick, 2023). The ability to recognise the relevance of learning content to life context and to see the purpose of the learning within their professional contexts are key motivations to engage in learning (Leberman & McDonald, 2016). In this same vein, adult learners are held accountable for their learning, and expected to manage their workload autonomously and to complete and submit their tasks (Hartree, 1984).

Adult learners have high expectations of their learning experience, and of educators to facilitate high-quality learning and teaching, and provide resources and learning materials that are accessible on demand (Kara et al., 2019). In providing the framework to guide the process and practice of teaching adults, andragogy accommodates the learning needs of both the student of Indigenous health, and the educator (including ourselves), who are each on a lifelong learning journey to develop cultural humility (Fisher-Borne et al., 2015), including through honing new ways of thinking, challenging preconceptions and nurturing critical reflexivity and growth.

Perspective transformation

According to Mezirow, 'conscience, awareness, control of one's thoughts and the transformation of meaning structures are central to the adult learning process and adult education' (Mezirow, 2007, p. 22). Expanding adult learners' frames of reference to unlock their unexamined assumptions and biases, involves a well-tested series of processes known as perspective transformation (Mezirow, 2007). For curriculum designers, this involves scaffolding skill development in critical reflection, and creating the

time and the safe space for respectful dialogue, exploration and sense-making (Hamlin, 2022). When such preconditions arise, students can experience positively directed psychosocial change, through affirming core values, re-evaluating expectations, feeling clear and calm, and becoming aware of their capacity to make change (Fitzpatrick, 2023).

The cultural interface

According to Torres Strait Islander scholar Martin Nakata, the cultural interface is the intersection of Indigenous knowledges, ways of knowing, being and doing and Western worldviews, science and epistemologies. It can also be used to describe the meeting point and collaborative space between the Indigenous community, academics and students (Nakata, 2007). The cultural interface is important to curriculum design as Indigenous health education involves the coming together of at least two world views to develop new knowledges and ways to approach learning and teaching that has the potential to benefit all peoples.

In designing and delivering a curriculum where the intention is to build the capabilities of the non-Indigenous workforce to work effectively with Indigenous peoples and communities as colleagues and as practitioners, a cultural interface is nurtured through the respectful relationships developed when a teaching team actively participates in community and engages in two-way learning (Coff & Lampert, 2019; Purdie et al., 2012), recognising that it takes place at all stages of curriculum development and renewal. According to Prout et al. (2014, p. 158) it is at such 'interactive interfaces' that deep, transformative learning occurs.

Further, an approach that accommodates the cultural interface facilitates leadership by all communities involved. This in turn has the potential to directly inform the university's curriculum in terms of broader skills, knowledge, and expertise needed, while at the same time, increasing community awareness of the skills, knowledge, expertise, and resources within universities, which may be of benefit to the community.

METHODOLOGY AND METHODS

In this section of the paper, we present the methodology and methods for developing the Bunya andragogy framework which is depicted in Figure 7.1 below. The imagery for the framework is inspired by the highly-valued 'nuts' of the Bunya tree (*Araucaria bidwillii*), sacred to Author A, the elements of which identify key concepts for learning and teaching about Indigenous health, including their explanations, and is designed to be a resource that provides a shared language for learning design across the institution.

We describe the grounded theory and participatory action research (Datta, 2023) study design and methodology used to develop the Bunya framework. These supported the centring and privileging of Indigenous ways of knowing (epistemologies) being (ontology) and doing (axiology) (Gilbert, 2021;

Manton et al., 2023; Williams et al., 2023), including researcher positionality in analysing the data, the importance of which cannot be overstated, particularly within the context of diverse team composition.

Positionality

Positionality acknowledges the intersecting identities, experiences and perspectives each team member brings to the table. The Bunya andragogy was led by two Aboriginal women from Wiradjuri and Barunggam backgrounds respectively, who were grounded and guided by community and culture through this process and thinking, along with two non-Indigenous senior academics. Positionality grounds data analysis in a nuanced understanding of power dynamics, privilege and cultural safety, ultimately contributing to more meaningful and respectful engagement with Indigenous communities. Drawing upon our teaching experiences and our multifaceted roles as educators, service providers and community members over three decades, it has become clear to us that university educators need to be equipped to effectively engage with Indigenous communities, to respect Aboriginal peoples' holistic concept of health and to acknowledge the importance of a social determinants of health approach. Moreover, there is a growing acknowledgment that such inclusive approaches hold potential benefits for all individuals involved.

Data collection

Development of the andragogical framework occurred within the mixed-methods Aboriginal-led Bunya Project (Manton & Williams, 2021; Manton et al., 2023). This gathered 24 face-to-face and online interviews to understand what local Indigenous community members recommended for health professional education, and identified three themes: 1) leadership of Indigenous-controlled health organisations, 'what we show you'; 2) curriculum content, 'what health practitioners need to know'; and 3) human rights practices for healthcare, 'what you need to show us' (Manton et al., 2024)

After producing the thematic analysis of the 24 interviews, themes were then interpreted by the current authors for what they mean for curriculum. An emergent framework developed through a collaborative reflective process, guided by ethical research principles (Sherwood & Anthony, 2020) and cultural protocols (Manton et al., 2023), while also meeting the needs and expectations of the students and institution (Enn, 2012).

We also discussed our experience of four iterations of teaching an introductory undergraduate Indigenous health and wellbeing subject, which was developed in the context of university and national guidelines (Bodkin-Andrews et al., 2023; Hammer et al., 2021; Universities Australia, 2023). The four iterations of subject delivery also provided formal and informal student feedback as data about how students perceived the content, what facilitated their learning and what would potentially benefit their future professional practice when working with the community. Separately, for the Bunya Project

qualitative research also occurred, with emergent results also informing the development and design of the Bunya andragogy framework for implementation. Further, we drew from the experience of refining our Indigenous health curriculum in response to student feedback, feedback from other faculty subjects, and from courses implementing Indigenous perspectives. This involved collaborative discussion as a team, particularly for adherence to external policies and guidelines, and meanings for the Bunya andragogy.

Ethical approval

The Bunya Project, within which the Bunya andragogy framework was developed, was designed following National Health Medical Research Council (2018) and Aboriginal Health Medical Research Council (2020) ethical guidelines, regarding studies conducted with Aboriginal and Torres Strait Islander peoples. Clearance to conduct the study was gained from the University of Technology Sydney Human Research Ethics Committee (ETH18-2618) as well as the Aboriginal Health and Medical Research Council of NSW Human Research Ethics Committee (1451/18).

Analysis

To develop the Bunya andragogy framework, we followed grounded theory processes for themes to arise from the different types of data collected – the three initial themes from analysis of the 24 interviews, as well as field notes from discussions and yarning sessions, and student feedback, were actively coded (Charmaz, 2014). The common themes arising from these various sources were then categorised (Charmaz, 2014). From this a total of 24 new content themes were identified as well as 26 principles for teaching and learning potentially relevant to an andragogical framework. This list was then refined to five overarching content themes and nine principles.

To further develop the andragogy framework, we worked collaboratively, critically reflecting on our own experiences with Indigenous communities, as Indigenous community members and as educators (Terry & Hayfield, 2020). We participated in formal and informal yarning sessions (Bond et al., 2019; Byrne et al., 2021; Sharmil et al., 2021) to discuss community members' firsthand experiences and our aspirations for healthcare education based on their experiences (Blignault et al., 2014, p. 32). Development occurred through a non-linear, circular process guiding us to understand the needs from both a community perspective as well as a student perspective, identifying problems, gaps and impact for the transformational learning (Blignault et al., 2014).

Limitations and opportunities

The Bunya andragogy framework content themes and principles were collaboratively developed but nonetheless represent a particular time and setting; the Bunya andragogy is grounded in the Australian context, especially in relation to policy and institutional systems and structures. The international

context will differ, while recognising the many similar challenges faced by Indigenous people globally (Wong et al., 2021).

The andragogy presented below is a 'living document', to critically reflect on and develop as Indigenous health service and education agendas change, and because of the importance of lifelong learning.

A strength of the framework is that it is theory- and evidence-informed, drawing from Indigenous and mainstream ways of being, doing and knowing, with mainstream theories such as perspective transformation gaining greater acceptance in Indigenous health education recently (Fitzpatrick, 2023). By drawing on our broader experience, we have sought to develop understanding and insights about how an andragogical approach is useful for both the teacher and the student – particularly given that in Indigenous health education, both teachers and students need a depth and range of resources, and to continue to learn over the life course.

The Bunya andragogy framework supports individual critical reflection, and helps navigate individual worldview bias, although its potential application in tertiary settings is focused on challenging actions and inactions of individuals (Liedtka, 2015). However, this in no way takes away from the need for collective alternatives such as community development required to address racism and other issues having serious implications (Heikkila & Gerlak, 2013; Simons & Laat, 2002). The framework does, however, promote opportunities for academics and students to work together and engage at the cultural interface, outside their comfort zones, including reflective questioning of assumptions and commitments to act (Brunstein & King, 2018) essential to cultural safety and cultural humility, through developing self-awareness and sensitivity to others (Yeager & Bauer-Wu, 2013).

FINDINGS

The following section introduces the Bunya andragogy framework, based on themes from grounded theory work outlined above. The framework's four interdependent elements, shown in Figure 7.1, are:

1. 'Culture' and 'Knowing, Being, Doing', as depicted in the image's outside circle, with culture as the foundation.

2. Five overarching themes for curriculum content, shown with Self in the centre, surrounded by clockwise from the top: Family, Sovereignty, Environment, and Systems and structures.

3. Four brown branches labelled Skills, Values, Knowledge, and Application, which intersect with each other and the Self.

4. Teaching and learning principles related to each content theme, woven into the model as an interactive web of dark green.

Figure 7.1: The Bunya andragogy framework.

Each of these elements will now be explained, with the information included here recommended for consideration by educators for curriculum content areas for students and staff alike to come to understand and use in healthcare education and clinical practice.

1. Culture and knowing, being and doing

Culture encompasses all aspects of teaching and learning within an Indigenous context. The cultural lens also directs the teaching and learning strategies for delivery and is underlying within all elements of the Bunya andragogy framework.

Being is the epistemology of giving and receiving, and carrying out all actions through relationships with others (Williams et al., 2023). Doing involves developing an axiology based on diverse information and tools, as well as principled and reflective action (Williams et al., 2023). Knowing, and developing your own ontology from the best available types of evidence, includes guidance of Elders, and self-trust about how best to proceed (Williams et al., 2023).

2. Five overarching themes for content

The five overarching themes for content are symbolised in the Bunya cone image with the Self at the core, surrounded by four brown seeds, clockwise from the top: Family, Sovereignty, Environment and Systems and structures, where they are encircled with the principles of Knowing, Being, Doing and Culture that infuse all aspects of teaching and learning.

The five themes for content provide a guide to help navigate the enormity of teaching and learning opportunities that exist. Emerging from our analysis of the interview material, and our own reflections, they also reflect current governance documents such as the *Australian Health Curriculum Framework* (Department of Health, 2021a). This content needs to stimulate critical thinking and analysis and be specific to the local context. This includes place-based cultural contexts and protocols, as well as socioeconomic, environmental, and political factors. Each of the five themes will now be discussed in turn.

Self

The primary purpose within this context is for the student to recognise their own standpoint and their own behaviours, to challenge and encourage students to understand that learning Indigenous perspectives and working with First Nations peoples is firstly about learning about themselves as a person. This is represented by Self, being at the core of the Bunya cone image. This process is also iterative or cyclical over one's life; we need to always return to self and be critically self-reflective to understand our own learning journey and unfolding cultural humility.

Interpersonal, communication, social skills and personal characteristics are foundational to effective healthcare (Minnican & O'Toole, 2020; NSQHS, 2017). However, there is little evidence-based research and evaluation on how these characteristics are integrated into curriculum and accounted for as part of the teaching and learning process. Hence, we draw on several disciplines to include this in the Bunya andragogy framework. The personal characteristics identified here are considered essential to working effectively with Aboriginal and Torres Strait Islander peoples, such as interpersonal and communication skills (Manton et al., 2024).

Self at the centre is also intersected by the brown band representing Skills, which includes the capacity and willingness to self-reflect. Further, these skills also encompass how we interrelate with everyone, as exemplified in the collective dimensions of the Aboriginal definition of health. Understanding our own positionality and the influence of our position on how we interact with the world and each other is the skill needed here. Self-reflection allows us to take the time to understand how we can improve and is essential to transformational learning that empowers one's inner self (Cajete, 1994, p. 208), energising us to seek, and contributing positively to personal, societal, and environmental healing and

growth. This includes honesty with self and others, confronting and challenging many preconceived notions about us and our perception of the world.

Integrity is also foundational to learning. Indigenous peoples in Australia continue to be mistreated, especially according to political agendas rather than human rights principles or what is morally right. Students require integrity to ensure they are not complicit and remain strong in their own principles, morals and values. Integrity also incorporates accountability, understanding how our actions influence outcomes intended and unintended.

Lastly, Self also includes designing teaching and learning where students learn the importance of inclusive, flexible, innovative, and proactive approaches to working with Indigenous peoples. This includes recognising and respecting the importance of collectively and relationality as being central to Indigenous ways of being, doing and knowing. Teaching and learning design needs to include deliberate opportunities to develop and experience the importance of relationships.

Family

Adult learners are seeking connection and to see something of themselves and their own experience to build from (Chuang, 2021). Family provides a platform for students to relate to within their own life and their own context, including roles and responsibilities we all carry as members of a family, or a community over our lifetimes. Within the Family seed is the centrality of family to concepts such as wellbeing, along with belonging, identity, intergenerational care, and lived experiences (Yunkaporta, 2019, p. 46). This theme facilitates the understanding of Indigenous approaches to health prevention and health management through intergenerational experiences. It also provides the opportunity to recognise the resilience of Indigenous peoples in the face of adversity and oppression over multiple generations. Students and practitioners need to understand the importance of relationships, and respecting patients and clients within their own context, including the influence of family, carer, kinship and other support networks (Huria et al., 2017).

Sovereignty

Sovereignty speaks to power and authority. In an Indigenous context, sovereignty is about self-determination and autonomy as a person and as peoples, as well as authority and cultural authority, to maintain our connection and fulfil our responsibilities as Custodians of the Country.

Sovereignty speaks to our Indigenous knowledges, of our connection to each other, our connection to our Country and our values and principles. Within Sovereignty, we convey to students the importance of local knowledges, and experiences of Indigenous peoples (Yunkaporta, 2019, p. 95).

This seed calls on us to demonstrate ample examples of Indigenous leadership and nation-building (Anthony-Stevens et al., 2020). Sovereignty also includes truth-telling, diversity, ingenuity and collectivism. Within this theme, we celebrate culture, peoplehood and Country.

Environment

Planetary health is inseparable from the health and wellbeing of all people (Brand et al., 2023). Indigenous knowledges and wellbeing are inextricably linked to the environment in which we function, in the broader sense, as well as the significance and importance of Country and our connection to our culture, our ancestors and our knowledge systems through our connection to Country (Redvers, 2018; Redvers et al., 2022).

The environmental seed includes learning about the significance of Country and caring for Country as well as the immense devastation caused by climate change, colonisation, land ownership regimes, and extractive land management practices. This theme directs students to understand the intricate relationship our peoples have with our environment, which impacts our wellbeing, culture, sense of belonging and identity, and the importance of land sovereignty to uphold our responsibility as custodians of this country (Yunkaporta, 2019, p. 86). This theme provides the opportunity to explore practices specific to the local context that are of global benefit (Sangha et al., 2019).

Environment and Country also contain our stories, our ways of being and learning by walking with our Elders, following their instructions and listening to the stories of our people containing cautioning, strategies and advice to benefit the environment for all peoples (Yunkaporta, 2019, p. 54).

Systems and structures

Systems and structures are very broad themes spanning racism, governance, and political and economic systems, such as the constitution as a document written to exclude and oppress First Nations peoples (Hauser, 2019; Williams & Bradsen, 1997).

Systems and structures also include methods and frameworks such as social determinants of health, the socio-ecological model, research and research ethics, data sovereignty, Indigenous Cultural and Intellectual Property rights and documents such as the Declaration of Human Rights, United Nations Declaration of the Rights of Indigenous Peoples, sustainable development goals and policies such as Closing the Gap.

The Systems and structures seed also includes models and specialised frameworks such as the social empowerment model, social-emotional wellbeing, and other holistic frameworks (Jackson Pulver et al., 2019). It also includes examples of regulation and accountability frameworks such as the Ahpra & National Boards Cultural Safety Framework (Ahpra, 2020).

Systems and structures provide an opportunity for educators to highlight inequities, inequalities, racism, and the culture of oppression within systems and structures of the Australian healthcare system itself and beyond. This opens their eyes to how much of the 'gap' in closing the gap is not due to Indigenous peoples' lack of expertise, complacency, or disregard; it is the systems and structures that are difficult and at times detrimental and unsafe to navigate. These also inhibit access to the health system and other systems upon which good health depends, such as environment, welfare, housing, education and the economy (Carson et al., 2020; Ungar, 2021).

The Systems and structures theme advocates for equipping staff and students with tools for working with communities and supporting advocacy, for implementing strengths-based approaches and multi-level empowerment, facilitating Indigenous leadership and co-design and developing partnerships.

Indigenous ways of knowing, being and doing have values for all people – 'get it right for Indigenous peoples and you will be well placed to get it right for all peoples' (Manton, 2023; Manton et al., 2024).

Four intersecting branches

The four intersecting branches of the Bunya andragogy framework relate to the foundational concerns of all curricula. Figure 7.1 shows the two pair of related branches: 'knowledge and skills' intersecting with 'application and values' – again with Self at the centre.

Knowledge

Indigenous knowledges are the principles, worldviews, traditions practices, language, songs, and healing practices – the knowledge held in community. 'Knowledge is a living thing' (Yunkaporta, 2019, p. 95) always evolving; it influences and sometimes challenges our own understanding of the world through the sharing of information. Knowledge is the starting point; it is where students begin their journey. Knowledge underpins the constructive alignment of a subject or course introducing students to concepts and theories to support their learning. Also important here is the distinction between Indigenous knowledges and Indigenous perspectives, the latter being the perspectives and stories of Indigenous individuals (Drummond, 2020, p. 128).

Knowledge is also multifaceted. Implicit knowledge is what is taught –the transfer of information (asynchronous). However, this intersects with explicit knowledge (synchronous), and how knowledge is applied in varied contexts as well as tacit knowledge, the knowledge gained from students' personal experiences within their own life context (Sternberg, 1999). In the context of Indigenous health, sometimes educators need to work with students to override or re-direct their implicit and tacit knowledge.

Skills

Skills reflect Indigenous ways of learning, learning by doing, deconstructing and reconstructing new knowledge (Yunkaporta, 2009). This is reflective of constructivist learning, constructing new knowledge rather than passively learning (Houghton et al., 2022), providing students with the opportunity to test new knowledge in real-world circumstances, modelling, testing and reflecting (Fitzpatrick, Haswell, Williams, Meyer et al., 2019; Fitzpatrick, Haswell, Williams, Nathan et al., 2019). Skills reflect epistemology in a Western knowledge system: how can the knowledge learned be put into action?

Within skills beginning the process of learning by reflecting enables students to become 'active agents' in their own learning (Freire, 2020), developing their own sense of personal power (Merriam, 1987; White, 2021). The points of intersection in the Bunya Andragogy Framework (Figure 7.1) are based on learning theories like Kolb's reflective cycle (Kolb, 2007), which includes concrete experience, reflective observation, abstract conceptualization, and active experimentation. These elements are also aligned with the Australian Qualifications Framework (AQF) and national regulatory requirements in Australia.

Application

Application is survival in an Indigenous context, the ability to apply, adapt and refine the knowledges and skills learned to various contexts independently. In a Western context it is the axiology – how the knowledge and the skills can be put into practice in specific professional contexts. It is an opportunity for students to apply their knowledge and skills in a real-life context, this is often student placements or opportunities such as work-integrated learning or independently students seek to engage with their local community to develop relationships. Application is essential for education to be a vehicle for change, if students do not understand how to apply their learnings and skills within their own personal and professional context the learnings may not be used when needed, opportunities missed and knowledge and skills can become dormant or worse, lost.

Values

Values are essential in any healthcare profession; however, they are hard to teach and often ignored in an already crowded curriculum. Within the knowledge and skills component of Indigenous healthcare education values must be central, as part of transformative learning. Values can be identified, discussed, applied, and reflected upon. Often values are assumed, it is assumed students are developing their own values as part of the hidden curriculum, there is no way of knowing this unless we make it explicit. Drawing on the concept of double loop learning, where we continuously question underlying

assumptions, values and beliefs and develop new strategies to meet the objective of 'doing the right things, the right way' (Argyris, 1977), upholding human rights principles and culturally safe care.

Principles for teaching and learning

Behind each of the brown seeds is a mat of green, depicting the new growth of teaching and learning; presented here as a series of principles that create the space for students to engage with the content and each other. What is taught and how it is taught are interwoven, co-dependent concepts that need to work harmoniously together. These include the following.

First Peoples first

- Ensure that the first words, voices, or evidence in education about Aboriginal and Torres Strait Islander people's health and wellbeing are by Aboriginal and Torres Strait Islander people.
- Bring community into the classroom, this is not limited to guest lectures and casual teaching. Build relationships within community to ensure what you are teaching and how you are teaching is following their leadership (Manton et al., 2023). It is about partnerships where power is equitably shared as both the academic and community are experts within their own contexts.

Strengths-based

- Design content and narrative based on a strengths-based approach which focuses on the strengths of the individual or community, specifically focusing on what is present and not what is absent. A strengths-based approach is foundational to creating a culturally safe learning environment.
- Thinking and speaking from a strengths-based perspective influences how a student/health professional views the world and can undermine otherwise common assumptions such as those based on profiling, stereotyping and racism (Geia et al., 2020; Wu et al., 2023).
- Ensure staff and students understand and have opportunities to develop the professional capability to apply a strengths-based approach in all aspects of their professional careers especially to approach challenges and stereotypes.

Create the space

- Promote psychosocial safety, establish a collaborative group agreement and ensure students are empowered to contribute boundaries for themselves and staff – reducing the power differential (Yunkaporta, 2019).

- Staff should be trauma-aware, healing-informed, with a collective healing lens applied, moving away from individualised solutions to health and complex issues; this is much easier and more impactful when conducted face-to-face (Coff & Lampert, 2019).

- Use music to transform the space. Music playing as students walk into a learning setting reorientates and claims the space (Martin, 2019).

- Activate student senses by using room spray or scents specific to the people or place, and introduce textures such as bush healing balms, bush medicine plants/clipping and artefacts. Incorporate colour, using fabrics, brightly coloured textas and paper!

Cultural safety

- Define cultural safety upfront, with students so they understand the context they are learning in. Use professional practice guidelines or context that is most relevant within the context of the students.

- Demonstrate cultural safety in action by being responsive to students.

- Prepare students by naming anti-racism strategies, processes and practices and implementing them in the classroom.

Use multimedia

- Amplify Indigenous voices through stories (Manton et al., 2023, 2024; Shay & Wickes, 2017).

- Provide students with a diversity of Indigenous peoples, voices and experiences that is reflective of the diversity of Indigenous peoples in Australia

- Draw on Aboriginal and Torres Strait Islander peoples expertise and interest in using technology, embrace the extensive content publicly available online (Ramsden et al., 2022).

Be evidence-informed

- Use evidence that respects the diversity of Aboriginal and Torres Strait Islander people and cultures, highlighting our similarities and differences across gender, age, location and experiences.

- Critique evidence: Who designed the research and reported the evidence; what are gaps in evidence, and what is its quality? Does the resource privilege Aboriginal and Torres Strait Islander-led research and decolonising methodologies?

Model, lead by example

- Acknowledge your own positionality, with humility and vulnerability; learning is lifelong.
- Use the Aboriginal and Torres Strait Islander definition of health, discussing all dimensions including connection to Country.
- Be human rights-informed: Use the United Nations Declaration on the Rights of Indigenous Peoples and name specific articles.
- Use a multilevel empowerment framework: Cite or develop a socio-ecological model of health that relates to the health issues and populations you're discussing.
- Identify social determinants of health: Identify influences of history, the setting and systems, power, politics, resources, and access to justice as well as education, employment, income and housing.

It's about you not us

- Turn the mirror inward; rather than learning 'about' Aboriginal and Torres Strait Islander peoples, staff and students need to learn about themselves.
- Choose a critical self-reflection framework to guide staff and students to staff and students to clearly name their positionality and biases.

Use recent and relevant examples

- Build and invest in strong relationships and partnerships between Aboriginal and Torres Strait Islander Community Controlled Health Organisations and mainstream organisations and draw on examples of solutions with related evidence by Aboriginal and Torres Strait Islander peoples and organisations.

The principles for teaching and learning are reflected subtly in the Bunya Andragogy Framework in green supporting the overarching themes for content.

DISCUSSION

Institutions such as universities have been described as lacking coherence and skillsets to collectively reflect and provide curriculum that graduates students ready to create a culturally safe environment (Manton & Williams, 2021; Manton et al., 2023, 2024). To rectify this, the Bunya andragogy framework has been produced from reflexive research, government frameworks, guidelines and policies and legislation. This provides clear guidance on Indigenous health curriculum including knowledges, skills and their application. The concepts in the Bunya andragogy framework are explained with actionable

directions for implementation tailored to reflect local contexts as well as the teaching style of the academic/s designing and facilitating the content.

The scholarship of learning and teaching has been consistently developing over the past 30 years (Boyer, 1990). The scholarship of learning and teaching in Indigenous contexts, Indigenous pedagogy and decolonising classrooms has also become increasingly developed (Flavell et al., 2013; Martin et al., 2017). In addition, government strategies and some theoretical frameworks regarding the scholarship of teaching have significantly progressed. These all advocate for moving curriculum and students beyond a focus on professional identity formation towards developing professional capabilities, including cultural capabilities (Department of Health, 2021a).

The Bunya andragogy framework provides concepts and content for developing professional and cultural capabilities of students; they are important agents of change and a voice for generations (Reconciliation Australia, 2023), building positive relationships based on connections from a strengths-based perspective (Fogarty et al., 2018). In approaching teaching and learning to develop students' cultural capabilities 'students need to see themselves' in the content and context they are learning (Honneth, 2014). However, the framework also focuses on staff professional and cultural capability development. It provides a practical evidence-based guide that can be implemented in tertiary education curriculum design as well as approaches to teaching, learning and assessment. Further, its principles for teaching and learning and its content themes are beneficial for teaching and learning relative to any health profession or discipline outside of health, through being based on the professional capabilities and the knowledge and skills graduates require to work with Indigenous peoples. Importantly, these are grounded in Indigenous ways of doing business, but they are not cultural; academics do not require cultural knowledge or permissions to implement the framework's principles or content.

The six characteristics of andragogy according to Knowles (Hartree, 1984) are reflected in the framework through emphasising content knowledge in each of the themes outlined. Fundamentally, through its emphasis on understanding of self through the centrality of self and critical self-reflection, its andragogical principles for teaching and learning provide students with a unique orientation to learning; the themes, principles, and opportunity to be agents of change providing students with the foundation to develop intrinsic motivation aligned with their experience, values and aspirations for the future.

Academics are entrusted to ensure graduates have the professional capabilities to work with the community and understand the importance of these skills. However, the task is more than just 1) upskilling teaching academics and 2) strengthening the skills of the future health workforce and thus the healthcare provision for all peoples. It is also about 3) not lowering expectations for Indigenous healthcare education. Developing skills to draw on Indigenous ways of working with patients and clients to develop the best practitioners. Ensuring high expectations for Indigenous curriculum in design

implementation and assessment is imperative. ‘When I lined up on the MCG to kick a goal, they didn’t pull the goal posts apart to make it easier to kick a goal; so, if you want to see an Aboriginal person get to the MCG or to get a degree from a university, the standards have to be the same for everyone – black and white’ (Graham ‘Polly’ Farmer, quoted in Polly Farmer Foundation, 2024). The commonalities in Indigenous ways of knowing, being and doing are tightly woven with principles of cultural safety and educational quality standards ensuring integrity in the Bunya andragogy framework. However, how these skills are assessed and measured needs careful consideration. This process needs evaluation and measurement, and begs the question: how do you measure humility and transformation that may occur years after formal education?

CONCLUSION

The task is three-fold: a) upskilling teaching academics, 2) strengthening the skills of the future health workforce and thus the healthcare provision for all peoples, and 3) creating workforces and universities as safe places for Indigenous people to inhabit, do well in, and lead. Academics are entrusted to ensure graduates have the professional capabilities to work with the community and understand the importance of these skills. The Bunya andragogy framework has been developed in the context of university learning; however, this can inform professional development in the workplace and be adapted and applied beyond the health context.

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7.3 Chapter conclusion

This chapter provides a starting point for academics; it is a living framework and process to nurture culturally safe teaching and learning environments, intertwining several crucial strategies.

Firstly, there is a commitment to empowering Indigenous communities through active involvement in curriculum design, collaboration with Aboriginal Community Controlled Health Organisations, and prioritising Indigenous voices, knowledge and experiences.

Secondly, systemic issues are addressed head-on, confronting racism's detrimental impact on Indigenous health, and actively working to deconstruct oppressive structures within the healthcare system. In an effort to prepare culturally safe healthcare professionals, equipping them with essential skills in cultural safety, effective communication, relationship-building, and advocacy, while also fostering an understanding of the historical legacy of colonisation and the ongoing challenges faced by Indigenous communities.

This framework guides staff and students to uphold human rights principles, with a focus on ensuring equitable access to safe, respectful, and culturally safe healthcare, free from any form of discrimination, as legislated in Australia.

Although the Bunya framework serves as a foundation for tertiary Indigenous health education and professional development, the ongoing challenge lies in assessing its long-term impact. Insights from the Bunya Project demonstrate the necessary steps for teaching academics and future healthcare workers to address racism and enhance healthcare delivery for all, extending beyond its original university-centred scope to broader societal impact.

The next chapter outlines the quantitative study conducted as part of the Bunya Project, to evaluate the impact of the Bunya Project on knowledge and awareness of students and staff for transformational change.

Handful of nourishing Bunya seeds

Chapter 8 – Quantitative Findings

Preface

The Bunya pine, nut and cone stand as potent symbols of nourishment, highlighting the indispensable role of Indigenous leadership in healthcare education. Renowned for its towering presence and gradual maturation, the Bunya pine tree embodies resilience and sustenance, mirroring the enduring strength of Indigenous communities. Similarly, Indigenous leadership imparts guidance and wisdom to healthcare education systems, providing a nurturing environment rich in cultural significance. Within the protective embrace of the Bunya cone lies the Bunya nut, symbolising vitality and knowledge drawn from Indigenous communities, mentioned earlier.

Indigenous leadership enriches healthcare education with diverse perspectives and holistic approaches to wellness, like the nourishing qualities of the Bunya seeds within the nut. Just as the Bunya cone shields its cherished seeds, Indigenous leadership safeguards Indigenous voices and rights within healthcare education. Through self-determination, Indigenous leaders champion culturally safe practices and equitable healthcare access, fostering inclusive learning environments. Including Indigenous voices and perspectives, healthcare education can tackle health disparities and cultivate self-reflective professionals, with the skills to work with Indigenous communities. Through authentic collaboration with Indigenous communities in integrating Indigenous expertise into tertiary education, a relationship of inclusivity and mutual respect, upholding principles of self-determination.

The Bunya Project signifies an opportunity for collective growth and change, where education becomes a transformative tool, preserving Indigenous knowledge and fostering a culture of respect and understanding.

8.1 Chapter overview

This chapter presents the quantitative study of the Bunya Project, which was introduced in Chapter 5: Methods. The study utilises a comprehensive survey instrument to assess students' attitudes and knowledge regarding Indigenous issues, aiming to gauge the impact of education on cultural competency. Ethically conducted data collection enabled statistical analysis revealing patterns across the surveyed themes. Results presented here explore the efficacy of authentic Indigenous-led teaching resources in fostering cultural awareness among students and staff.

The key aims of this chapter are to:

1. Present the quantitative study.
2. Measure the impact of the Bunya Project resources for Indigenous learning opportunities for staff and students.
3. Identify and address limitations of the study.
4. Outline implications for healthcare education.

8.2 Bunya Project Quantitative Findings

Abstract

This study investigates the impact of education on students' attitudes and knowledge regarding Indigenous matters in Australia, focusing on the efficacy of Indigenous-led teaching resources in fostering cultural capability. Utilising a comprehensive survey instrument, data was collected ethically and analysed statistically to reveal patterns across surveyed themes. Results indicate the effectiveness of authentic Indigenous-led teaching resources in enhancing cultural awareness among students and staff. However, challenges persist in translating these educational efforts into workplace attitudes and ensuring sustained effectiveness. The study highlights the need for ongoing research, evaluation and broader implementation of culturally safe educational initiatives to eliminate racism in healthcare and uphold principles of self-determination. The findings emphasise the importance of addressing discriminatory preconceptions and biases through education and fostering meaningful engagement with Indigenous communities.

INTRODUCTION

Aboriginal and Torres Strait Islander peoples in Australia make up 3.8% of the total population (Health & Welfare, 2023), with the larger proportion of Aboriginal and Torres Strait Islander peoples aged 29, one-third of this proportion being under 15 (AIHW, 2023). As 3.8% of the overall Australian population, Indigenous peoples have little democratic influence regarding decisions that are made to the benefit of the majority; this, coupled with the significant young age of the population, demonstrates

the little influence Aboriginal and Torres Strait Islander peoples have to effect change in Australia. It is the majority population who are influential in the overall governance of Australia, with the majority holding power. The government tends to target policies, programs and campaigns towards the population that will get them the most votes (Betts & Birrell, 2024). It is also this population that holds individual power, the decision-makers in leadership positions within institutions, systems and companies (Lucas, 2021). It is the attitudes and approaches of this population that continue to perpetuate stereotyping and discriminatory practices relating to Indigenous peoples (Anderson et al., 2023; Forrest et al., 2016; Rowse, 2021). In a recent analysis of the 2023 Voice to Parliament Referendum and related social and political attitudes, 51.3% of respondents agreed or strongly agreed with the statement *If Aboriginal and Torres Strait Islander people tried harder, they could be just as well off as non-Indigenous Australians* (Biddle et al., 2023, p. viii). This attitude demonstrates that efforts to address racism against Indigenous Australians require systemic changes at multiple levels, including legislative reforms, education and genuine efforts to engage with Indigenous communities, respecting their rights and self-determination. Truth-telling about Australia's colonial past and ongoing injustices that continue to impact and oppress Indigenous peoples today is crucial for the elimination of racism in Australia (Reconciliation Australia, 2019).

In the past decade, much research has focused on Indigenous peoples' experiences of racism. Racism experienced by Indigenous Australians is deeply entrenched in the systems, structures and ongoing social dynamics of Australia (Allison et al., 2023; United Nations, 2023). Indigenous Australians continue to endure racism in many forms from the deliberate design of oppression in Australia's institutions and systems, including universities (Povey et al., 2023) to overt racism (Hickey, 2016) or more subtle coded racism (O'Donnell, 2020; United Nations, 2023). This unfounded prejudice and discrimination is woven throughout the Australian population (Taylor & Habibis, 2020). Within research, there is a focus on Indigenous peoples and their experiences, but very few focus on the attitudes and biases of the perpetrators of racism (Forrest et al., 2016).

According to the *Call it Out Racism Register Report 2022–2023*, 48% of the reports received were from an Indigenous person who had directly experienced racism (Allison & Cunneen, 2022, p. 8), 51% were experienced or witnessed in person (Allison & Cunneen, 2022, p. 9) and 20% related to negative attitudes and stereotyping (Allison & Cunneen, 2022, p. 10). The workplace was the primary location where Indigenous peoples experienced racism, accounting for nearly one in four reported incidents (17%) (Allison & Cunneen, 2022, p. 16). The second location was a commercial setting, accounting for 16% (p. 16). Universities aim to prepare students for their professional careers, this should include understanding racial discrimination laws (Hollinsworth et al., 2021) as they pertain to Indigenous peoples and proactive strategies to ensure graduates have the knowledge and skills to apply to their professional practice to work safely with Indigenous colleagues and stakeholders (Hassen et al., 2021; Jankowski, 2022; Nissim, 2014).

Drivers have been put in place by leading organisations generally, such as the Australian Human Rights Commission (Australian Human Rights Commission, 2009), as well as more specifically in the context of healthcare with the cultural safety legislation (NSW Legislation, 2022). There is little research focused on measuring change in the attitudes and biases of the perpetrators of racism (Fredericks et al., 2023). The impact of tertiary education on challenging and changing discriminatory preconceptions, bias and stereotyping remains unclear. The purpose of this study was to measure social change through education, measuring student attitudes and the impact of teaching and learning in changing those attitudes by implementing an evaluation framework to assess the changes in student knowledge and awareness of cultural capability measures (Bodkin-Andrews et al., 2019). This chapter shifts its focus to the educational content aimed at portraying Indigenous peoples and communities accurately and explores how non-Indigenous individuals can learn to work effectively with Indigenous colleagues and communities free from discrimination and racism (Bodkin-Andrews et al., 2019).

Five broad themes were recognised through the Indigenous Graduate Attribute evaluation conducted by Bodkin Andrews et al. (2019). The five themes are:

1) Colonial knowledges, defined by the authors of the framework as the 'misrepresentation of the lived realities for Indigenous Australians' (Bodkin-Andrews et al., 2019, p. 237). This aligns with the Bunya andragogy framework concept of sovereignty, specifically through truth-telling
2) Reflectivity refers to the development of critical self-awareness, to be able to recognise and deconstruct eurocentrism and 'othering' mentality concerning Indigenous peoples. This theme aligns with the concept of self in the centre of the Bunya andragogy framework.
3) Indigenous voices recognises the importance of ensuring students learn directly from Indigenous peoples, regarding Indigenous matters and experiences. Privileging Indigenous voices is reflected in the Bunya andragogy framework through the sovereignty theme. This is also a central tenet throughout the entire Bunya Project.
4) Indigenous ways describe Indigenous approaches to knowing, being and doing as a point of difference to western ontology, epistemology and axiology (Williams et al., 2023). Culture, Indigenous ways of knowing, being and doing, encircle the elements of the Bunya andragogy framework as no matter what is taught or learned, it needs be bound in Indigenous ways, Indigenous culture – otherwise it is assimilation.
5) Indigenous Engagement – the aforementioned themes provide students with sound foundational knowledge and skills for more meaningful engagement with Indigenous peoples and communities. To some extent this is reflected in the systems and structures theme of the Bunya andragogy framework in preparing students to work in a professional capacity within the systems and structures, to be impactful change agents aligned with Indigenous leadership in the global, national and local context.

METHOD

Context

Our team acknowledges the importance of articulating the standpoint we bring to this research (Yunkaporta & Shillingsworth, 2020). The first author (DM) is a Barunggam PhD candidate, the second author (MW) is a senior Wiradjuri researcher with extensive expertise in qualitative, quantitative, mixed methods research and Indigenous health research. The third author (AH) is a non-Indigenous researcher with experience in biostatistics and epidemiology, quantitative and mixed methods research.

This project is part of the larger Bunya Project as described in previous chapters and publications (Manton & Williams, 2021; Manton et al., 2023, 2024).

The initial baseline survey no resources from the Bunya project had been implemented. The follow-up survey was designed to measure the implementation of the resources gathered from the community data, influence of academic participation in the Bunya Nuts working party and the conscious thought and deliberate action of academics involved in the project to privilege Indigenous voices.

Measurement

The CAIK survey used was developed by the Centre for the Advancement of Indigenous knowledges (CAIK) to be a university-wide instrument at the time of the study design (appendix B). The instrument was validated by the Centre (CAIK). ‘Based on the IGA framework a self-report student evaluation instrument was developed to measure the beliefs, attitudes and learning experiences of students who have undertaken course work that may have Indigenous learning content embedded within it’ (Bodkin-Andrews et al., 2019, p. 237).

The five overarching themes are measured through the factors as follows (Bodkin-Andrews et al., 2019)

1) Colonial knowledges, is measured by questions regarding deficit discourses through the representation of Indigenous disadvantage, as well as overlapping with critical cultural representations
2) Reflectivity is measured by factors of critical cultural representations, future Indigenous engagement, Indigenous assessment and Indigenous learning value
3) Indigenous voices are measured by Indigenous diversities, Indigenous standpoints and Indigenous representatives
4) Indigenous ways are measured by factors of respectful learning, Indigenous diversities, Indigenous learning value and Indigenous standpoints
5) Indigenous Engagement is measured by future Indigenous engagement, Indigenous representatives, Indigenous assessment and Indigenous learning value

The instrument is designed to measure two aspects of student knowledges and attitudes to Indigenous matters and applied Indigenous learning. The survey instrument is divided into five sections. Each section utilises a Likert scale ranging from 1 to 6, 1 being completely false, 2 mostly false, 3 more false than true, 4 more true than false, 5 mostly true and 6 completely true.

- Section 1 collects background information; the purpose of this is to gauge the demographics of the respondents.
- Section 2 measures students' knowledges and beliefs about Aboriginal peoples and communities. An example of a statement included in this section is:
    - *'On average when compared to non-Indigenous Australians, Indigenous Australians: Have more stressful life events.'*
- Section 3, Indigenous learning opportunities, measures participants' experiences within the subject or course. An example of a statement in this section is:
    - *'Overall, this subject showed me how important learning about Indigenous Australians for my future employment.'*
- Section 4: Personal attitudes measures personal attitudes towards learning. An example of a statement is:
    - *'I personally enjoy: knowing that a university education lies in being different.'*

The survey included free text sections, however, these sections were significantly underutilised with very few written responses. The extremely low engagement in the free text sections limited the validity and usefulness for inclusion in the analysis.

Data collection and participants

The data used in this study was collected by both paper-based surveys and Qualtrics online survey tool.

Initially, the data for this project was collected face-to-face. The baseline data was collected in February 2020 and the CI attended the orientation week sessions of the first-year postgraduate allied health courses, across six disciplines within the Faculty of Health at an Australian University. The CI provided a brief presentation outlining the research project. The CI then left, and students were recruited through self-nomination via teaching staff. The academics later returned any completed surveys to the CI. This approach was to ensure the students did not feel pressured to participate in the survey due to the CI's presence. In all, 215 completed surveys were received.

In 2021 the world had changed dramatically; face-to-face data collection was not an option. As a result of federal health directives and laws restricting all in-person activities, it was not feasible to implement a paper-based survey. An ethics amendment was submitted and approved to collect data via the Qualtrics online tool. The same cohort of students, now second year students were recruited through self-nomination. The CI briefly visited the virtual classes to reintroduce the Bunya project and the

survey; however, instead of a paper survey a link was sent via Zoom chat for students to access and complete if they chose to participate in the project, the teaching staff assisted in facilitating this, reminding students to complete and circulating link on course notice boards etc. This approach yielded significantly fewer results, with 54 students completing the survey.

Data collected via Qualtrics was non-identifiable and password-protected, utilising the UTS account. The data was then downloaded and stored on the secure password-protected UTS server.

Statistical analysis

The quantitative data was cleaned, with frequencies conducted using SPSS to identify overall patterns including across the five basic themes the instrument focuses on. Other basic statistical data analysis occurred including identifying the mean and median results.

Ethical approval

UTS Human Research Ethics Committee (HREC) approved the project (ETH18-2618) as did the Aboriginal Health & Medical Research Council of NSW Human Research Ethics Committee (1451/18).

The Bunya Project has been designed according to National Health and Medical Research Council (NHMRC) guidelines with respect to the ethical considerations for research being conducted with Aboriginal and Torres Strait Islander people. The Bunya Project is designed to facilitate Aboriginal community participation in developing culturally respectful engaging resources for student learning at UTS across disciplines that have few such resources.

RESULTS

The results of the survey have been analysed to measure the impact of the implementation of Bunya Project resources and andragogical approaches to meet the Indigenous Graduate Attribute requirements for the staff and students' cultural awareness and engagement. This is a significant point of difference as very little data has been collected to evaluate the effectiveness of embedding Indigenous Graduate Attributes into the healthcare curriculum (Bullen & Roberts, 2019).

Section 1: Background information

In the first baseline survey there were 215 respondents out of 275, of which 186 (86.5%) were female. The median age was 22 years. Participants came from five programs (clinical psychology, orthoptics, genetic counselling, pharmacy and speech pathology). In the second survey, there were 54 respondents, of which 40 were female (74.1%). The median age was 25 years and participants represented six programs (clinical psychology, orthoptics, genetic counselling, pharmacy, physiotherapy and speech pathology).

Section 2: Knowledge and beliefs

The results demonstrate little change in attitudes from the 2020 baseline survey to the 2021 survey. While most of the responses demonstrate the students are informed with positive attitudes toward working with Indigenous peoples, the results demonstrate some students require further opportunities to challenge their assumptions and attitudes. This is specifically evident in the 2020 baseline survey section 2 statement *Most of the inequalities suffered by Indigenous Australians: exist because of their own choices* where the median was *mostly false*, indicating respondents perceived some truth in the statement. The statement *Most of the inequalities suffered by Indigenous Australians: exist because they refuse to move on from the past* and had the same result. The survey results indicate some movement is evident.

Section 3: Indigenous learning opportunities

Section 3 of the survey demonstrates students have received Indigenous learning opportunities, although it is impossible to draw a conclusive correlation between the implementation of the Bunya Project resources and andragogy principles.

Section 4: Personal attitudes

In the section 4 statement *Attitudes towards Indigenous Australians: Universities make it too easy for Indigenous Australians to get accepted to undertake degrees*, the median moved from *more false than true* in the 2020 baseline to *mostly false* in the 2021 survey.

Section 5: Attitudes towards Indigenous Australians

The results do demonstrate the importance of further learning opportunities to influence address students' attitudes and biases, ensuring they are self-aware and informed with correct information from the knowledge and experiences of Indigenous peoples and communities.

The surveys conducted in 2020 and 2021 revealed minimal changes in student attitudes toward Indigenous Australians, despite overall positive views. Although many students demonstrated informed perspectives, some still held misconceptions, as reflected in their responses to statements about the causes of Indigenous inequalities. Indigenous learning opportunities were present, but it was difficult to link them directly to the Bunya Project's impact. The results highlight the need for further educational efforts to challenge biases and deepen students' understanding of Indigenous issues.

Section 1: Background information

Table 8.1 below outlines respondents demographic information regarding gender, age, and the course they are studying.

CAIK BASELINE SURVEY (2020)		CAIK FOLLOW UP SURVEY (2021)	
	Overall (N=215)		**Overall (N=54)**
Gender		**Gender**	
Male	29 (13.5%)	Male	8 (14.8%)
Female	186 (86.5%)	Female	40 (74.1%)
Age		Missing	6 (11.1%)
Mean (SD)	23.8 (4.64)	**Age**	
Median [Min, Max]	22.0 [20.0, 49.0]	Mean (SD)	26.4 (5.22)
Missing	3 (1.4%)	Median [Min, Max]	25.0 [22.0, 48.0]
Program		Missing	5 (9.3%)
Clinical Psychology	34 (15.8%)	**Program**	
Genetic Counselling	22 (10.2%)	Clinical Psychology	23 (42.6%)
Orthoptics	42 (19.5%)	Genetic Counselling	7 (13.0%)
Pharmacy	49 (22.8%)	Orthoptics	1 (1.9%)
Speech Pathology	56 (26.0%)	Pharmacy	2 (3.7%)
Missing	12 (5.6%)	Physiotherapy	12 (22.2%)
		Speech Pathology	4 (7.4%)
		Missing	5 (9.3%)

Table 8.1: CAIK survey respondent background information

Section 2: Knowledge and beliefs

The following section is designed to measure respondents' beliefs and knowledge about Indigenous Australian peoples and communities. This is reflected in Table 8.2 below:

CAIK baseline survey results 2020	**Overall (N=215)**	CAIK follow-up survey results 2021	**Overall (N=54)**
On average when compared to non-Indigenous Australians, Indigenous Australians: - have a lower life expectancy		**On average when compared to non-Indigenous Australians, Indigenous Australians: - have a lower life expectancy**	
Mean (SD)	4.88 (1.14)	Mean (SD)	5.53 (0.654)
Median [Min, Max]	5.00 [1.00, 6.00]	Median [Min, Max]	6.00 [4.00, 6.00]
Missing	5 (2.3%)	Missing	7 (13.0%)
On average when compared to non-Indigenous Australians, Indigenous Australians: - have lower educational outcomes		**On average when compared to non-Indigenous Australians, Indigenous Australians: - have lower educational outcomes**	
Mean (SD)	4.80 (1.07)	Mean (SD)	5.34 (0.731)
Median [Min, Max]	5.00 [1.00, 6.00]	Median [Min, Max]	5.00 [4.00, 6.00]
Missing	3 (1.4%)	Missing	7 (13.0%)
On average when compared to non-Indigenous Australians, Indigenous Australians: - have more stressful life events		**On average when compared to non-Indigenous Australians, Indigenous Australians: - have more stressful life events**	
Mean (SD)	4.49 (1.11)	Mean (SD)	5.04 (1.12)
Median [Min, Max]	4.00 [1.00, 6.00]	Median [Min, Max]	5.00 [1.00, 6.00]
Missing	4 (1.9%)	Missing	7 (13.0%)
On average when compared to non-Indigenous Australians, Indigenous Australians: - have higher incarceration rates		**On average when compared to non-Indigenous Australians, Indigenous Australians: - have higher incarceration rates**	
Mean (SD)	4.79 (1.17)	Mean (SD)	5.51 (0.748)

Median [Min, Max]	5.00 [1.00, 6.00]
Missing	9 (4.2%)
On average when compared to non-Indigenous Australians, Indigenous Australians: - are less likely to own a home	
Mean (SD)	4.48 (1.19)
Median [Min, Max]	5.00 [1.00, 6.00]
Missing	7 (3.3%)

Median [Min, Max]	6.00 [4.00, 6.00]
Missing	7 (13.0%)
On average when compared to non-Indigenous Australians, Indigenous Australians: - are less likely to own a home	
Mean (SD)	5.26 (0.820)
Median [Min, Max]	5.00 [4.00, 6.00]
Missing	7 (13.0%)

	Overall (N=215)
Most of the inequalities suffered by Indigenous Australians: - exist because of their own choices	
Mean (SD)	2.20 (1.16)
Median [Min, Max]	2.00 [1.00, 6.00]
Missing	5 (2.3%)
Most of the inequalities suffered by Indigenous Australians: - exist because they refuse to move on from the past	
Mean (SD)	2.11 (1.23)
Median [Min, Max]	2.00 [1.00, 6.00]
Missing	6 (2.8%)

	Overall (N=54)
Too many: - representations of Indigenous Australians in the media are just inaccurate stereotypes	
Mean (SD)	4.19 (1.01)

	Overall (N=215)
Too many: - representations of Indigenous Australians in the media are just inaccurate stereotypes	
Mean (SD)	4.13 (1.04)
Median [Min, Max]	4.00 [1.00, 6.00]
Missing	9 (4.2%)
Too many: - politicians refuse to listen to the voices of Indigenous Australians	
Mean (SD)	4.41 (1.13)
Median [Min, Max]	4.50 [1.00, 6.00]
Missing	5 (2.3%)
Too many: - researchers refuse to consider how Indigenous Australians may see things	
Mean (SD)	3.63 (1.12)
Median [Min, Max]	4.00 [1.00, 6.00]
Missing	8 (3.7%)

	Overall (N=215)
In the future, I would: - be confident to work with Indigenous Australians	
Mean (SD)	5.03 (1.13)
Median [Min, Max]	4.00 [2.00, 6.00]
Missing	7 (13.0%)
Too many: - politicians refuse to listen to the voices of Indigenous Australians	
Mean (SD)	4.79 (0.977)
Median [Min, Max]	5.00 [1.00, 6.00]
Missing	7 (13.0%)
Too many: - researchers refuse to consider how Indigenous Australians may see things	
Mean (SD)	3.96 (1.12)
Median [Min, Max]	4.00 [1.00, 6.00]

	Overall (N=54)
In the future, I would: - be confident to work with Indigenous Australians	
Mean (SD)	4.57 (1.06)
Median [Min, Max]	5.00 [2.00, 6.00]
Missing	7 (13.0%)
In the future, I would: - get along well with Indigenous Australians in the workplace	
Mean (SD)	5.55 (0.619)
Median [Min, Max]	6.00 [4.00, 6.00]
Missing	7 (13.0%)

Median [Min, Max]	5.00 [2.00, 6.00]
Missing	2 (0.9%)
In the future, I would: - get along well with Indigenous Australians in the workplace	
Mean (SD)	5.47 (0.781)
Median [Min, Max]	6.00 [2.00, 6.00]
Missing	3 (1.4%)
In the future, I would: - be happy to consult with Indigenous Australian community representatives	
Mean (SD)	5.56 (0.742)
Median [Min, Max]	6.00 [2.00, 6.00]
Missing	3 (1.4%)

	Overall (N=215)
Both Indigenous and non-Indigenous: - perspectives can combine to produce productive outcomes for Indigenous communities	
Mean (SD)	5.47 (0.718)
Median [Min, Max]	6.00 [3.00, 6.00]
Missing	3 (1.4%)

	Overall (N=215)

In the future, I would: - be happy to consult with Indigenous Australian community representatives	
Mean (SD)	5.64 (0.735)
Median [Min, Max]	6.00 [2.00, 6.00]
Missing	7 (13.0%)

	Overall (N=54)
Both Indigenous and non-Indigenous: - perspectives can combine to produce productive outcomes for Indigenous communities	
Mean (SD)	5.40 (0.925)
Median [Min, Max]	6.00 [2.00, 6.00]
Missing	

	Overall (N=54)
Indigenous Australians: - have nations and clans that have many different customs	
Mean (SD)	5.87 (0.397)
Median [Min, Max]	6.00 [4.00, 6.00]

Indigenous Australians: - have nations and clans that have many different customs		Missing	7 (13.0%)
Mean (SD)	5.60 (0.680)		
Median [Min, Max]	6.00 [3.00, 6.00]		
Missing	6 (2.8%)		

Table 8.2: CAIK survey responses to section 2: Knowledge and beliefs

Section 3: Indigenous learning opportunities

The following section is about the respondents' experience with the course they are studying. No data for first survey as students had not commenced subject or course. This is reflected in Table 8.3 below:

No data for first survey as students had not commenced subject or course

CAIK follow-up survey results 2021	**Overall (N=54)**
In this subject we: - were able to discuss Indigenous Australians issues respectfully	
Mean (SD)	5.49 (0.748)
Median [Min, Max]	6.00 [4.00, 6.00]
Missing	7 (13.0%)
In this subject we: - were required to engage with Indigenous Australian authors	
Mean (SD)	3.64 (1.42)
Median [Min, Max]	4.00 [1.00, 6.00]
Missing	7 (13.0%)
In this subject we: - have had the opportunity to learn from a number of Indigenous Australian representatives	
Mean (SD)	3.79 (1.38)
Median [Min, Max]	4.00 [1.00, 6.00]

	Missing	7 (13.0%)
	In this subject we: - were taught about important ethical considerations (e.g. reciprocity, intellectual property rights) that are needed for working with Indigenous Australians	
	Mean (SD)	4.98 (1.22)
	Median [Min, Max]	5.00 [2.00, 6.00]
	Missing	7 (13.0%)
	In this subject we: - Learned of many unique Indigenous Australian Knowledges that have survived colonisation	
	Mean (SD)	3.94 (1.41)
	Median [Min, Max]	4.00 [1.00, 6.00]
		7 (13.0%)
	In this subject we: - had an assessment to critically evaluate multiple perspectives on an issue affecting Indigenous Australians	
	Mean (SD)	3.77 (1.62)
	Median [Min, Max]	4.00 [1.00, 6.00]
	Missing	7 (13.0%)

Table 8.3: CAIK survey responses to section 3: Indigenous learning opportunities

Section 4: Personal attitudes

The following section is about the respondents' personal attitudes towards learning. This is reflected in Table 8.4 below:

CAIK baseline survey results 2020	**Overall (N=215)**	CAIK follow-up survey results 2021	**Overall (N=54)**
I personally enjoy: - knowing that university education lies in being introduced to different values		**I personally enjoy: - knowing that university education lies in being introduced to different values**	
Mean (SD)	5.51 (0.713)	Mean (SD)	5.43 (0.620)
Median [Min, Max]	6.00 [3.00, 6.00]	Median [Min, Max]	5.50 [4.00, 6.00]
Missing	4 (1.9%)	Missing	8 (14.8%)
I personally enjoy: - talking with people who have values different from mine because it helps me understand myself and my values better		**I personally enjoy: - talking with people who have values different from mine because it helps me understand myself and my values better**	
Mean (SD)	5.59 (0.686)	Mean (SD)	5.57 (0.688)
Median [Min, Max]	6.00 [3.00, 6.00]	Median [Min, Max]	6.00 [4.00, 6.00]
Missing	2 (0.9%)	Missing	8 (14.8%)
I personally enjoy: - taking courses that make me think about things from a different perspective		**I personally enjoy: - taking courses that make me think about things from a different perspective**	
Mean (SD)	5.65 (0.625)	Mean (SD)	5.67 (0.598)
Median [Min, Max]	6.00 [4.00, 6.00]	Median [Min, Max]	6.00 [4.00, 6.00]
		Missing	8 (14.8%)

Table 8.4: CAIK survey responses to section 4: Personal attitudes

Section 5: Attitudes towards Indigenous Australians

The following section is about the respondents' personal attitudes towards learning, this is reflected in Table 8.5 below:

CAIK baseline survey results 2020	**Overall (N=215)**
Attitudes towards Indigenous Australians. - Discrimination against Indigenous Australians is still a major problem	
Mean (SD)	5.28 (0.934)
Median [Min, Max]	6.00 [1.00, 6.00]
Missing	2 (0.9%)
Attitudes towards Indigenous Australians. - Universities make it too easy for Indigenous Australians to get accepted to undertake degrees	
Mean (SD)	2.68 (1.40)
Median [Min, Max]	3.00 [1.00, 6.00]
Missing	6 (2.8%)
Attitudes towards Indigenous Australians. - I don't like Indigenous Australians	
Mean (SD)	1.13 (0.483)

CAIK follow-up survey results 2021	**Overall (N=54)**
Attitudes towards Indigenous Australians. - Discrimination against Indigenous Australians is still a major problem	
Mean (SD)	5.54 (0.808)
Median [Min, Max]	6.00 [3.00, 6.00]
Missing	8 (14.8%)
Attitudes towards Indigenous Australians. - Universities make it too easy for Indigenous Australians to get accepted to undertake degrees	
Mean (SD)	1.98 (1.20)
Median [Min, Max]	2.00 [1.00, 6.00]
Missing	8 (14.8%)
Attitudes towards Indigenous Australians. - I don't like Indigenous Australians	
Mean (SD)	1.07 (0.327)
Median [Min, Max]	1.00 [1.00, 3.00]
Missing	8 (14.8%)

Median [Min, Max]	1.00 [1.00, 4.00]
Missing	1 (0.5%)
Attitudes towards Indigenous Australians. - I wouldn't like any member of my family to marry an Indigenous Australian	
Mean (SD)	1.53 (1.14)
Median [Min, Max]	1.00 [1.00, 6.00]
Missing	3 (1.4%)
Attitudes towards Indigenous Australians. - Indigenous Australians get a lot more money to study when compared to non-Indigenous Australians	
Mean (SD)	2.90 (1.35)
Median [Min, Max]	3.00 [1.00, 6.00]
Attitudes towards Indigenous Australians. - I wouldn't like any member of my family to marry an Indigenous Australian	
Mean (SD)	1.24 (0.848)
Median [Min, Max]	1.00 [1.00, 6.00]
Missing	8 (14.8%)
Attitudes towards Indigenous Australians. - Indigenous Australians get a lot more money to study when compared to non-Indigenous Australians	
Mean (SD)	2.54 (1.43)
Median [Min, Max]	2.00 [1.00, 6.00]
Missing	8 (14.8%)
Attitudes towards Indigenous Australians. - On the whole, Indigenous Australians are a loud and noisy lot	
Mean (SD)	1.37 (0.741)

Missing	6 (2.8%)
Attitudes towards Indigenous Australians. - On the whole, Indigenous Australians are a loud and noisy lot	
Mean (SD)	1.61 (1.02)
Median [Min, Max]	1.00 [1.00, 5.00]
Missing	4 (1.9%)
Attitudes towards Indigenous Australians. - I would not like an Indigenous Australian to be my boss	
Mean (SD)	1.29 (0.820)
Median [Min, Max]	1.00 [1.00, 6.00]
Missing	4 (1.9%)
Median [Min, Max]	1.00 [1.00, 4.00]
Missing	8 (14.8%)
Attitudes towards Indigenous Australians. - I would not like an Indigenous Australian to be my boss	
Mean (SD)	1.02 (0.147)
Median [Min, Max]	1.00 [1.00, 2.00]
Missing	8 (14.8%)

Table 8.5: CAIK survey responses to section 5: Attitudes towards Indigenous Australians

DISCUSSION

The survey, conducted in 2020 and 2021, revealed minimal changes in attitudes over the year. Some respondents still held misconceptions, such as attributing Indigenous Australians' inequalities to their own choices or their refusal to move on from the past. However, there was evidence that Indigenous learning opportunities, such as that offered through the Bunya curricula, had some positive effects, such as a shift in attitudes towards university acceptance for Indigenous Australians. The results demonstrate the need for continued efforts to provide learning opportunities that challenge biases and promote self-awareness through authentic curriculum engaging Indigenous knowledges, expertise and experiences.

Despite initiatives such as cultural safety legislation, there is a gap in research focusing on changing the attitudes of individuals perpetrating racism, particularly within tertiary education (Fredericks et al., 2023). This study aimed to gauge the impact of education on students' perspectives, with a focus on accurately depicting Indigenous peoples and promoting discrimination-free collaboration. Understanding shifts in student attitudes and evaluating the project's efficacy in fostering inclusive environments in both educational and workplace settings are vital considerations (Bodkin-Andrews et al., 2019).

The research was conducted amid global shifts highlighting the entrenched racism experienced by people of colour, such as the resurgence of the Black Lives Matter Movement due to the murder of George Floyd, a direct result of racist attitudes, and behaviours within the workplace (Bowman Williams et al., 2021). Addressing attitudes, and approaches in professional practice and explicitly confronting racism are essential steps to creating inclusive and supportive learning environments where all students can thrive. As mentioned in Chapter 2, the Universities ACCORD interim report emphasises the importance of fostering culturally inclusive environments for the benefit of all stakeholders (O'Kane, 2023). Among the five priority areas outlined in the interim report, priority action 3 stands out. The commitment to ensuring that all First Nations students have access to funded university places, including metropolitan students, is a commendable step toward reducing barriers to tertiary education. However, simply increasing the number of supported places is insufficient if the educational environment remains culturally unsafe. Despite the positive initiatives of the Accord, if even a minority of students hold racist attitudes toward Indigenous Australians, as reflected in the survey responses, such as the misconception about Indigenous funding for education, Indigenous students will continue to face challenges in tertiary education settings (Fredericks et al., 2023).

LIMITATIONS

The shift from in-person to online survey methods posed significant challenges for the quantitative data collection process. While the initial survey yielded responses from over 200 participants, the transition to online administration led to a decreased response rate, with just over 50 respondents. This decline

highlights the pandemic's impact on maintaining the reach and integrity of research efforts. Another obstacle stemmed from the potential bias resulting from the relatively low participation rate of students in the follow-up survey, necessitating careful consideration when generalising findings to all students (Fitzpatrick et al., 2019).

Curriculum delivery also affected the Bunya Project, as academic staff had to quickly design courses for online delivery. The project was perceived as an additional burden by both staff and students, especially amid the institution's transition between learning platforms. Academic staff faced the challenge of redesigning course materials on an unfamiliar system while adapting to online teaching tools like Zoom. Although the project aimed to integrate teaching resources into subject materials, extensive disruptions caused by COVID-19 made it unclear if and how these resources were utilised, or if any impact on students could be attributed to the project amidst numerous educational changes during this period (McGaughey et al., 2022).

CONCLUSION

While the persistence of misconceptions regarding Indigenous Australians is concerning, initiatives like the Bunya Project offer hope for positive change. Continued efforts to provide authentic Indigenous learning opportunities and address biases are essential for creating inclusive educational environments and combating racism in all its forms.

Challenges persist in evaluating the translation of these educational efforts into workplace attitudes and ensuring their sustained effectiveness. While progress has been made in addressing racism through education, ongoing research, evaluation, and broader implementation of culturally safe educational initiatives are required to eliminate racism in healthcare and uphold principles of self-determination. A notable gap in current research lies in understanding and addressing the attitudes of individuals perpetrating racism, particularly within tertiary education. While legislative measures like cultural safety laws have been introduced, there remains a lack of comprehensive studies evaluating their efficacy in fostering inclusive environments. Future evaluations should consider incorporating qualitative methodologies to provide deeper insights into the complexities of attitudes and behaviours, especially in the context of ongoing global discussions around systemic racism.

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8.3 Chapter conclusion

The quantitative data presented in this chapter offers valuable insights into respondents' understanding of and attitudes towards Indigenous issues and applied Indigenous learning across five distinct sections.

Each section explores various dimensions, including colonial knowledge, reflectivity, Indigenous voices, Indigenous ways and Indigenous engagement, drawing upon factors such as critical cultural representations, future Indigenous engagement and respect for Indigenous diversity and perspectives.

This study faced challenges in conclusively measuring the impact of the Bunya Project resource due to several variables introduced during the research period. These variables included the COVID-19 pandemic, the transition to online learning, changes in the learning management system and a notable decrease in response rates between surveys. Despite these challenges, the gathered and analysed data shed light on the significance of addressing and challenging stereotypes about Indigenous peoples.

Two Bunya Trees with two River Red Gum Trees in Mudgee by the Cudgegong [photograph], by Megan Williams, (2024)

Chapter 9 – Discussion and Conclusion

Preface

The Bunya Pine, thriving amid a diverse ecosystem of trees and plants, serves as a metaphor for Indigenous leadership and collaboration that guides all peoples to grow together in healthcare education. Just as the Bunya pine coexists harmoniously with other flora, Indigenous communities and healthcare practitioners can flourish, with Indigenous leadership providing the essential wisdom and guidance needed to navigate the complexities of healthcare education. Through studies like those presented in the thesis for the Bunya Project a holistic approach to healthcare education is possible, rooted in upholding human rights principles for Indigenous leadership and self-determination in healthcare and education. By embracing Indigenous ways of doing business and honouring Indigenous voices, the

Bunya Project establishes the stem for a future where healthcare education can grow inclusive and culturally safe, healthcare students and future healthcare leaders in 'proper ways of working' with Indigenous peoples.

9.1 Chapter overview

This chapter outlines the importance of leading Indigenous health curriculum development with Indigenous perspectives, knowledge, and voices in healthcare education, using Participatory Action Research (PAR) to advance cultural safety, call out racism and enhance health outcomes with Indigenous communities in Australia.

The key aims of this chapter are to:

1. Bring together all of the findings of the Bunya Project.
2. Discuss how Indigenous leadership in tertiary education can be used to improve the healthcare needs, experiences, knowledges and aspirations of Indigenous peoples.
3. Identify implications and opportunities for further research

Key findings of the Bunya Project that are explored in this chapter include:

1. Leadership in our community voices: The Bunya Project exemplifies the necessity of embedding Indigenous worldviews and values into healthcare education to address cultural determinants of health and support holistic healing practices.
2. Indigenous expertise ('blakspertise') in the university: Indigenous leadership in healthcare education is essential for ensuring that curricula align with Indigenous values, fostering cultural safety, and promoting community well-being.
3. Accountability: Current university curricula needs to adequately prepare graduates to provide culturally safe healthcare, minimising ongoing racism in healthcare settings that hinders Indigenous peoples' access to treatment.
4. Addressing Racism: Racism is identified as a significant barrier to improving healthcare outcomes for Indigenous peoples, emphasising the need for education to combat racism through cultural safety, critical self-reflection, and the amplification of Indigenous perspectives.
5. Cultural Safety: Enhancing cultural safety within healthcare is pivotal for improving quality and accessibility. Tertiary institutions must integrate Indigenous perspectives and facilitate critical self-reflection with healthcare students to foster cultural safety within their professional practice.

The limitations section acknowledges challenges faced by the Bunya Project, particularly due to the COVID-19 pandemic, and underscores the necessity for future research to validate the project's impact

and expand its reach to include diverse Indigenous communities. Additionally, it emphasises the more research is needed to better understand the dynamics in the transition from student learning to professional practice and the dynamics of community-university relationships in promoting Indigenous peoples, voices, knowledges, perspectives, experiences and practices within academia.

9.2 Discussion

A key strength this thesis draws on is that Aboriginal and Torres Strait Islander cultures are among the oldest surviving in the world, showcasing resilience and adaptability (Charles & O'Brien, 2020; Maclean et al., 2013). Before colonisation, Indigenous Australians enjoyed superior health to Europeans (Rasmussen et al., 2011; Sherwood, 2013). However, post colonisation a significant health gap emerged and persists, largely related to social determinants of health underpinned by racism in systems, structures, institutions and workforce, which emphasises the need for access to culturally safe healthcare (Australian Human Rights Commission, 2019). The failure to recognise and value Indigenous cultural knowledges, contributes to the widening gap in societal disparities in Australia (Rigney, 2023; Taylor & Habibis, 2020).

Indigenous peoples have tirelessly promoted their cultures as solutions to global challenges, serving as the inspiration for this thesis. However, Elders also call upon us to deepen our efforts – by strengthening our cultures, advocating for human rights, confronting racism, and guiding the next generation of knowledge holders. The oversight of Indigenous sovereignty in race theory highlights the imperative to acknowledge and uphold Indigenous governance (Williams & Marlin, 2022). Bunya embodies Indigenous sovereignty, promoting themes of equity and self-determination through an ethical, principled process guided by Indigenous peoples (Manton et al., 2023; Manton, Williams, & Hayen, 2024). This process integrates Indigenous knowledges across the research governance, design, and communication of the Bunya Project, emphasising the intersections between Indigenous and dominant Western academic knowledge systems in healthcare education (Bodkin-Andrews et al., 2022; Williams & Marlin, 2022). It offers valuable opportunities to learn, grow and flourish.

The Bunya Project outlined in this thesis has worked to incorporate Indigenous worldviews and values into healthcare curriculum, given culture underpins all knowledges and practices for health, wellbeing and healing (Manton & Ragg, 2023). Indigenous culture encompasses Indigenous values, principles, and interactions, serving as a determinant of wellness (Salmon et al., 2018). However, healthcare practitioners often overlook Indigenous peoples culture in treatment plans, processes and approaches (Manton & Ragg, 2023).

Indigenous peoples approaches to healthcare are holistic, emphasising the importance of addressing health needs alongside cultural, environmental and contextual factors. The 1989 National Aboriginal Health Strategy outlines the Aboriginal definition of health as the interconnectedness of physical, social,

emotional and cultural well-being, in supporting and achieving health outcomes that benefit the whole community (National Aboriginal Health Strategy Working Party, 1989).

As explored in the next sections of this thesis chapter, Indigenous peoples have clear structures within cultures that show us 'proper ways' to do business, including caregiving for wellbeing and following our rightful leaders and experts with accountability.

9.2.1 Leadership in our community voices

The Bunya project reinforced that Indigenous leadership in healthcare education is paramount (Bearskin, 2023; Biles et al, 2024), entailing the importance of Indigenous academics overseeing the curriculum and co-designing content with community members to ensure alignment with Indigenous values, experiences and healthcare aspirations (Kennedy et al., 2022; Manton et al., 2023). Indigenous peoples in Australia seek broader change and recognition from all Australians, and education serves as a vital conduit to bring all Australians on a learning journey in which community determines the knowledge and narrative as well as how it is shared (Manton, 2023b).

Ample guidelines and frameworks are available emphasising wise practices for education, standards and partnership. These are crucial for facilitating collaborative work between academics, researchers and practitioners (NHMRC, 2018; Paul et al., 2010). Given the ready availability of these resources but the limited availability of workplace cultural capability training, academics are encouraged to take responsibility for their own learning journey to 'prepare the soil' before they start (Manton et al., 2023). This was reflected in the findings, where the 'participants conveyed that there is immense expertise and experience that mainstream health services could learn from Aboriginal peoples not only about cultural knowledge, but about flexible and multi-faceted ways to make healthcare accessible' (Manton, Williams, & Hayen, 2024).

Upholding existing ethical principles guides academics in how to work alongside communities, utilising Indigenous knowledges and solutions that are beneficial to healthcare education (AIATSIS, 2020; NHMRC, 2018). As the Bunya Project found, Indigenous community members have invaluable knowledge and expertise integral to healthcare education. To meet Universities Australia's strategy, and individual institutions' goals, it is imperative to create space in tertiary education for Indigenous leadership; the Bunya Project demonstrates how this is possible (Manton & Williams, 2021). The Bunya Project emphasises the importance of Indigenous leadership and collaboration to bridge the gap between Indigenous and Western knowledge systems, outlining skills and approaches to enhance education and professional practice through the Bunya andragogical framework (Manton, Fitzpatrick, et al., 2024).

Indigenous peoples and Elders persistently advocate for the integration of Indigenous practices, knowledge and voices to benefit Indigenous communities (Ullrich et al., 2022; Woodward et al., 2020).

Recognising, honouring, and valuing Indigenous leadership, expertise and contextual understanding are essential (Kennedy et al., 2022) for enhancing policies, practices and approaches to achieve better health outcomes for Indigenous peoples, and these will benefit all peoples (Pandey et al., 2023; Stajic, 2020). Community engagement is also an ethical principle that can guide decision-making (West et al., 2017; Biles et al., 2024) and is imperative to upholding principles of self-determination (Carroll et al., 2015; Dreher et al., 2018; Dreise et al., 2021; McCausland et al., 2021). In shaping future health education and professional care strategies, space must be made for Indigenous voices to carry the wisdom of families and communities across generations (Geia et al., 2020; Geia et al., 2013). The Bunya Project demonstrated how to gather stories in Indigenous communities. This creating of and holding space for communities' to assert self-determination influences informed discourse regarding Indigenous experiences in healthcare both positive and negative, as well as challenging assumptions and stereotypes, creating a culturally safe and responsive healthcare system for all Australians (Crooks et al., 2020).

9.2.2 Blakspertise in the university

'Blakspertise' is a word created to express Indigenous expertise. The word 'blak' was originated in 1994 by Aboriginal artist Destiny Deacon to reclaim the colonist language (Munro, 2020).

In tertiary education, there is a push to embed Indigenous cultural capabilities into curricula (Department of Health, 2021a; Universities Australia, 2022), but challenges exist due to academic staff reluctance and lack of expertise (Manton & Williams, 2021; Norman, 2014). The Bunya Project addressed these challenges by developing strong reciprocal relationships with Aboriginal communities, evaluating curriculum effectiveness, and providing ongoing support for academic staff, recognising that effective embedding of Indigenous perspectives requires ongoing commitment, as one-off lectures or workshops are insufficient (Manton et al., 2023; Manton, Williams, & Hayen, 2024).

Indigenous leadership in tertiary education organically generates inclusive and respectful learning environments in which students can feel valued regardless of cultural background, fostering engagement and academic success (Bin-Sallik, 2003; Hall & Wilkes, 2015). It bridges the gap between classrooms and real-world settings, preparing students for diverse workplaces and societal contributions. Inviting Indigenous peoples into university teaching and learning involves policies, practices and curricula prioritising and valuing Indigenous peoples as educators and leaders (Milne et al., 2016). This collaborative approach aligns with the United Nations Declaration on the Rights of Indigenous Peoples, affirming communities' expertise and right to address their social, cultural and economic needs (UN General Assembly, 2007). Self-determination in both education and healthcare is further reinforced by Australian national and state government frameworks recognising Indigenous Peoples' inherent right to determine their healthcare (Dudgeon et al., 2017; Freeman et al., 2022).

The Bunya Project emphasised the importance of lived experience, critical self-reflection, reciprocity and working collectively. It acknowledges the complexity of the lived experience of Indigenous peoples in Australia and its impact on individuals, families and communities, serving as a valuable teaching tool for authentic and relevant education (Manton, 2023b; Manton et al., 2023). Through critical self-reflection, the project establishes guiding principles aligned with Indigenous cultural expectations, promoting best practices in community engagement and lived experience and Blakspertise.

To facilitate Blakspertise, reciprocity was central to the Bunya Project, and is expected of research teams including actively and continuously engaging with Indigenous community organisations and fostering mutual outcomes and impact for the project to achieve (NHMRC, 2018; Biles et al., 2024). The Bunya Project's contributions to communities included developing partnerships providing authentic learning and assessment opportunities for students whilst developing high-quality resources for organisations that they otherwise would not have the opportunity to develop ie health promotion materials. The relationships and access to university staff and resources have also been of benefit to the Aboriginal Community Controlled Organisations (ACCHOs). Under the leadership of the ACCHOs, these relationships have assisted in hosting events, evaluations, grant applications and publications, increasing the evidence base of the organisation on their terms as well as research milestones for the academic staff.

Additionally, the Bunya Project emphasised collective work, with representatives from various health disciplines contributing expertise to inform questions and understand the disconnect or connection between participants' experience and best practice within the field, in some cases raising the expectations of best practice. This helped ensure academic rigour and alignment with Indigenous knowledge and cultural protocols (Williams et al., 2023b). Overall, the Bunya Project serves as a model for collaborative partnerships with Indigenous communities and the academy highlighting the importance of integrating diverse Indigenous knowledges, Blakspertise, lived experience and voices with authenticity and humility in university education (Cerna et al., 2021; Manton, Williams, & Hayen, 2024; McCausland et al., 2021).

9.2.3 Accountability

Accreditation is the key measure of accountability for tertiary healthcare curricula (Weber et al., 2021) yet Indigenous Australians remain on the outskirts of the accreditation processes of many health professions. While most healthcare curricula have integrated cultural capabilities (Department of Health, 2021a; Wilson et al., 2020) within their requirement benchmarks and professional standards, there remains a disconnect between the directive and the action. An even wider gaps pertains to measurement and accountability. While the Bunya Project found this is possible, by working with community and implementing a tailored andragogical framework, key questions remain.

The questions for future research to answer, and for tertiary institutions and Universities Australia to answer, include:

- How much is enough to achieve the standard? Or academic qualification threshold?
- What does this look like?
- What are the professional development requirements and opportunities for academic staff to teach to these standards?

While these questions remain ambiguous from a measurement, accreditation and industry-standard perspective, the Bunya Project has provided academic staff with a starting point. Bunya Project findings shaping *Preparing the soil* in Chapter 5 (Manton et al., 2023) outline a process for community engagement, while *planting the seed* provides a process for curating and creating resources to implement into teaching and learning. Resources need to be used as uniformly as possible across diverse health curricula help set up necessary conditions for evaluation and accountability – a type of 'baseline' against which student assessment can be developed and vertical and horizontal alignment of curriculum that is assessable. Chapter 7 builds further on this providing academic staff with the Bunya andragogy, outlining practical adult teaching and learning strategies that are essential for assessable quality curricula.

Also related to accountability are the actions and critical self-reflection of individual teaching staff. The Bunya Project draws on transformational learning theory and practice to emphasise critical self-reflection, hands-on experience and mentor feedback as integral components of andragogy, curriculum and evaluation (Fitzpatrick et al., 2019). In Australian Indigenous health education, immersive, transformational opportunities are lacking, particularly in ways that support students in becoming culturally safe healthcare providers and improving service accessibility (Fitzpatrick, 2023). Urgent efforts are needed to provide these immersion opportunities and evaluate them for accountability to Universities Australia, industry accreditation and tertiary institutions' goals. This extends to institutions operating accountably by ensuring that staff and students receive support to develop knowledge and skills in real-world contexts that align with community needs and priorities (Fitzpatrick, 2023).

9.2.4 Racism

Throughout the Bunya Project, racial discrimination emerged as a recurring issue, recognised as a significant determinant in healthcare outcomes for Aboriginal and Torres Strait Islander peoples. Racism was described as influencing access to information, treatment, follow-up care and treatment adherence (Manton, Williams, & Hayen, 2024). In combating racism in healthcare, education plays a pivotal role; the implementation of comprehensive, practical and purposeful education is required for healthcare professionals, to eliminate racism from healthcare practice, including by promoting

principles of cultural safety and strategies for critical self-reflection (Parter et al., 2021; Thomas & Booth-McCoy, 2020; Vora et al., 2021).

The Bunya Project found that the curriculum on anti-racism, and skills of teaching staff and students was lacking (Manton, Williams, & Hayen, 2024). It found much more action is required by tertiary institutions, with leadership by Universities Australia. The findings from the Bunya Project provide a structure to start, for academics to lead within their own sphere of influence while advocating systemic and structural change (Manton, Fitzpatrick, et al., 2024).

Globally, racism is acknowledged as a social determinant of health (Johnson, 2020), existing within an ecosystem of oppressive structures perpetuated by the actions and inactions of individuals within the system (Paradies, 2018; Phillips & Schrempf-Stirling, 2022). The recent referendum in Australia has brought to light the racism deeply ingrained in Australian society (Anderson et al., 2023; I. Anderson et al., 2023; Foley, 2023; McKenna, 2022). Aboriginal and Torres Strait Islander peoples report an increasing prevalence of experiencing racism (Reconciliation Australia, 2020), directly impacting their decisions regarding healthcare access (Gatwiri et al., 2021; Parter et al., 2021). Added to this Indigenous Australians frequently report experiencing racism in their daily lives, predominantly within the healthcare system (Godlee, 2020).

In the latest report by the Call It Out register of racism against Aboriginal and Torres Strait Islander people, health services employees were more frequently identified as perpetrators. (Allison et al., 2023, p. 51). Racism constitutes a pandemic in Australia, necessitating leadership in implementing anti-racism strategies across all systems, including education and healthcare. These strategies must challenge existing systems (Allison & Cunneen, 2022; Allison et al., 2023; Bodkin-Andrews & Carlson, 2016; Tan, 2023). Reducing experiences of racism could significantly impact healthcare outcomes for Aboriginal and Torres Strait Islander peoples (Parter et al., 2021; Tan, 2023; Vora et al., 2021). However, where do we begin? It has long been acknowledged that universities are well-positioned to effect change by graduating students with a robust understanding of Indigenous Australia grounded in principles of self-determination, cultural rights through transformative learning and change agency (Fitzpatrick, 2023; Freeman et al., 2022).

Drawing on principles, practices and processes outlined in the Bunya Project, universities can mitigate the impact of institutional racism by incorporating Indigenous leadership, voices, and perspectives across all facets of their educational offerings (Manton et al., 2023; Murray & Campton, 2023). This entails university governance and accountability systems that prioritise participation by Indigenous peoples in decisions affecting them and their communities. Indigenous-led solutions, enhance students' conceptualisations of health and healthcare through engagement with alternative knowledge systems and worldviews (Manton & Williams, 2021; Manton, Williams, & Hayen, 2024). Essential to this endeavour is supporting students in developing critical self-reflection skills to prepare them for

contributing to the conditions for cultural safety (Ahpra, 2020). Critical reflection is a powerful tool for driving continuous improvement, promoting self-awareness and enhancing the quality of care and education provided in healthcare and educational settings.

9.2.5 Mainstream workforce and racism

As the Bunya Project shows, current university curricula are likely to fail to adequately prepare graduates to address urgent health system and workforce changes needed to improve outcomes for Indigenous peoples (Manton & Williams, 2021; Williams et al., 2023a; Williams et al., 2020). This is a widespread issue globally (Anderson et al., 2016). While the incorporation of Indigenous perspectives into mainstream university curricula has been discussed in Australia for over two decades (Bodkin-Andrews et al., 2019; Universities Australia, 2023), as mentioned above tangible structures supporting this initiative have only recently emerged in some universities (Anderson et al., 2023). Despite statements of intent from peak bodies such as Universities Australia, these initiatives remain largely unevaluated and out of touch (Bodkin-Andrews et al., 2023; O'Kane, 2024; Universities Australia, 2023). Nevertheless, most Australian universities have committed to integrating Indigenous perspectives into their curriculum and are actively seeking Indigenous leadership (Bodkin-Andrews et al., 2023; Woodward et al., 2020). The Bunya Project sought to ask and answer, 'How to do this?'.

The workplace has been identified as a prominent location for experiences of racism. Given universities' role in preparing students for professional careers, they must educate students on racial discrimination laws and equip them with strategies for working safely with Indigenous colleagues and stakeholders (*Health Practitioner Regulation National Law 2009* (NSW)).

Racism also persists in the way health professionals are educated (Ahuriri-Driscoll et al., 2021). Without addressing racism in teaching, learning, and assessment, universities will remain complicit in perpetuating racism (Manton et al., 2023).

Reconciliation Australia's annual barometer highlights the lack of insight and self-awareness in the mainstream Australian population (Reconciliation Australia, 2020). The survey found that most Australians have limited interaction with Indigenous peoples, with only a quarter expressing high or fairly high levels of trust in Indigenous peoples. This has ramifications for Indigenous peoples as colleagues, healthcare providers and as patients (Reconciliation Australia, 2020; Rowse, 2021). This concept is compounded by the absence of Indigenous visibility in education and is often reinforced by health curricula content centring on deficit data highlighting inequities experienced by Indigenous Australians across various life domains compared to the broader population, which predominantly reinforces negative stereotypes and assumptions without focusing on strengths or protective factors such as culture, family and local contextual health perspectives (Abubakar et al., 2022; Kairuz et al., 2021; Paradies et al., 2008).

As the Bunya Project found, while we are preparing students to graduate as culturally safe healthcare practitioners the reality is they may be entering a workforce with an unsafe discriminatory culture, as demonstrated on the findings based on participants' experiences (Manton, Williams, & Hayen, 2024). Therefore, education must serve as a catalyst for change in addressing racism in the workforce by equipping individuals with the knowledge, skills and mindset needed to challenge prejudice, promote inclusivity and foster cultural safety for staff, patients, and stakeholders (Fitzpatrick et al., 2019). From an adult learning perspective, universities can commit to graduating students equipped with lifelong learning skills, knowledge, and an awareness of unchecked biases and assumptions within their disciplines (Fitzpatrick, 2023; Williams et al., 2023b). They can also provide experiential learning opportunities aimed at helping students articulate their positionality and apply new skills in collaborating effectively with Aboriginal and Torres Strait Islander community members (Meyer et al., 2011; Vora et al., 2021).

The integration of Indigenous voices and knowledge into healthcare education, as promoted by the Bunya Project, benefits the health workforce by fostering authenticity, relevance and cultural safety in healthcare practice (Corporal et al., 2020; Schultz, 2020). This integration emphasises the holistic nature of Indigenous health, aligning with overall principles of quality healthcare (Eades et al., in press). By recognising Indigenous knowledges, practices and experiences as valuable, future health professionals are empowered to engage effectively with Indigenous communities, advocating for Indigenous health rights and promoting self-determined models of healthcare (Kennedy et al., 2022; McCausland et al., 2021). Furthermore, collaboration between universities and ACCHOs is crucial for improving health curriculum and fostering reciprocal partnerships, ultimately contributing to intergenerational change and the realisation of human rights in healthcare practice (Manton, 2023a; Manton, Williams, & Hayen, 2024). Additionally, the Bunya andragogy provides evidence-based guidance for curriculum design, teaching, learning, and assessment, ensuring integrity in healthcare education and upskilling both teaching academics and the future health workforce to meet the needs of diverse populations (Manton et al., 2023).

9.2.6 Cultural safety

To enhance healthcare quality, accessibility, and mitigate racism, cultural safety has emerged as a central focus within the Australian healthcare system (AHMAC, 2016; Department of Health, 2021a, 2021b). There persists historical confusion surrounding the concept of cultural safety and its practical application (Lock et al., 2021; Manton & Williams, 2021). As defined by Aphra and National Boards, culturally safe practice entails 'the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours, and power differentials in delivering safe, accessible, and responsive healthcare free of racism' (Ahpra, 2020, p. 9). The Bunya Project quantitative data found some respondents maintained incorrect knowledge, which influenced their attitudes and beliefs. Culturally

safe practice can be unsettling for educators, practitioners and students as it prompts organisations and individuals to reflect on power dynamics. This signifies that health professionals and educators must possess the knowledge and skills to introspectively analyse themselves and the potential impacts of their own cultures – both personal and professional – on their interactions with Indigenous peoples (NSQHS, 2017, 2022). Crucially, cultural safety can only be gauged by the individual receiving care or education, not by the provider (Ahpra, 2020), again highlighting the need for careful consideration in assessing and measuring these skills.

The amendment to Australian national law regarding access to healthcare that is free of racism signifies a shift in accountability towards fostering a culturally safe and respectful health workforce, representing a significant step forward. This legislative change also serves as a significant driver in holding universities, accrediting bodies, and workplaces accountable for adequately preparing students to be culturally safe practitioners (Brumpton et al., 2023). These recent reforms have prompted tertiary external accreditation bodies for Ahpra-registered professions to enhance and assure their standards, ensuring education facilities prepare graduates to be culturally safe practitioners (Australian Pharmacy Council; Australian Physiotherapy Council, 2021; Blouin & Tekian, 2018; Speech Pathology Australia, 2018).

Consequently, tertiary institutions must maintain accreditation by providing curricula that afford students learning opportunities to understand and develop the knowledge and skills required for cultural safety, with evidence of student achievement (ABSTARR Consulting, n.d.). The Bunya Project came to clearly understand how university academics, particularly those with limited formal training in Indigenous health or cultural safety, face mounting pressure to increase their knowledge and skills to contribute effectively to teaching and learning design, and delivery of culturally safe experiences for students (Bin-Sallik, 2003; Brumpton et al., 2023; Dawson et al., 2022; Power Wiradjuri et al., 2021; Wong et al., 2021).

However, despite these efforts, the Bunya Project found there remains a lack of strategies to support staff in teaching content about other cultures, the ongoing impact of colonisation or the acknowledgment and celebration of Indigenous leadership, expertise, and approaches (Manton, 2023b; Manton & Williams, 2021; Manton, Williams, & Hayen, 2024). This shift highlights the need for universities to ensure students are adequately prepared to be culturally safe practitioners. Initiatives like the Aboriginal and Torres Strait Islander Health Curriculum Framework and Indigenous-specific frameworks aim to enhance cultural capabilities within healthcare education and practice (AHMAC, 2016; Department of Education, 2013; Cerna et al., 2021; Chandanabhumma & Narasimhan, 2020; IAHA, 2019; Martin & Mirraboopa, 2003; Mbaki et al., 2021; NATSIHWA, 2013; Page et al., 2019). These frameworks guide improving professional skills, fostering culturally safe healthcare environments, and promoting respectful care for Indigenous peoples. Several questions remain – do

these frameworks contain the correct information, reflective of community aspirations for healthcare and guidance for implementation as demonstrated in the Bunya protocol and Bunya andragogical framework? How will we know progress is being made as the statistics do not demonstrate change?

Additionally, there is insufficient recognition of the educator's significant influence or their responsibility to identify and transparently address their positionality through critical self-reflection (Attree et al., 2024; Fitzpatrick et al., 2019; Manton & Williams, 2021). Overall, these efforts reflect a collective commitment to collaborative approaches for improving healthcare outcomes and promoting cultural safety in Australia's healthcare landscape.

9.3 Limitations and opportunities

The COVID-19 pandemic has significantly influenced the trajectory and execution of the Bunya Project, altering fundamental aspects of its research methodology and participant engagement strategies. The qualitative component of the study was initially designed to include face-to-face interviews with representatives from six organisations and a total of 36 participants; however, the project faced unavoidable changes due to pandemic-related restrictions. Consequently, the research team encountered delays caused by waiting times related to amending ethical approvals to transition interviews to an online format which impacted the overall project timeline. Ultimately, the project was conducted with four organisations and 24 participants, resulting in fewer Aboriginal and Torres Strait Islander interviewees than planned, although data saturation was achieved within the reduced number.

Furthermore, the quantitative data collection process experienced a substantial impact due to the shift from in-person to online survey collection methods. The initial survey collected responses from over 200 participants, while the transition to online administration resulted in a decreased response rate, with just over 50 respondents. This reduction in participant engagement highlights the challenges posed by the pandemic in maintaining the integrity and reach of research initiatives.

Lockdown measures heightened community caution, increased cultural load and participants being overstretched amidst the pandemic further exacerbated the project's challenges and reliance on investing time in relationships with participant organisations and community members. Despite efforts to adapt events to web-based platforms, cancellations, competing priorities and hesitancy to engage persisted, impeding the project's ability to fully capture the intended breadth of perspectives and experiences.

Amid these challenges, the Bunya Project also recognised this as an opportunity to highlight Indigenous excellence in response to the pandemic. Indigenous communities showcased exemplary adaptability in embracing web-based connectivity and demonstrated resilience in navigating public health messaging and responses. Despite the limitations imposed by COVID-19, the project highlights the importance of

acknowledging and amplifying Indigenous voices and experiences, particularly in the context of global crises.

Additionally, the project acknowledges its initial limitations in reflecting the diversity of Aboriginal peoples and Indigenous communities globally. The concentration of the project within one university and six communities fails to capture the full spectrum of Indigenous identities and experiences. Moving forward, the project's strategies, published papers and andragogy are useful for others to apply in their communities.

In summary, the Bunya Project experienced significant disruptions and adaptations in response to the COVID-19 pandemic, necessitating adjustments in methodology, participant engagement, and project scope. While challenges persisted, the project also seized opportunities to spotlight Indigenous resilience and excellence amidst adversity, highlighting the importance of relationships with communities, students and teaching staff in adaptive and inclusive research practices.

9.4 Future research

The Bunya Project has demonstrated the importance of working collaboratively to develop impactful and safe student learning, growth, professional cultural capability development and evaluation within tertiary settings. Further work is needed to design and validate an assessment tool that captures the nuanced shifts in perspectives and behaviours resulting from participation in the Bunya Project. This tool should not only quantify changes in attitudes towards Indigenous issues but also evaluate their practical application within professional contexts. By highlighting the link between student learning and workforce integration, researchers can provide valuable insights into the project's long-term impact and effectiveness in preparing students for ethical and culturally sensitive engagement in their careers.

Additionally, the Bunya Project acknowledges its initial limitations in reflecting the diversity of Aboriginal peoples and Indigenous communities globally. While the project has made strides within one university and four NSW-based communities, there is a pressing need to expand its scope and inclusivity to ensure comprehensive representation. Moving forward, efforts to broaden engagement with diverse Indigenous communities are essential for enriching the project's findings and fostering greater representation of the cultural diversity, by developing partnerships with a wider array of Indigenous peoples nationally and internationally.

The Bunya Project recognises the importance and inherent value of Indigenous peoples' knowledges within the academic sphere. Central to the project's mission is the cultivation of reciprocal, safe, and empowering relationships with Indigenous communities, ensuring that voices, knowledges, experiences and practices are not only heard but also valued within university settings. Further research is essential to delve deeper into the impact of creating such relationships with Indigenous peoples' influences on their perceptions of engagement with university education. By holding space for Indigenous voices,

perspectives, experiences and practices, the university can foster an environment in which Indigenous communities feel respected, empowered and motivated to participate in higher education. Exploring the dynamics of the relationship between Indigenous communities and the university within the Bunya Project context is critical. Further research could be conducted to understand how the university's engagement with Indigenous knowledges, voices, perspectives, experiences and practices influence factors such as enrolment rates, academic success among Aboriginal and Torres Strait Islander students, and increased representation within the university workforce, which is vital for fostering stronger partnerships and promoting Indigenous inclusion within academia.

Future research within the Bunya Project must focus on understanding the transition from student learning to professional practice, expanding inclusivity, and exploring the dynamics of community–university relationships. By addressing these areas of inquiry, the project can continue to advance knowledge, promote cultural capabilities, and contribute to the empowerment and success of Indigenous communities within academic and professional spheres.

9.5 Research Translation

Research from the Bunya Project was translated into a range of knowledges throughout the process and with a range of impacts. The Bunya Project highlighted to the university that Indigenous leadership in healthcare education is crucial. The Bunya Project demonstrated an opportunity for Indigenous leadership and oversight over the curriculum ensuring excellence in Indigenous teaching and learning while improving accountability in meeting the legislative requirements and accreditation standards. This provided evidence for the creation of a new position within the University a *Director of Indigenous Healthcare Education.* The aim of the position is to facilitate curriculum to be co-designed with Indigenous academics, discipline experts and stakeholders to ensure what is taught aligns with internal and external accreditation requirements. This position requires an Indigenous academic with specific expertise in teaching and learning, curriculum design and constructive alignment, accreditation standards and legislative requirements as well as community networks with the Indigenous health academic community, Aboriginal community-controlled health organisations and the Indigenous community (Manton et al., 2023).

9.5.1 Impact

The work of the Bunya Project has seamlessly integrated into the authors' professional practice through the embedding of the University Indigenous Graduate Attributes into teaching and learning Other translation activities I undertook included leading systematic reviews and providing recommendations to course-level learning outcomes, showcasing the ability to translate the Bunya research findings into actionable improvements, and transforming theoretical frameworks into practical curriculum applications with significant impact. The Bunya Project has also provided the evidence and platform to

mentor other university staff to embed Indigenous professional capabilities and lead innovative, industry relevant, collaborative teaching approaches, which further highlighted how applying this Bunya research can enhance educational practices. This work has been formally recognised with the 2023 UTS Vice-Chancellor Learning and Teaching Academic Support Award, reflecting the success in translating research into meaningful educational advancements.

9.6 Summary

The Bunya Project began with Indigenous community engagement, centred on critical self-reflection to establish genuine partnerships for developing a new Indigenous health curriculum, symbolically described as 'preparing the soil' to nurture future generations' knowledge and skills in healthcare. Through Participatory Action Research, the project highlighted the expertise within Indigenous communities and emphasised the importance of relationships and partnerships in accessing this expertise, advocating for practical aspects like time allocation, collaborative research design, and reflective practices. The research highlights the significance of establishing safe relationships based on communication and respect, particularly crucial for addressing power dynamics and ensuring cultural safety in healthcare. Moreover, the Bunya Project stressed the importance for educators to equip future health professionals, evaluating the extent to which they exit universities with practical skills to promote human rights, including creating as safe, accessible healthcare environment, active listening and empowering Indigenous self-determination in healthcare solutions that relate to them.

9.7 Chapter conclusion

The Bunya Project, a collaborative partnership between Indigenous communities and academia, advocates for integrating diverse Indigenous knowledges and voices to advance cultural safety, combat racism and enhance healthcare outcomes for Indigenous peoples in Australia.

Through the Bunya Project, this concluding chapter has highlighted the necessity of embedding Indigenous worldviews and values into healthcare education, emphasising cultural determinants of wellness, health and holistic healing practices. Indigenous leadership within university healthcare education is crucial for aligning curricula with Indigenous values, promoting cultural safety and enhancing community well-being.

Tertiary institutions can play a vital role in advancing cultural safety within healthcare by ensuring Indigenous leadership, knowledges, experiences and perspectives are included in the curriculum, with appropriate accountability mechanisms and governance structures. Education is a key strategy to address ongoing racism in healthcare settings and develop a culturally safe healthcare workforce. Recognising racism as a significant barrier to improving healthcare outcomes for Indigenous peoples,

education initiatives must prioritise combating racism through cultural safety principles, critical self-reflection and amplification of Indigenous perspectives.

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Appendix A. Qualitative Interview Question Bank

Previous experience
• Have you or someone you know have experience accessing healthcare including any of the following:
  ▪ Physio
  ▪ Psychologist
  ▪ Pharmacist
  ▪ Genetic Counsellor
  ▪ Speech Pathologist
  ▪ Orthoptist
• Why? Or why not?
	Locating yourself
	• Where is your mob from?
	• How would you introduce yourself?
	• How do you think a health professional should introduce himself or herself to make you feel safe and valued?
		Culture
		• What is the influence of culture on your health? And how you get better?
		• What is the influence of family on your health? And how you get better?
		• What is the influence of your culture, spirituality on your health? And how you get better?
		• How do you think healthcare professionals could work better with this?

Motivations • What keeps you healthy? What do you need to be healthy? • What are your biggest motivations to access health care? • What was the best experience you had with a health professional? What made it the best? • Is there something that always happens when you see a healthcare professional that you wish you could change?	**Limitations** • What are your biggest concerns to access health care? • What are the barriers or limitations? • What makes you trust a health professional? • How do you feel about it when they are asking questions and talking about family history or other things that influence your health? • What about if someone has to give bad news is there a way you think they should approach it?	**The future** • Imagine you are specking to future healthcare professionals what advice would you give them to work well with Aboriginal clients? • What are your aspirations for the future of healthcare, to benefit Aboriginal and Torres Strait Islander peoples involving contributions from all healthcare professionals?

Appendix B. Quantitative sample survey

BUNYA PROJECT Stage 3:

Evaluation of Indigenous Graduate Attribute

SECTION 1: Background Information

1. Please indicate your age.	_____
2. Please indicate your gender.	_____
3. Please indicate the post code of where you live	_____
4. Where were you born?	☐ Australia ☐ Other (please list) _____
5. Please list what you feel is your cultural identity (e.g., Australian, Chinese, Indian Australian)	_____
6. Are you an Aboriginal and/or Torres Strait Islander person?	1☐ Aboriginal 2☐ Torres Strait Islander 3☐ Both Aboriginal & Torres Strait Islander 4☐ None of the above
7. If you are Aboriginal and/or Torres Strait Islander, please write which Nation(s), Language group(s), and/or Clans do you identify with (e.g., D'harawal, Eora, Wiradjuri, Gadigal).	_____
8. What is the highest form of education have previously completed?	☐ Did not finish High School ☐ High School ☐ TAFE ☐ University ☐ Other (please list): _____
9. What year of study are you currently in at UTS.	☐ First Year ☐ Second Year ☐ Third Year ☐ Fourth Year/Honours ☐ Post-graduate ☐ Other (please list): _____
10. What university degree are you currently enrolled in?	_____
11. What faculty are most of your studies located in?	_____
12. Are you an international student?	☐ Yes ☐ No

8. Please tick which sentence best describe your personal money situation?	☐ I run out of money before payday ☐ I am spending more money than I get ☐ I have just enough money to get me through to the next pay day ☐ There's some money left over each week but I just spend it ☐ I can save a bit every now and then ☐ I can save a lot

SECTION 2: Knowledge and Beliefs

The following section is designed to measure assess your beliefs and knowledge about Indigenous Australian peoples and communities. Please circle the answer you feel is most appropriate

	Completely False	Mostly False	More False Than True	More True Than False	Mostly True	Completely True
On average, when compared to non-Indigenous Australians, Indigenous Australians:						
- have a lower life expectancy.	1	2	3	4	5	6
- have lower educational outcomes.	1	2	3	4	5	6
- have more stressful life-events.	1	2	3	4	5	6
- have higher incarceration rates.	1	2	3	4	5	6
- are less likely to own a home.	1	2	3	4	5	6
Most of the inequalities suffered by Indigenous Australians:						
- exist because of their own choices.	1	2	3	4	5	6
- exist because they refuse to move on from the past.	1	2	3	4	5	6
Too many:						
- representations of Indigenous Australians in the *media* are just inaccurate stereotypes.	1	2	3	4	5	6
- *politicians* refuse to listen to the voices of Indigenous Australians.	1	2	3	4	5	6
- *researchers* refuse to consider how Indigenous Australians may see things.	1	2	3	4	5	6
In the future, I would:						
- be confident to work with Indigenous Australians.	1	2	3	4	5	6
- get along well with Indigenous Australians in the workplace.	1	2	3	4	5	6
- be happy to consult with Indigenous Australian community representatives	1	2	3	4	5	6
Both Indigenous and non-Indigenous:						
- *perspectives* can combine to produce productive outcomes for Indigenous communities.	1	2	3	4	5	6
Indigenous Australians:						
- have nations and clans that have many different customs.	1	2	3	4	5	6

SECTION 3: Indigenous Learning Opportunities

The following section is about your experiences within the subject you have just studied. Please circle the answer you feel is most appropriate.

	Completely False	Mostly False	More False Than True	More True Than False	Mostly True	Completely True
In this subject, we:						
- were able to discuss Indigenous Australian issues respectfully.	1	2	3	4	5	6
- were required to engage with Indigenous Australian authors.	1	2	3	4	5	6
- have had the opportunity to learn from a number of Indigenous Australian representatives.	1	2	3	4	5	6
- were taught about important ethical considerations (e.g., reciprocity, intellectual property rights) that are needed for working with Indigenous Australians.	1	2	3	4	5	6
- learned of many unique Indigenous Australian Knowledges that have survived colonisation.	1	2	3	4	5	6
- had an assessment to critically evaluate multiple perspectives on an issue affecting Indigenous Australians.	1	2	3	4	5	6
Overall:						
- this subject showed me how important learning about Indigenous Australians may be for my future employment.	1	2	3	4	5	6
- I think every student must learn more about Indigenous Australian peoples and their communities, regardless of their discipline.	1	2	3	4	5	6

Can you please list below which scholars/academics you found most influential for your studies on Indigenous Australians:

_____

SECTION 4: Personal Attitudes

The following section is about your personal attitudes towards learning

	Completely False	Mostly False	More False Than True	More True Than False	Mostly True	Completely True
I personally enjoy:						
- knowing that university education lies in being introduced to different values.	1	2	3	4	5	6
- talking with people who have values different from mine because it helps me understand myself and my values better.	1	2	3	4	5	6
- taking courses that that make me think about things from a different perspective.	1	2	3	4	5	6
I feel:						
- emotionally drained by my studies.	1	2	3	4	5	6
- less interested in my studies since my enrolment at the university.	1	2	3	4	5	6
- that I am enthusiastic about my studies.	1	2	3	4	5	6
- that I am proud of my studies.	1	2	3	4	5	6

SECTION 5: Attitudes towards Indigenous Australians

	Completely False	Mostly False	More False Than True	More True Than False	Mostly True	Completely True
Discrimination against Indigenous Australians is still a major problem.	1	2	3	4	5	6
Universities make it too easy for Indigenous Australians to get accepted to undertake degrees.	1	2	3	4	5	6
I don't like Indigenous Australians.	1	2	3	4	5	6
I wouldn't like any member of my family to marry an Indigenous Australian.	1	2	3	4	5	6
Indigenous Australians get a lot more money to study when compared to non-Indigenous Australians.	1	2	3	4	5	6
On the whole, Indigenous Australians are a loud and noisy lot.	1	2	3	4	5	6
Most Indigenous Australians are dirty and unkempt.	1	2	3	4	5	6
I would not like an Indigenous Australian to be my boss.	1	2	3	4	5	6

What do you feel is the most important lesson you have been subjected to within your studies on Indigenous Australians?