FINAL REPORT

Moving beyond the front line: A 20-year retrospective cohort study of career trajectories from the Indigenous Health Program at the University of Queensland

Chelsea Bond[A]
Mark Brough[B]
Jon Willis[A]
Janet Stajic[A]
Bryan Mukandi[D]
Condy Canuto[A]
Shannon Springer[C]
Deborah Askew[D]
Nell Angus[A]
Tara Lewis[A]

Institutes

[A]The University of Queensland Poche Centre for Indigenous Health

[B]Queensland University of Technology

[C]Bond University

[D]Faculty of Medicine, The University of Queensland

Contents

Executive Summary....7
Research Approach 7
Findings.... 7
Building leaders through building confidence 8
Building leaders through building capabilities 8
Transformative Learning Through Supportive Relationships 8
Transformative Learning Through Innovating Indigenous Health 8
A Different Kind of Health Professional in a not so different Health System 9
A different kind of leadership 9
Conclusion 9
Background to the Indigenous Health Program 10
Literature Review.... 11
The Aboriginal Health Worker 12
Indigenous People in the Health Professions 13
Beyond the Pipeline 15
Methodology 17
Phase One: Recruitment 17
Research Participants 17
IHP Symposium 18
Phase Two: Data collection and analysis.... 19
Phase Three: Knowledge Translation.... 21
National Conference on Indigenous Health Workforce Leadership 21
Herston Workshop 24
Policy Brief 24
Ethics 25
Demographic Data 26
Findings 31
Building leaders through building confidence 31
Building leaders through building on Indigenous capabilities.... 33
Transformative Learning Through Supportive Relationships 35
Transformative Learning Through Innovating Indigenous Health.... 39
A Different Kind of Health Professional in a not so different Health System 43
A Different Kind of Leadership....48
Discussion.... 53
Conclusion.... 56
Appendices.... 57

Appendix A – IHP Symposium Flyer....... 57

Appendix B – IHP Symposium Schedule....... 58

Appendix C – IHP Symposium Twitter Activity....... 59

Appendix D – *UQ Indigenous alumni close the gap as leaders*, The University of Queensland, Faculty of Health and Behavioural Sciences, 2 March 2018....... 61

Appendix E – National Conference on Indigenous Health Workforce Leadership Flyer....... 62

Appendix F – National Conference on Indigenous Health Workforce Leadership Program....... 63

Appendix G – IndigenousX Articles....... 65

Appendix H – Croakey Article....... 66

Appendix I – National Conference Twitter....... 67

Appendix J – Vodcasts....... 68

Bibliography....... 69

Index of Figures

Figure 1 - Aboriginal and Torres Strait Islander registered health practitioners as a percentage of their respective professions, 2013-2016 14
Figure 2 – Total population – Interview Participants 26
Figure 3a – IHP Alumni – Indigenous Identification 27
Figure 3b – Educators/staff – Indigenous Identification 27
Figure 4a – IHP Alumni – Gender 28
Figure 4b – Educators/staff – Gender 28
Figure 5 – IHP Alumni – Currently working in sector 29
Figure 6 – IHP Alumni – Graduated 29
Figure 7 - IHP Alumni – First in family (to go to university) 30
Figure 8 – IHP Alumni – Highest level of education achieved 30

Acknowledgements

The authors would like to acknowledge and thank The Lowitja Institute for its support in funding this project. The authors would also like to thank the University of Queensland (UQ), UQ Poche Centre for Indigenous Health, Bond University, and Queensland University of Technology (QUT) for their support of this project. The authors would like to further acknowledge and thank the Melbourne Poche Centre for Indigenous Health as well as the Leaders in Indigenous Medical Education (LIME) Network for their support and involvement in the National Conference on Indigenous Health Workforce Leadership.

Finally, the authors would like to express their gratitude to all the alumni, staff and stakeholders of the Indigenous Health Program who inspired and informed this project and who each demonstrate through their own work and lived experiences, the depth and scope of Indigenous workforce leadership in health.

Acronyms

AHW	Aboriginal Health Worker
IHP	Indigenous Health Program
LIME Network	Leaders in Indigenous Medical Education Network
PBL	Problem Based Learning
QUT	Queensland University of Technology
UQ	University of Queensland

In honour of Bachelor of Applied Health Science (Indigenous Primary Health Care)
The University of Queensland, 1994-2005.

Artist: Aunty Iris "Bubby" Smith, 1994

Executive Summary

This report examines critical success factors for enabling Aboriginal and Torres Strait Islander leadership across the health system as demonstrated by alumni of the University of Queensland (UQ) Indigenous Health Program (IHP) (1994–2005) who today work in various leadership roles throughout the country.

This report maps the career trajectories of a multidisciplinary cohort of Aboriginal and Torres Strait Islander graduates of the UQ IHP. It determines the enablers of professional success of these health leaders in various facets of the health system and investigates the impact of active participation in the community of Aboriginal and Torres Strait Islander health professionals over the course of a career. Through this analysis, the report further theorises the confluence of community, subjectivity, self-determination and health.

This report contests dominant discourses in Indigenous health workforce scholarship that rely upon 'capacity-building' and 'aspirations' through 'pathways' and 'pipelines' to instead demonstrate the importance of scholarship founded upon Indigenous sovereignty (Bond, 2018). To centre sovereignty means to recognise the strength, power and resistance of those Aboriginal and Torres Strait Islander health workers who operationalise leadership across the health system and beyond. It calls for a contestation of power relations that limit and devalue the contributions of Indigenous health workers and Indigenous health education, to throw into sharp relief an Indigenous health workforce that is always and already resisting, reimagining and restructuring the conditions that will best serve the health and wellbeing of Aboriginal and Torres Strait Islander people. It demands an educational approach that dismantles structures that inhibit Indigenous students from pursuing their already well established, yet often ignored or overlooked, aspiration to build new educational models that better support students to become the next generation of Indigenous health workforce leaders.

Research Approach

This retrospective cohort analysis takes a strengths-based approach which privileges the narrative accounts of a multidisciplinary cohort of approximately 70 Indigenous health professionals which includes Chief Executive Officers of medical services, General Practitioners, clinical specialists, senior policy advisors, program managers and senior academics. Foregrounding their testimony illuminates our understanding of Aboriginal and Torres Strait Islander health workforce leadership across the health system. Led by a predominantly Aboriginal and Torres Strait Islander investigative team (including researchers from UQ, Queensland University of Technology (QUT), and Bond University), this report elevates Indigenous knowledges, insights and experience in order to advance a more sophisticated Aboriginal and Torres Strait Islander health workforce agenda. 'Moving beyond the frontline' refers to the task of promulgating a health workforce agenda grounded in both the collective goal and realities of Aboriginal and Torres Strait Islander health workforce leadership across the health system, moving beyond the existing emphasis upon aspiration and capacity building within specific health professions.

Findings

Drawing upon the rich narratives shared through the data collection process, six key domains were identified that captured the Indigenous health workforce leadership experiences of the cohort analysed.

Building leaders through building confidence

Many of the graduates interviewed were the first in their family to attend university and had not followed a singular or straight path to higher education. For many, experiences in school had undermined their desire or capacity to pursue further education and many subsequently experienced a high degree of anxiety or self-doubt when applying to the IHP.

The IHP developed students' confidence and strengthened graduates' sense of themselves through affirming and centring Indigeneity. The IHP itself drew strength from the non-traditional pathways that students took to enter the program; and through the collective support of the cohort and staff, fostered a community of Indigenous health workforce graduates who used this to shape future careers.

Building leaders through building capabilities

Graduates brought to the IHP a wealth of knowledge, skills and experience. Many were self-motivated having already witnessed in their own lives and relationships the profound impact of health inequality. In coming to the program aware that existing approaches were failing Indigenous families and communities, many harboured a strong sense of the transformative potential of Indigenous knowledge. They sought to use the program to contest existing approaches that fail Indigenous people and as a means to implement Indigenist strategies and knowledges that would transform the health system.

The IHP was unique in its creation of a collective Indigenous learning environment through which Indigenous student's identities were affirmed as critical sources of knowledge and power.

Transformative Learning Through Supportive Relationships

A key dimension of the IHP experience was the uniqueness of the program as an educational experience. Critically, all participants described the importance of the relationships they enjoyed with fellow classmates, professional staff and academic staff throughout the program and beyond.

The staff were critical to fostering the supportive learning environment. The staff created a safe learning environment that meant students did not need to expend energy battling rigid and inflexible learning spaces. The isolation of the Herston campus was also seen to be an advantage, giving students time to develop strong relationships with their cohorts as part of a more intimate hospital campus.

Transformative Learning Through Innovating Indigenous Health

Participants attributed the transformative work of IHP to the innovative approach it took in regard to Indigenous health, and the skills, attributes and understandings it sought to inculcate in students. It utilised an Indigenous health pedagogy that relied upon input from Indigenous community stakeholders in the design of the degree.

The IHP was an active research centre where students acquired foundational research skills and experience in communities. The role of Problem Based Learning (PBL) impacted participants and may reflected how this learning approach became a skill for life. It allowed for a two-way learning environment where students were able to teach the educators by drawing upon their prior knowledge. For educators, they spoke of how their teaching and knowledges were enriched as a result of working with the IHP students.

A Different Kind of Health Professional in a not so different Health System

The program developed "a different kind of Aboriginal Health Worker" with participants reflecting on how they felt better equipped to effect tangible changes through a community development and social determinants approach. It empowered and nurtured students, not just as 'health professionals' but also as advocates and activists within a health system still failing to adequately meet the needs of Indigenous peoples. For many participants, this equipped graduates to take on further study after completing the IHP.

For some graduates, there was frustration after graduation that employers did not sufficiently recognise the degree or that career trajectories were not always clear after graduating. There was at that time a political climate opposed to the community-controlled health sector and the Aboriginal Health Worker (AHW) role. There were also critical barriers, including structural and interpersonal racism, that denied recognition of a new kind of Indigenous health professional.

A different kind of leadership

While the goal of the IHP was to develop Aboriginal and Torres Strait Islander leadership through a highly skilled AHW workforce, it also proved to be an enabler of non-Indigenous leadership for both staff and students. For non-Indigenous graduates, discussion centred on the challenges of being exposed to racist comments in the work space and the work needed to educate and challenge the assumptions held by non-Indigenous colleagues.

For Indigenous students, a new kind of leadership emerged of which their own Indigeneity was central. Many students discussed how the IHP helped them connect with and/or affirmed their cultural identity. Leadership was characterised as relational rather than hierarchical, emphasising one's Indigeneity and accountability to community. Participants spoke of leadership and success in a collective rather than individual sense with many not only proud of their own achievements but also the collective achievements of the cohort.

Conclusion

While Indigenous health workforce issues may often be understood in terms of numbers and statistics, the findings of this project reveal that such an approach may often overlook the underlying human stories which give depth and nuance to the complexities of Indigenous health workforce leadership. Through a strength-based approach that centred the lived experiences of graduates from the IHP, there emerged a new way of thinking about leadership; one that centres Indigenous sovereignty so that it underpins educational and career pathways. It understands Indigeneity as an asset that engenders Indigenous knowledge and strength, so providing for effective leadership in the Indigenous health workforce.

Centring Indigenous sovereignty requires a reimagining of the *Indigenous* health workforce agenda so that it becomes an *Indigenist* health workforce agenda; one that conceptualises resistance as an emancipatory imperative and seeks to demonstrate political integrity through Indigenous control and the privileging of Indigenous voices. By advocating for an Indigenist health workforce agenda we seek to unsettle and fracture dominant discourses that frame Indigenous peoples as less than and that fail to account for structures and relations of power that deny Indigeneity as a source of power, authority and knowledge. We seek to ignite a space through which a varied and diverse Indigenous health workforce can resist, reimagine and recreate the conditions that nurture the health and wellbeing of Indigenous peoples.

Background to the Indigenous Health Program

The University of Queensland (UQ) Bachelor of Applied Health Science (Indigenous Primary Health Care) or Indigenous Health Program (IHP) was a unique three-year undergraduate program that ran from 1994 to 2005. At the time the program was first developed, there was a significant lack of recognition of the critical role of the Aboriginal Health Worker (AHW) within the health system. As a result, there were also limited career structures available to AHWs. The IHP sought to respond to this lack of recognition and lack of educational support by providing next level training for TAFE educated AHWs.

Development of the program curriculum commenced in 1992 through consultation with Indigenous community health leaders and other stakeholders across Queensland. While there were challenges in obtaining university endorsement for the program, the IHP was ultimately supported by UQ and courses were run through UQ Herston campus in Brisbane.

The IHP pioneered Problem Based Learning (PBL) which centres students' prior knowledge in approaching an unfamiliar issue or problem. Students were asked to draw upon their prior knowledge and work collaboratively in small groups to identify gaps in knowledge. Through this network approach, students utilised prior knowledge while also developing and expanding their knowledge and understanding of an issue or problem.

The program was highly successful with a strong cohort of over 70 Indigenous and non-Indigenous students graduating from the program. Unfortunately, UQ felt that the program had an unsustainable funding model. With a national shift in emphasis on mainstreaming Indigenous programs in higher education, the IHP was seen to be increasingly at odds with such an approach. The last cohort of graduates completed the program in 2005.

CLICK ABOVE TO WATCH

Moving Beyond the Frontline: A 20 Years Journey

Literature Review

There is a documented need for and benefit of an increase in Indigenous participation in the health workforce (Curtis, Wikaire, Stokes, & Reid, 2012; Anderson, Ewen, & Knoche, 2009). This tends to be framed in terms of recruitment and retention, capacity building, and raising the aspirations of Aboriginal and Torres Strait Islander health students and professionals (Aboriginal and Torres Strait Islander Health Workforce Working Group, 2017; Thomas, Bainbridge, & Tsey, 2014). These are the areas to which four of the six key strategies of the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2023 are directed. This is also the approach that tends to be taken when addressing Indigenous health leadership (Hill, Wakerman, Matthews, & Gibson, 2001).

This report takes a broader, multidisciplinary, strengths-based approach to Indigenous participation in the health workforce by using the unique opportunity to investigate the insights offered by a diverse range of Indigenous health leaders who had a shared educational starting point. Beyond the issue of cultural safety (Taylor & Guerin, 2010), there is the opportunity here to determine what enables a group of Indigenous health professionals – inductees of a community based around a dedicated Indigenous health program designed for a predominantly Indigenous cohort of students – to rise into leadership positions in such a broad range of domains of the health system. While Indigenous health professionals and leaders may be implicitly understood as constituting a 'community', this has not been the frame used in health policy and systems research, such that the value of that community of practice (MacIntyre, 2007) and epistemic community (Haas, 1992), to Indigenous health professionals and to the health system has not been examined adequately. This study examines the movement, over 20 years, of this community of Indigenous health professionals into leadership roles across disparate parts of the health system.

The current National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2016-2023) acknowledges that ensuring the provision of an appropriate health workforce is necessary to addressing the health inequality faced by Aboriginal and Torres Strait Islander people. Paramount here is an accountability to ensure Aboriginal and Torres Strait Islander people are present in numbers across the health disciplines that they are valued and supported to take on leadership roles within the health system. While workforce development has been a regular component of various national and state policies concerned with the health of Aboriginal and Torres Strait Islander people – for example, National Aboriginal Health Strategy (1989), Deaths in Custody Report (Johnson, 1991) – change remains slow. According to the 2011 census, 3.4% of non-Indigenous Australians worked in the health system, but only 1.6% of Indigenous people worked in health. The largest gaps in rates of health workforce participation in 2014 were among nurses and medical practitioners (ATSIHWWG, 2015). A more recent national study of the Aboriginal and Torres Strait Islander Health Worker workforce between 2000 and 2016 (Wright, Briscoe, & Lovett, 2019) found overall growth was not commensurable with population growth and in some regions was on the decline.

Higher education has a significant role to play in health workforce supply, but there are few indications that it will be making a difference anytime soon. Although Aboriginal and Torres Strait Islander enrolments in tertiary health-related courses have been increasing since the early 2000s, lower than expected completion rates have meant that the number of Indigenous graduates entering the workforce has not increased significantly (ATSIHWWG, 2015). With this in mind, we seek here to provide an overview of the workforce literature to inform ways forward in this

important area of Indigenous health. The purpose here is not to simply review the disparities in Indigenous health workforce participation but to critically appraise how the barriers and enablers to Indigenous health workforce participation have been conceptualised within the published literature -- and by extension, by the health system as a whole -- to date.

The Aboriginal Health Worker

The starkest pattern within the workforce literature is the difference between the literature concerned with AHWs and the literature reporting on those health disciplines situated more squarely within the academy of western health sciences. The critical role of AHWs in the history of Indigenous health is evident in the workforce literature where they embodied Indigenous led health long before any of the 'mainstream' disciplines took up any interest in Aboriginal and Torres Strait Islander people occupying any roles in the health system other than the patient role. The pivotal contribution made by the Aboriginal Health Worker Journal from its first issue in March 1977 cannot be underestimated. It provided the first significant forum for the discussion of Indigenous health by Indigenous people and remains a vital archive of that ongoing discussion. A short article in the second edition of the journal by Kumunjayi Jakamarra (1977) entitled *From Health Worker to Health Worker* subtitled, *A Ngangkari speaks*, led with the following words:

> *"I have been working as a Ngangkari or Medicine Man for my people for a long time. It took many years to train for this vocation. I still continue to learn many things from the old people."*

Like so many other health workers, Jakamarra was of the community rather than of a 'discipline'. Knowledge of practice was held by the community and was passed down rather than learnt at university. Before non-Indigenous health sciences became concerned with the social epidemiology of Aboriginal and Torres Strait Islander health, a group of AHWs from East Arnhem Land wrote a paper on *Our Social Environment* (Munungguritj, Purray, Gemuluwuy, Bara, & Mamarika, 1978). Among other social issues, they spoke of their own dilemmas as health workers:

> *"Our new job as health workers isn't an easy one in some communities. A lot of our people don't trust us. If somebody dies in the hospital, they demand we close it down. We tell them to ask the Council, but they still threaten us. We don't feel safe. Some people seem very jealous of us. Maybe they think we're too European."*

The history of the AHW role since this time deserves its own thorough articulation. It is evident that over the years, a significant literature has evolved which has sought wide and institutional recognition of this role (Abbott, Gordon, & Davison, 2007; Hill et al., 2018), and has built the evidence base to demonstrate the importance of the health worker to health outcomes for Aboriginal and Torres Strait Islander people in a variety of areas including cardiovascular disease (Deshmukh, Abbott, & Reath, 2014), maternity care (Stamp et al., 2008), cardiology (Taylor, Thompson, Smith, Dimer, & Ali, 2009), sexual health (Templeton et al., 2010), and smoking cessation (Thompson, 2011). This literature could be valued for the evidence it provides of the 'value' of AHWs, and the authority it commands for this role, but it also indicates a hierarchy within health professions -- it is unlikely that there is contemporaneous research seeking to validate the need for doctors, for example. Biomedical research is free to focus on the efficacy of particular practices rather than on establishing the validity of the practitioners. Much of the literature about and by health workers demonstrates that deep knowledge of community informs

an Indigenous practice not simply tethered to biomedical ‘competencies’ but centring culturally safe models of effective health care for Aboriginal and Torres Strait Islander people.

Despite the crucial capacity of AHWs to provide leadership in culturally safe health service provision, the literature about them (rather than by them) emphasises the task of ‘upskilling’, ‘development’, ‘empowering’ and ‘enhancing’ the capabilities of the AHW rather than reconfiguring the provision of health care. Here our attention is drawn to the ‘challenges’ and ‘barriers’ to better health outcomes *because* of the AHW workforce via high smoking rates, poor retention, lack of awareness of specialist expertise and poor numeracy and literacy levels (Hecker, 1997; Pacza, Steele, & Tennant, 2001; Williams, 2001; Mark, McLeod, Booker, & Adler, 2005; Bailey et al. 2006; Harris and Robinson 2007; McRae, Taylor, Swain, & Sheldrake, 2008; Dawson, Cargo, Stewart, Chong, & Daniel, 2012). The AHW is rendered ‘part of the problem’ that the health system must remedy. This is exemplified in Indigenous smoking cessation literature which concerns itself with the smoking habits of AHWs (Dawson et al., 2012; Mark et al., 2005) rather than the failure of mainstream approaches to smoking cessation. Would it be pertinent to consider the extent to which failures in the national effort to reduce obesity or cardiovascular risk can be blamed on the eating habits of nutritionists, or the exercise routines of doctors?

Indigenous People in the Health Professions

Outside of the AHW role, the Indigenous health workforce literature is a phenomena of the 2000s. Concerns about the substantial disparities in health outcomes for Aboriginal and Torres Strait Islander people became a feature of Australian health research in the 1990s, and it took a decade or more for a concern about workforce disparities to be attached to this research agenda. Despite the importance of national strategies to address health workforce disparities, the underpinning evidence to inform these strategies is piecemeal across health disciplines.

The dominant consideration in the literature is about improving the supply chain of Indigenous health professionals. Murray and Wronski (2006) utilise a common metaphor for this in their concern for ‘the pipeline’. Goold (2006) does not use the metaphor but addresses the pragmatics of ‘gettin em’ and ‘keepin em’. Whether explicitly stated or implied, the notion of securing an adequate supply of workers to meet a chosen need is a common way in which workforce issues are considered. Ironically, this ostensibly pragmatic agenda rarely struggles with other genuinely pragmatic concerns, including most importantly, accountabilities for the ways in which the health system works for Aboriginal and Torres Strait Islander people.

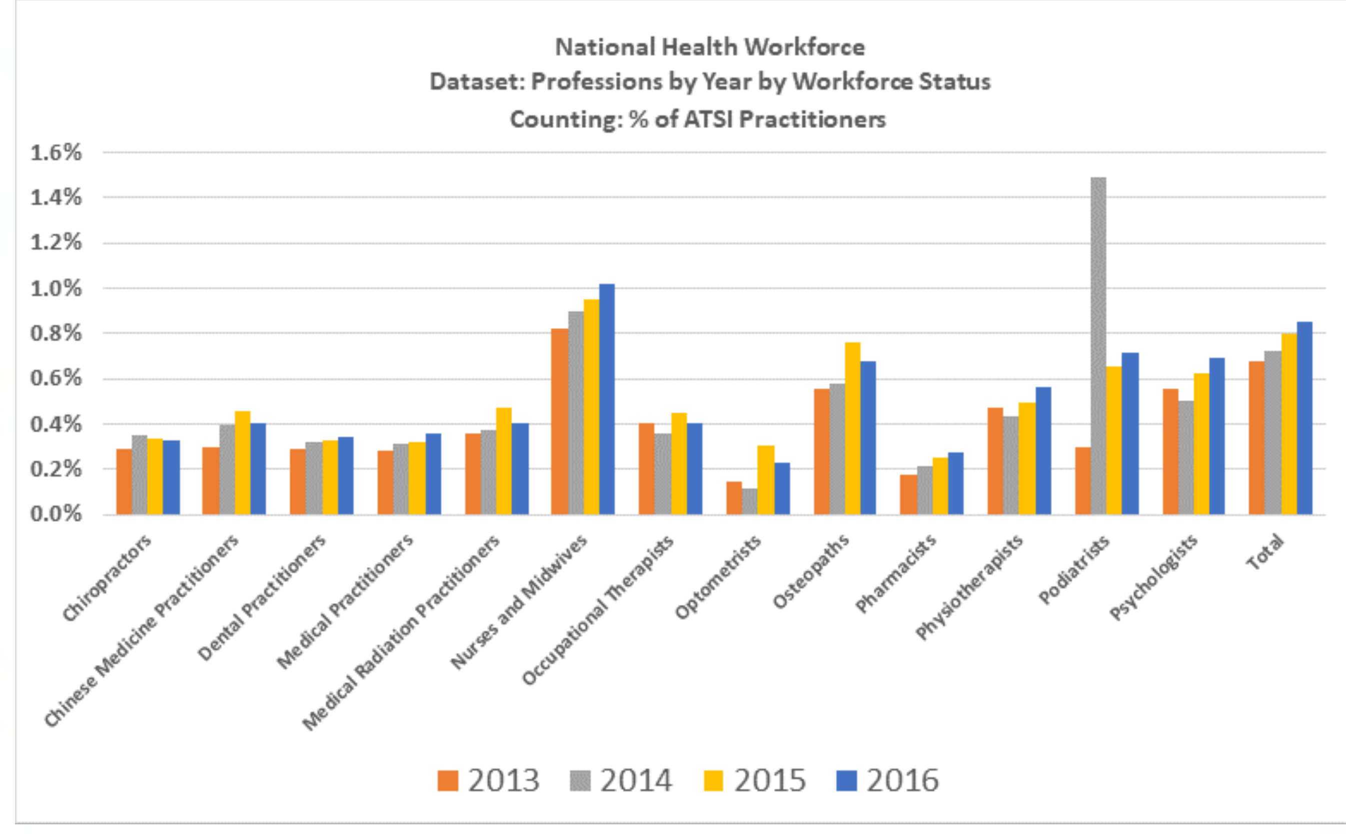
The data presented in Figure 1, drawn from the National Health Workforce Dataset (2019) demonstrate that if such pipelines exist, someone has forgotten to turn on the tap. Other than an anomalous spike in podiatry in 2014, no discipline other than nursing and midwifery boasts a rate of Indigenous practitioners that exceeds 1% of their profession, and most disciplines languish below 0.5%. By comparison, Aboriginal and Torres Strait Islander people represented 2.8% of the general population in the 2016 census (ABS, 2017). The largest Indigenous profession by numbers was Nursing and Midwifery, with 3202 registered practitioners in 2016, with Medical Practitioners coming in a distant second with 329 registered practitioners in 2016. The rest of registered Indigenous practitioners combined would struggle to fill a lecture theatre. This is not a pipeline. This is a thin dribble.

Despite medicine and nursing being poor performers in terms of shifting Indigenous workforce participation, they are the most visible health disciplines in Indigenous workforce research. The

Medical workforce research deals mostly with issues in medical education: the role of pre-med programs (D'Antoine & Paul, 2006); reasons for Indigenous students withdrawing from medical degrees (Ellender et al., 2008); Indigenous Medical Students' perceptions of their training (Garvey, Rolfe, Pearson, & Treloar, 2009); and reforming medical training (Mackean et al., 2007). The Nursing workforce literature is similarly focused on training, with an emphasis on support strategies for nursing students (Cameron, 2010; Usher, Lindsay, Miller, & Miller, 2005; Stuart, Nielsen, & Horner, 2010; Felton-Busch et al., 2013; Mills et al., 2014; Goold, 2016), as well as a variety of other issues: 'reducing reality shock' for Indigenous nursing graduates (Hinton, 2010); the factors shaping nursing experience (Martin & Kipling, 2006); attracting and retaining Indigenous nursing students (Wollin et al., 2006); and the value of Aboriginal nurses for nursing Aboriginal patients (Stuart & Nielsen, 2010; West, Usher, & Foster, 2010).

Other health-related disciplines are much less represented in the literature – see, for example, psychology (Wainwright, Gridley, & Sampson, 2012; Cameron & Robinson, 2013), disability work (Gilroy, Dew, Lincoln, & Hines, 2017), and social work (Walter, Taylor, & Habibis, 2011). Many other allied health disciplines don't appear to have engaged with concerns about Indigenous representation within their ranks, at least in their respective workforce literatures, and accountabilities of professional bodies to strategize or even report on their Indigenous workforces are missing from available literature. These silences are echoed in the registration data presented in Figure 1.

Figure 1 - Aboriginal and Torres Strait Islander registered health practitioners as a percentage of their respective professions, 2013-2016



Source: National Health Workforce Datasets (2019)

Beyond the Pipeline

Beyond the pipeline of Indigenous recruits into the health professions lie other concerns, reflected, for example, in Fredericks' (2009) consideration of the positioning of Aboriginal women working in health. When Walter et al. (2011) ask how white is social work, they are not asking about the numbers. Their consideration of the habitus of social work via whiteness theory asks how social work practice is entrenched within a white habitus. When Kelaher et al. (2014) ask if more equitable governance leads to more equitable health care in Aboriginal health, they are questioning the contours of power not a simplistic enumeration of workforce management. When Whiteside, Tsey, Cadet-James, & Wilson (2006) consider empowerment as a framework for Indigenous workforce development they demonstrate that power operates for Indigenous workers within organisations in the same way as for Indigenous clients. When Humphreys et al. (2008) consider the needs of rural and remote health they highlight systemic organisational structures not just pipelines of workers. These are all important papers for injecting alternate questions into the workforce literature, but they are few in number and may not represent all that happens beyond the pipeline. We are not suggesting that increasing the supply chain doesn't matter. Like Cannady, Greenwald, & Harris (2014), who critiqued the dominance of the 'pipeline' framework in STEM efforts to improve workforce diversity, we worry about what else there is to consider.

We argue that we need to hear more from Indigenous health professionals who have made it through 'the pipeline', and how those individuals might have experienced their Indigenous 'selves' within disciplinary spaces dominated by non-Indigenous knowledges. Such people could inform the workforce agenda at a powerful and useful experiential level. We acknowledge the emergent literature of testimonies (in text book case studies, online opinion pieces and reflective essays) from Indigenous health professionals speaking about the inadequacies of the health system, made more powerful by their location as members of the health workforce. Take for instance the writings of Best (2014), an Aboriginal nurse, and later Buzzacott (2018), an Aboriginal midwife, who both talk about their experiences of racism as recipients of care. It is via their knowledge of what constitutes 'clinical care' in a biomedical sense that they were able to illuminate more powerfully the mechanisms by which racism was so readily enacted, and they speak to its embodied consequences upon their health and that of others. Rallah-Baker (2018), the first (and only) Indigenous Ophthalmologist most recently spoke back to his discipline:

> *"My own dealings with blatant racism, degradation, training delays, bullying, harassment and racial vilification are unfortunately considered an unremarkable experience amongst my Indigenous medical brethren. To many of us, racially motivated workplace violence is the norm. Institutionalised racism, unconscious bias and cultural insensitivity might sound like buzzwords people kick around, but they are real and their impact is real."*

Experiences like these disrupt paternalistic assumptions within the health system and higher education that focus attention on various ways the system might 'better support' Indigenous people either in training for the workforce or in the workforce, while at the same time never acknowledging the institutional abuses which lead to the need for that support.

It is not surprising that racism might be a central feature of the experiences of Indigenous health professionals, whether one is an 'untrained' health worker, or a medical specialist. In fact, racism remains the elephant in the room when it comes to the Indigenous health workforce literature –

for it is racism that long prohibited Indigenous peoples' access to educational and employment opportunities within the health system. The recent emergence of an Indigenous health workforce has resulted in a richer understanding of the experiences of Indigenous health professionals, but this contribution still remains marginalised. The real challenge in addressing the disparities of health workforce representation lies in a preparedness to consider how power operates in the production and maintenance of health inequalities.

In 1989, John Newfong wrote the forward to the National Aboriginal Health Strategy. He argued that any measure aimed to address Indigenous health could not dismiss the realities of Indigenous Australia. He observed that Aboriginal Australians were "not even kept alive for their labour", and when they were, were underpaid and considered "unreliable". Thirty years on we need to heed John's advice. Indigenous health workforce issues exist in the same realities. There's no pipeline we know of that lets Indigenous people escape them.

Methodology

This retrospective cohort study takes a strengths-based approach which privileges the narrative accounts of Indigenous health professionals who graduated from the IHP at UQ between 1994 and 2005. Cohort studies are well suited for the investigation of the development or progression of phenomena over time (Grimes & Schulz, 2002).

This research design therefore allows for an understanding of the enabling factors that have seen members of this multidisciplinary cohort assume diverse leadership roles. A mapping exercise was undertaken, following the career of each study participant, taking into account: the background of each participant prior to enrolment in the IHP; professional milestones; and significant professional relationships over a twenty-year period across various facets of the health system. Foregrounding each participant's testimony, thought and experience informs an understanding of Indigenous health workforce leadership across the health system and allows for a complex analysis of the path to leadership for Indigenous professionals.

To undertake this work, there were three phases to the project: first, recruitment of research participants; second, data collection and analysis; and finally, dissemination of findings through knowledge translation activities.

Phase One: Recruitment

Research Participants

There were three groups of participants:

1. **Graduates** of the IHP at UQ, which ran between 1994 and 2005. This represents a multidisciplinary cohort of approximately 70 health professionals, the vast majority of whom are Aboriginal or Torres Strait Islanders. They include CEOs of medical services, GPs, clinical specialists, senior policy advisors, program managers and senior academics. All IHP graduates, including non-Indigenous graduates and those who are no longer working within the health system, were invited to participate.
2. **Academic staff** who taught on the IHP were also identified and invited to participate in the research. Included are all those who taught into the program on some sort of regular basis. Guest lecturers are excluded.
3. **Stakeholders** such as professional staff in administrative roles, and those in senior management roles within the university at the time as well as external stakeholders involved in the development of IHP - that is all those who had an ongoing role providing a support role to the program were also invited to participate in this project.

Recruitment was facilitated by the contact details held by the UQ Alumni and Community Relations Centre, and existing IHP student enrolment records. This was augmented by a network recruitment strategy. A key part of this strategy was contacting alumni to attend an 'IHP Symposium' where the project was introduced and for those alumni interested in becoming involved, to obtain their consent to be contacted at a later date to be part of the interview process.

IHP Symposium

Indigenous Health Program graduates, academic staff and stakeholders were invited to attend a symposium held in Brisbane on Friday, 2 March 2018 at the Rydges Fortitude Valley, Brisbane. The IHP Symposium gathered a large number of the student cohort and staff to reflect on the legacy of the program and its impact upon building an Indigenous health workforce. On the day there were 51 attendees.

The electronic invitations included a study protocol and a consent form regarding the documentation of the proceedings at the symposium. Consent was sought from symposium keynote speakers to record, publicly disseminate and use their presentations for research purposes in an identified manner. The invitation letter included a request to bring any memorabilia (such as photographs, course materials, assignments and so forth) from the IHP course either in advance of the symposium or at the symposium. The research team gave a presentation on the research project at the symposium, which was followed by a question and answer session. Alumni, staff and stakeholders were invited to participate in in-depth interviews, conducted at the symposium and at a later date. From the symposium attendees and through the network approach, individuals were asked if they would be willing to sit for a video interview to be edited into a vodcast for public distribution (see Appendix J).

Phase Two: Data collection and analysis

Yarning was the methodology used at the symposium (Bessarab & Ng'andu, 2010; Walker, Fredericks, & Anderson, 2014; Geia, Hayes, & Usher, 2013) in both informal and formal settings. Following the keynote address, three themed panels generated discussion around areas of 'first in family', 'educational journeys' and 'Indigenous leadership' which involved past IHP Alumni, including staff and students. Delegates were invited to participate in these panel discussions which helped the research team develop the question guide for follow up individual interviews. Participants also gathered in a break out room where discussions were sparked by memorabilia.

A series of videos were also recorded at the symposium with IHP graduates who volunteered to tell the story of their career to date on camera; and the keynotes were also recorded. While this process was separate from the formal interviewing process, it informed the formulation of the interview guide. The videos were turned into a series of publicly available vodcasts (see Appendix J) to be used as a teaching resource for students, and as a means of publicly celebrating Aboriginal and Torres Strait Islander accomplishment and leadership – a small step in the process of reversing the dominant negative representation of First Nations peoples within the Australian public health discourse (Bond, 2007).

The recruitment strategy was highly successful, with 40 interviews with Indigenous IHP graduates conducted post-symposium. It was during these interviews that the participants were asked to map their career trajectory since completion of the program; describe the factors to which they attribute their success; account for their development of those attributes; list fellow graduates with whom they remain in contact; describe the nature of those interactions; and other questions which arose from deliberations over the symposium. These interviews were transcribed, de-identified and thematically analysed.

In order to ensure inclusivity of participants located outside Brisbane (particularly Torres Strait Islander graduates) face-to-face interviews were carried out in Cairns and Sydney. Additionally, there were six phone interviews and three written interviews. All interviews were transcribed and analysed by the primary Research Officer and members of the investigative team, having developed a coding framework. The qualitative data obtained was analysed thematically, with team members comparing each other's coding and analysis. A deliberative, dialogic process was undertaken in the analysis of findings. The preliminary findings and key themes were presented at the National Conference on Health Workforce Leadership as well as a student-centred Indigenous health workforce symposium, enabling the team to reflect on and refine the findings.

Phase Three: Knowledge Translation

National Conference on Indigenous Health Workforce Leadership

A key research translation activity was the one-day National Conference on Indigenous Health Workforce Leadership convened with the Lowitja Institute, Melbourne Poche Centre for Indigenous Health and the Leaders in Medical Education (LIME) Slice of LIME Series. The National Conference was held at the Hotel Grand Chancellor, Spring Hill, Brisbane on 2 November 2018.

The National Conference on Indigenous Health Workforce Leadership examined critical success factors for enabling Indigenous leadership across the health system (See Appendix E and F). It provided a critical intervention to shift the dominant narrative within the Indigenous health sector from one of 'aspiration' and 'capacity building' to 'transformation'. The National Conference brought together Indigenous health leaders from across the health system throughout Australia including clinical practice, research, administrative and advocacy. The National Conference reflected on the transformative presence of a rapidly growing Indigenous health workforce over the past few decades. It illuminated not only the diverse and rich experiences of Indigenous health leaders, but reveal new and emerging workforce opportunities. By fostering dialogues that privilege Indigenous knowledge, insights and experience, the conference advanced understandings of Indigenous health workforce leadership and excellence beyond the frontline.

Keynote presenters for the National Conference included Honorable Ken Wyatt AM, MP (Minister for Indigenous Health and Minister for Senior Australians and Aged Care), Professor Cindy Shannon (Professor of Indigenous Health, QUT) and Dr Kristopher Rallah-Baker (President, Australian Indigenous Doctors' Association). The National Conference included concurrent panel sessions of Lowitja Institute projects on Indigenous Health Workforce and the interim research findings from this project were presented as part of this panel session. The Chief Executive Office of The Lowitja Institute, Romlie Mokak chaired one of these sessions and the other was chaired by IHP academic, Associate Professor Jon Willis (UQ Poche Centre for Indigenous Health).

The plenary panel sessions included key leaders, researchers and practitioners from across the Indigenous Health Workforce. Panel sessions included 'Changemakers: Building an Indigenous health workforce' chaired by Professor Shaun Ewen which considered the success factors for building an Indigenous health workforce including supporting the training of Indigenous health professionals, the usefulness of cohorts and the enablers for Indigenous leadership within the health system and beyond. 'Unfinished business: The Aboriginal health worker workforce' was chaired by Neil Willmett (Chief Executive Officer of Queensland Aboriginal and Islander Health Council) which looked at the AHW as central to the health system's ability to provide comprehensive, culturally safe and clinically competent care, yet they remain one of the least recognised occupational groups. This panel considered the past, present and future role of the AHW in community, clinical, government and non-government contexts across the country. The final panel of the conference was 'Reimagining the Indigenous Workforce: Moving beyond the frontline' chaired by Professor Gregory Phillips (Chief Executive Office of ABSTARR Consulting and Professor of First People's Health in the School of Medicine at Griffith University (Adjunct)) which considered what a strong Indigenous health workforce looks like and what new territory can be traversed in advancing Indigenous health outcomes.

The National Conference was an enormous success with a capacity attendance of 135 people. The keynote plenary session and the 'Changemakers: Building an Indigenous Health Workforce' session were live streamed as part of the LIME Network's Slice of LIME Seminar Series. This Slice of LIME Seminar is available at: https://www.limenetwork.net.au/slice-of-lime-seminar-10/.
The conference was also promoted by IndigenousX with live tweeting through the day and the #MovingBeyondTheFrontline trending, as well as a series of contributions published on their blog from Associate Professor Chelsea Bond 'Moving Beyond The Frontline: The Power and The Promise of an Indigenous Health Workforce' (2018), and Dr Tess Ryan 'It's Mob That Build Our Capacity In Health Research' (2018) (see Appendix G). The Conference delegates were also central to a critical and immediate intervention in support of the Keynote Presenter Dr Kris Rallah-Baker to the Royal Australian and New Zealand Journal of College of Ophthalmology in the concerns he raised about racism within the College, which was covered by NITV and resulted in an unreserved apology from RANZCO. An overview of the Conference was published by Dr David Singh in Croakey titled 'RANZCO urged to apologise to first Indigenous Ophthalmologist' (2018) (Appendix H).

As part of the study's knowledge translation strategy, a selection of conference participants were invited to submit their work for publication in a special issue of The Australian Journal of Indigenous Education focused on Indigenous health workforce leadership. In this way, study findings will be placed in conversation with other work that is being undertaken in this area. Submissions are due by 31 July 2019 and these publications will form part of the Special Issue to be published in December 2020.

Herston Workshop

A workshop hosted by the institutions of the research team (UQ, QUT and Bond University) was convened at UQ Herston campus for current Indigenous and non-Indigenous students and academic staff from higher education institutions in health-related programs. The findings from the research were presented for deliberation on panels, on which IHP graduates, health managers, senior academics and university managers were invited to sit. The workshop deliberations were documented, analysed and incorporated into the policy brief developed which outlines future directions for Indigenous health workforce leadership.

Policy Brief

The policy brief developed as a result of these deliberations at the UQ Herston Workshop and the National Conference for Indigenous Health Workforce Leadership will be disseminated to state and federal health workforce stakeholders, such as the: Leaders in Indigenous Medical Education (LIME) network, Poche network, Institute for Urban Indigenous Health, Lowitja Institute, National Aboriginal and Torres Strait Islander Health Worker Association, Australian Indigenous Doctors Association, Indigenous Allied Health Association, National Aboriginal Community Controlled Health Organisation and Public Health Indigenous Leaders in Education (PHILE) as well as at the forthcoming Lowitja International Indigenous Health Research Conference as part of a poster display.

Ethics

Ethical approval was provided by the University of Queensland Human Research Ethics Committee.

Upon recruitment, a staged consent process was employed as follows:

1. Invitation to the symposium: with accompanying information sheet and Consent Form A (allowing a member of the research team to document group discussions in a de-identified manner);
2. Invitation to keynote speakers at the symposium: with accompanying information sheet and Consent Form B (to video record the presentation and publicly distribute it in an identified manner);
3. Invitation to allow the research team to electronically reproduce memorabilia from the program and use that memorabilia for research analysis and in multimedia productions: with accompanying information sheet and Consent Form C
4. Invitation to be video interviewed at the symposium for the purposes of producing a publicly distributed informational vodcast: with accompanying information sheet and Consent Form B;
5. Invitation to participate in a one-on-one interview: with accompanying information sheet and Consent Form D

At each stage, participants were informed of their right to withdraw from the study. The project manager, under the supervision of the chief investigators, ensured that each contribution had an accompanying consent form. Consent was sought by the member of the research team performing that particular aspect of the study.

Besides the audio-visual material that was produced, the data gathered in this project was de-identified, and aggregated. Information has been reported in such a way that it is not attributable to any single individual. Interviews were transcribed and immediately de-identified, with an electronic key linking the identity of the participant to the de-identified transcript kept on a password protected file. Furthermore, de-identified transcripts were not available to people outside the research team. The voice recordings, transcripts and the password protected file was stored in a password protected folder on the password protected University storage system.

The primary source of data was the recollections of IHP graduates who were invited to share aspects of their career trajectories that they so wish. Every care was taken to ensure that nothing said in this context had a negative bearing on the informant. Prior to dissemination of any materials, final versions, whether identified or de-identified, were shown to the informant, with an opportunity to make amendments, and used only upon their agreement.

Demographic Data

Forty participants were interviewed which included 31 (77%) IHP Alumni, and 9 (23%) Educators/staff.(Figure 2)

Of the 31 IHP Alumni:

- 19 (61%) identified as Aboriginal, 3 (10%) Torres Strait Islander, 3 (10%) both Aboriginal and Torres Strait Islander, and 6 (19%) identified as non-Indigenous.(Figure 3a)
- 17 (45%) were female and 14 (55%) male.(Figure 4a)
- 11 (36%) were working in government, 9 (29%) in the ACCHO sector, 9 (29%) in universities/research institutes, 1 (3%) worked for a not-for-profit organization, and 1 (3%) in the "other" category.(Figure 5)
- 29 (94%) graduated from the IHP, and 2 (6%) did not graduate from the IHP but completed Bachelor degrees at other universities.(Figure 6)
- 20 (65%) said they were the first in their family to go to university (11 (35%) were not the first).(Figure 7)
- The highest level of education achieved for the IHP alumni interviewed were(Figure 8):

Bachelor	10 (32%)
Graduate Certificate	4 (13%)
Graduate Diploma	1 (3%)
Master	8 (26%)
PhD	7 (23%)
Fellowship	1 (3%)

Of the 9 Educators/staff interviewed:

- 8 (89%) identified as non-Indigenous and 1 (11%) identified as Aboriginal.(Figure 3b)
- 5 (56%) were female, and 4 (44%) were male.(Figure 4b)

Figure 2 – Total population – Interview Participants

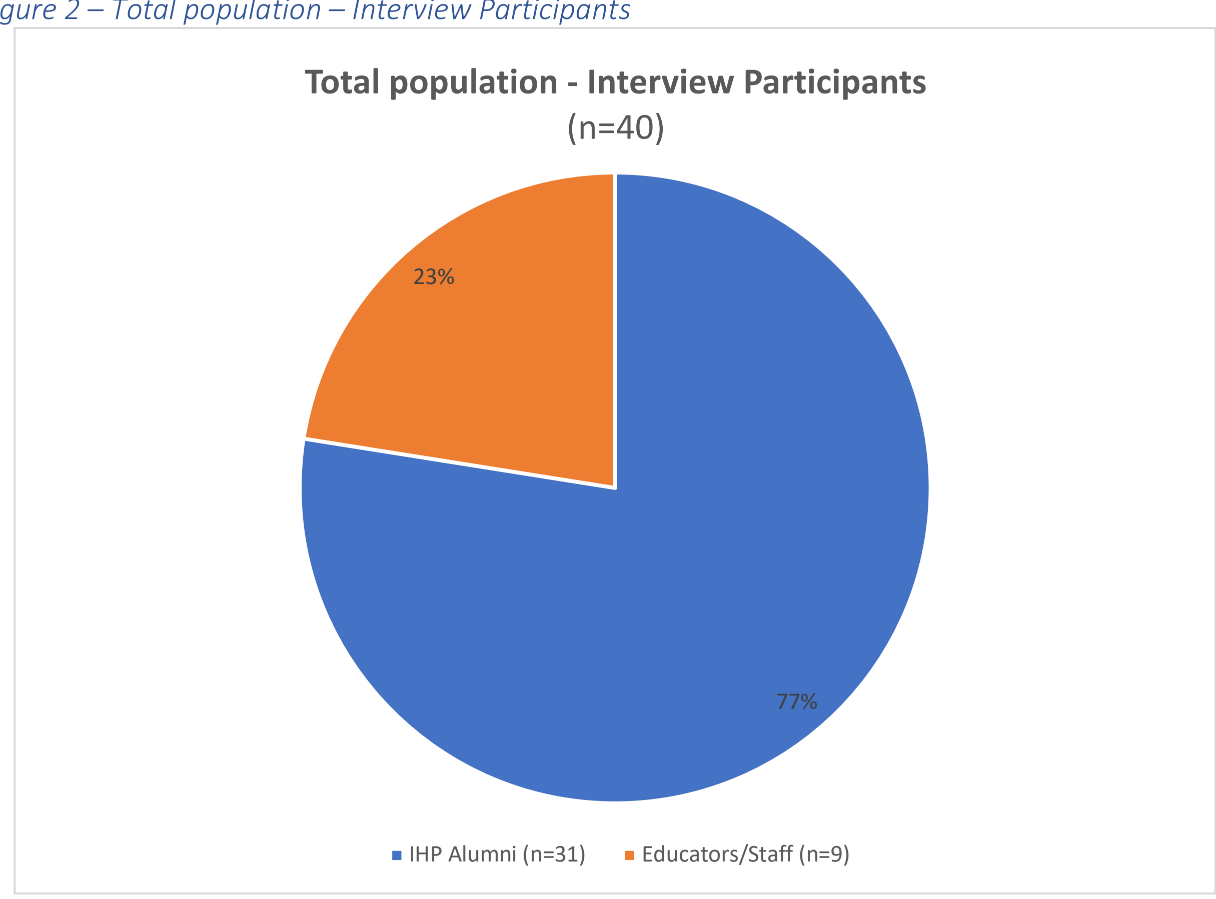


Figure 3a – IHP Alumni – Indigenous Identification

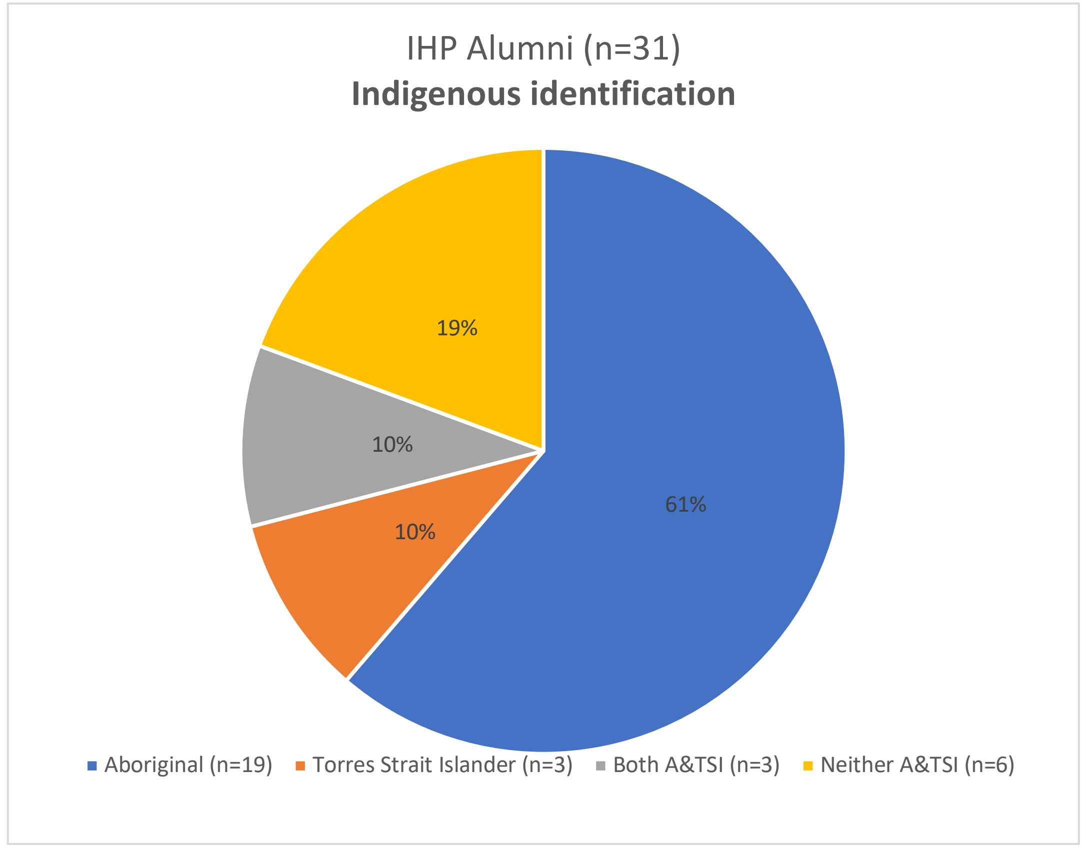


Figure 3b – Educators/staff – Indigenous Identification

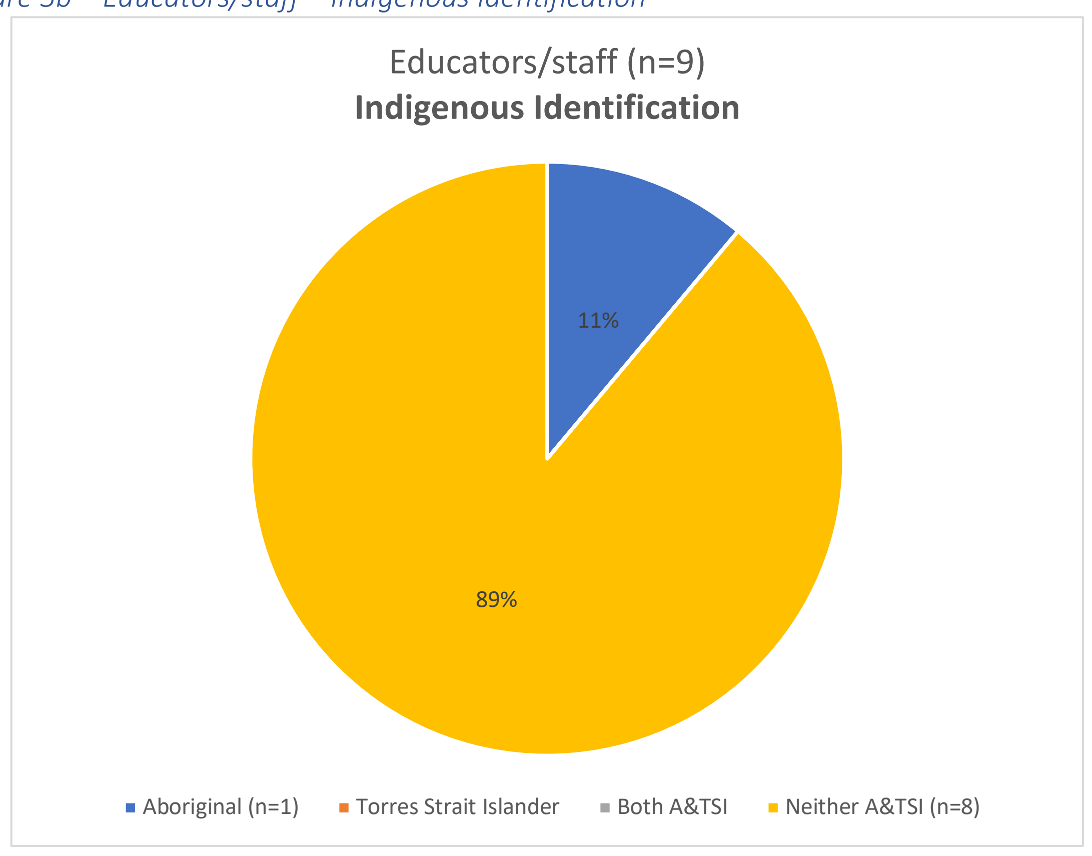


Figure 4a – IHP Alumni - Gender

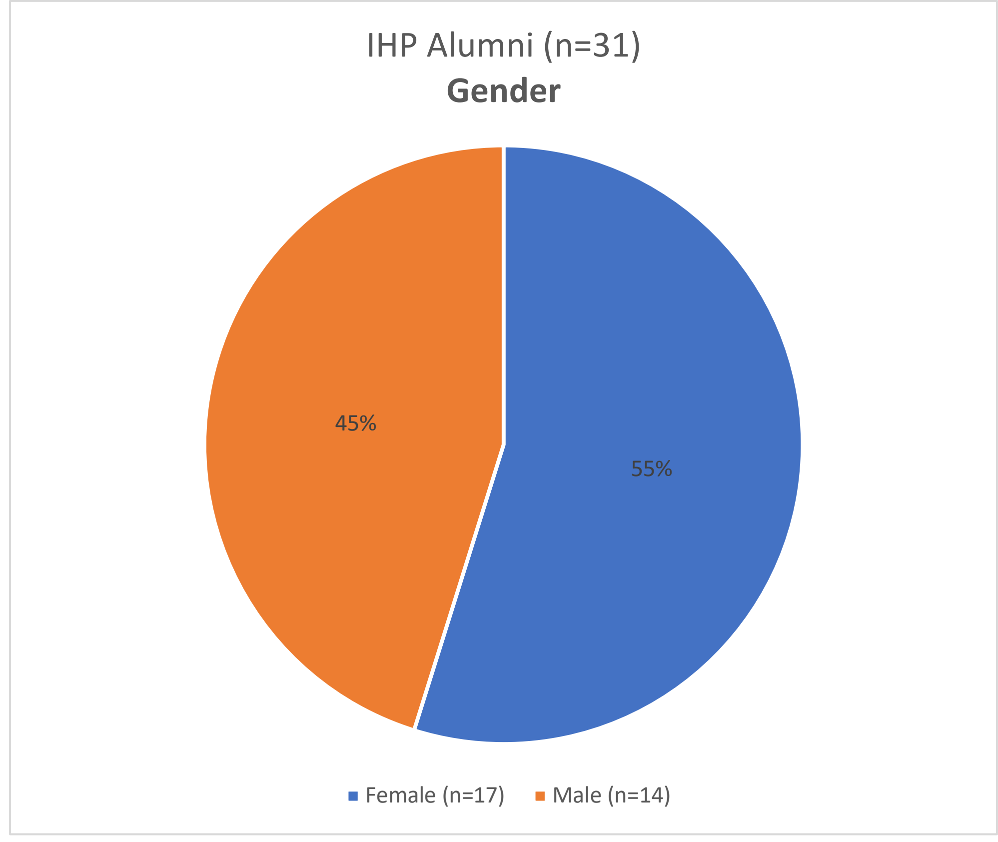


Figure 4b – Educators/staff - Gender

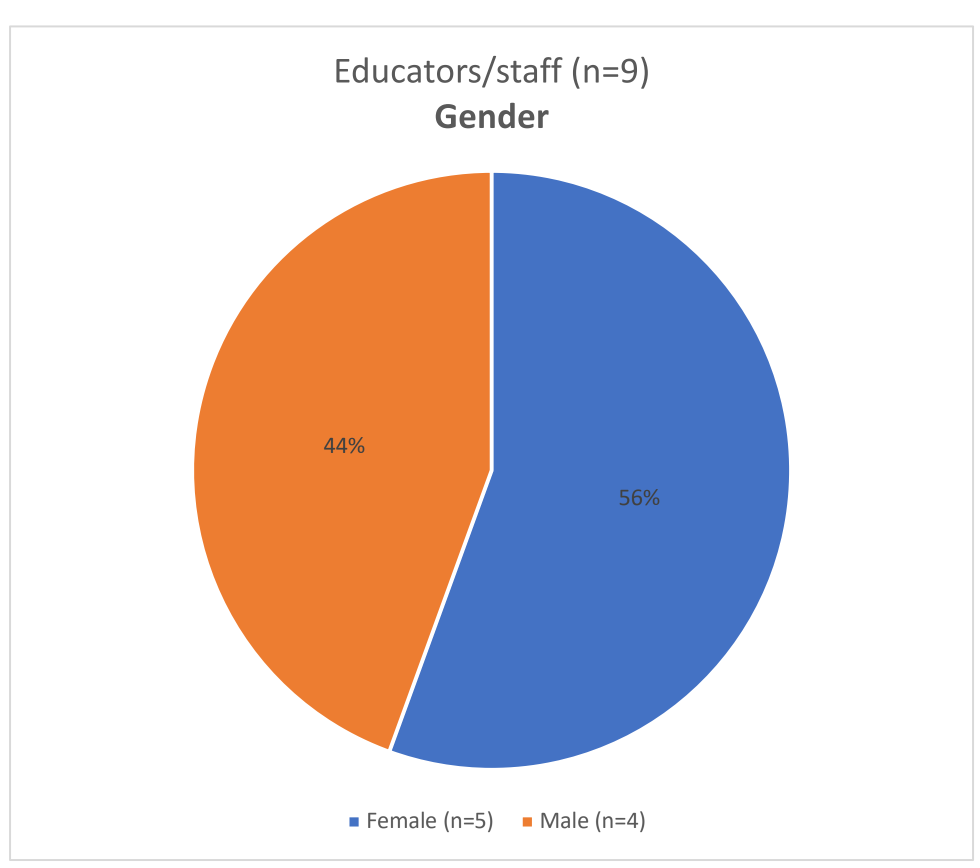


Figure 5 – IHP Alumni – Currently working in sector

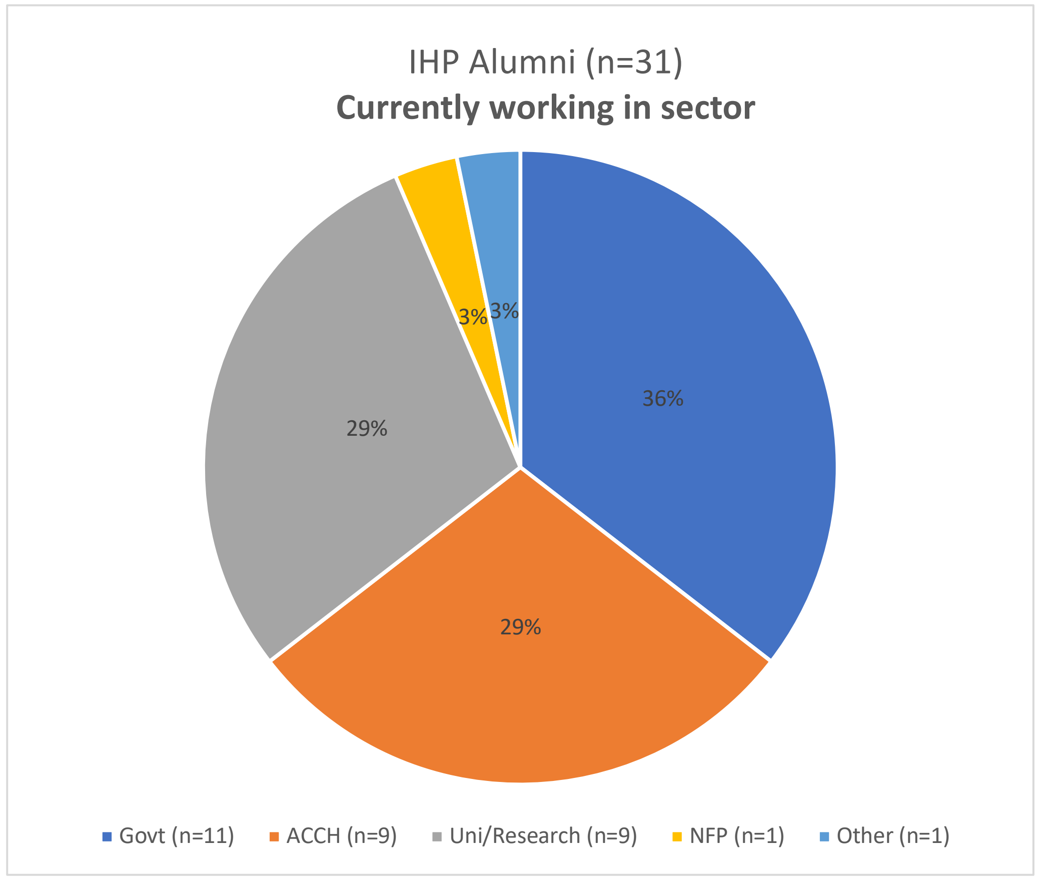


Figure 6 – IHP Alumni - Graduated

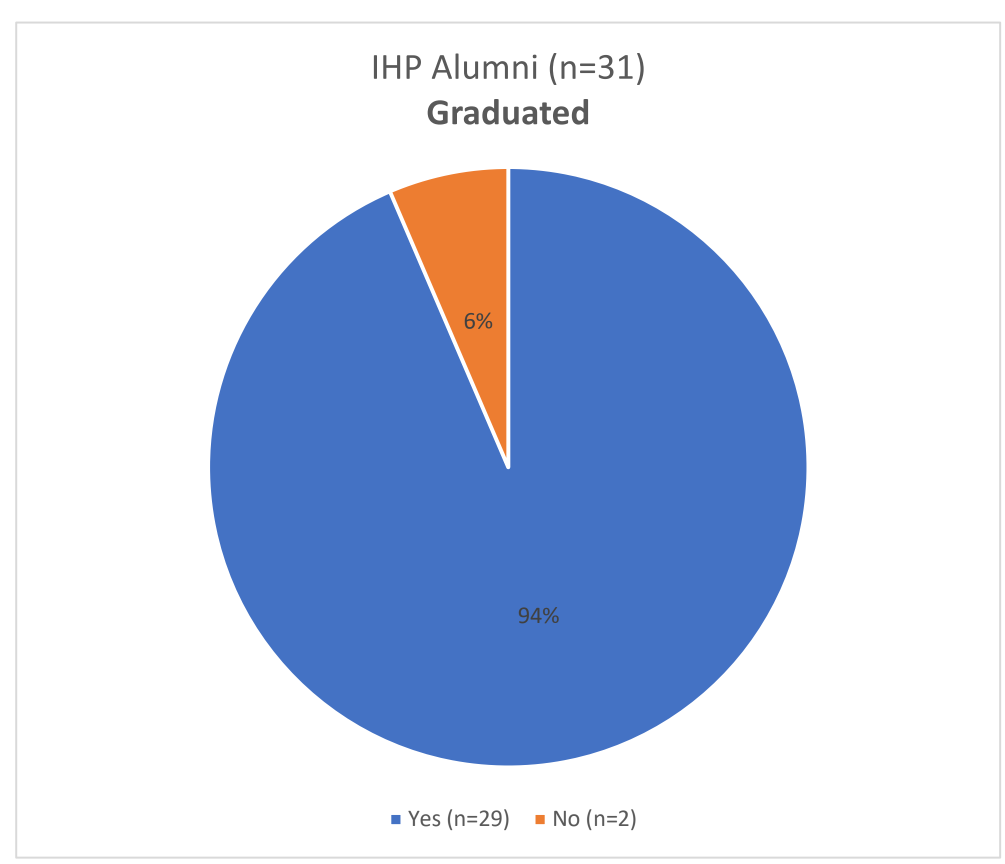


Figure 7 - IHP Alumni – First in family (to go to university)

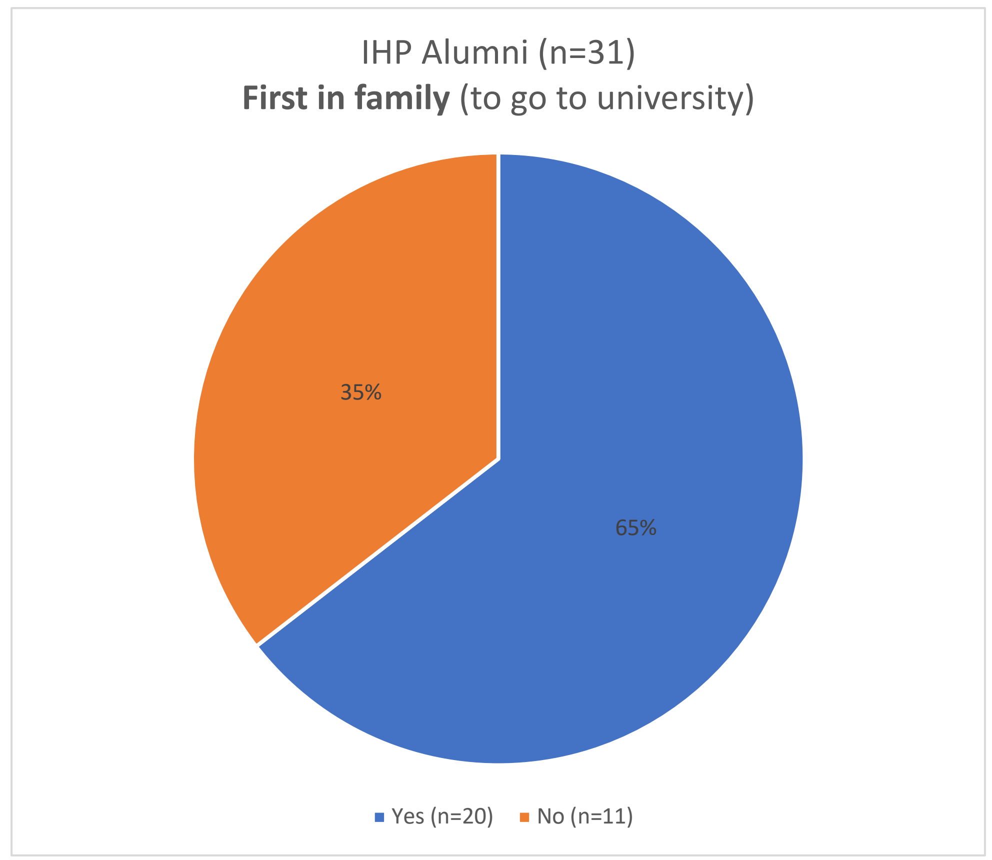
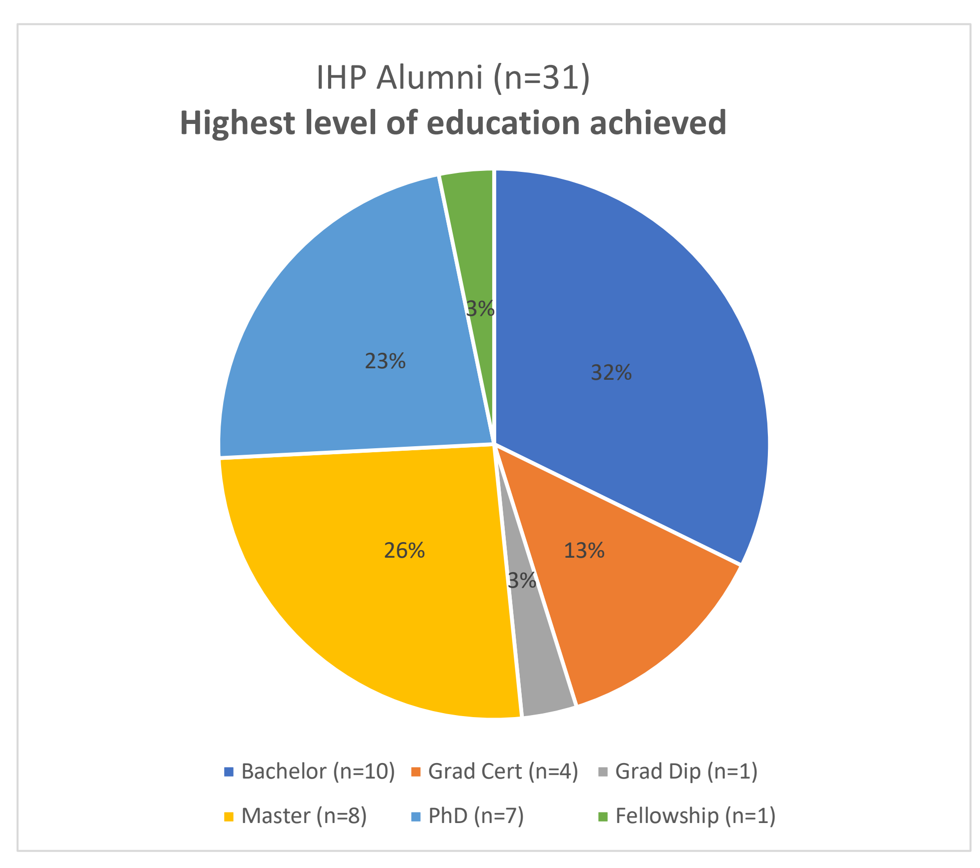


Figure 8 – IHP Alumni – Highest level of education achieved



Findings

The research findings are organised across 6 key domains which attempt to chronologically categorise the journey of IHP Alumni. While the experiences of Indigenous and non-Indigenous students were captured including that of staff members, the experiences of Indigenous students has been the focus of our analysis. The career trajectories have been mapped along the lines of pre-enrolment, educational journeys and health workforce experiences. Alongside each of the moments in time are rich and complex personal stories that extend beyond the typical health workforce story. These stories have been amended slightly to protect the anonymity of participants who have been assigned pseudonyms. We include across these key domains Indigenous health leadership stories as case studies/vignettes to illuminate the broader context within which these leaders emerged. In the context of examining Indigenous leadership journeys, the research team considered leadership in its broadest sense, emphasising transformative action, rather than hierarchical positions within the health system.

Building leaders through building confidence

From the accounts of IHP alumni, the pathway to enrolling in IHP was as varied as the places from which the graduates were drawn. Most did not follow the traditional 'pipeline' or 'pathway' into university, in fact few were school leavers, and even those that were, many were not expected to undertake university study or were not considered suitably prepared academically.

> *"… my high school told me I'd never even complete year 12, let alone go to uni, so, it was quite an ambition and drive to make myself better - but also prove them wrong." [30 Indigenous student]*

There was an interview process for those who did not have the "right" grades or Overall Position (OP) score and many were grateful for this special entry pathway. Travel and expenses to attend the interview were provided for people living outside the Brisbane area and a few IHP students commented that this made attending the interview possible for them. Many Indigenous students, particularly mature age students recalled histories of educational exclusion, having been described as intellectually inferior and incapable. Mature age students, high school leavers and non-Indigenous students alike expressed feelings of self-doubt before they commenced the course and some described themselves as "non-academic" "troubled" "dyslexic" and "backward".

> *"I felt really dumb. So, to be accepted into that degree, to go there I had no confidence. I was like I'm going to fail. I felt like I was setting myself up to fail … And, then I kind of went I can do this. You know, it started to give me that confidence of I'm not as dumb as I think, you know, all that kind of stuff." [11 non-Indigenous student]*

Most of the IHP students reported they were the first in their family to go to university. Some talked of earlier feelings of university being a place that was not for them, and were told they weren't smart enough and would never amount to anything by school teachers and principals. Some were even told by their families that university is "not for us" and were encouraged to enter the workforce. For many, this perception changed as they enrolled and commenced the IHP with 68% of students going on to successfully complete post-graduate degrees.

> *"And so, university was never, ever an aspiration for us growing up. You finish school and you get a job, and that's pretty much how we were raised. So, I remember when I applied to*

go to university my dad actually roused me about it, because university was not – the people who went there, they weren't like us, and it's not real work … we had a strong work ethic growing up, but to be an academic or even go to university was seen as something that people like us didn't get access to or shouldn't. You know, it wasn't for us. [02 Indigenous student]

The initial students first recruited to the IHP were practising AHWs and in the first few years, this group represented a significant proportion of IHP alumni, mixed with high school leavers and students looking for a new career or study path. Many of the students recall encountering the program opportunistically and haphazardly, through a relative, a friend, or a cursory glance at a QTAC guide, not really knowing what the course would offer them professionally upon graduation. For some students, part of the appeal of the course was its potential to help students become more confident in their own understanding of their Indigeneity.

"… what made me do the course, it was because I was craving a need for more information and cultural connection to my Aboriginality. So, identity was a very big issue for me at that time, which often it is I guess in those teenage years. And, it was almost obsessive I guess, you know, who am I, where am I from, what does that mean. And, then I was also very sensitive to outside judgments about who I was and any sort of racism or anything like that … I was just prowling the QTAC … book, and I came across this. And, I thought I think this will give me what I want. It will be able to one, fulfil my need of helping others, which is really important to me, and it will give me the information and learning connection with my Aboriginality that I am needing." [18 Indigenous student]

Among these different journeys we found almost identical stories amongst graduates of entering the program not feeling capable and graduating with a sense of confidence and self-belief that carried through with them in their careers.

"More confident than anything else of my decision making. I've noticed in terms of my colleagues back in [workplace], they basically didn't have the confidence. And, it wasn't because they never had that kind of degree behind them. They all had a Cert III and that, which still is good, they should be proud of it, but they just never had those skills like I had in terms of backing wise and just pushing me up. …We had a lot of great programs thanks to the skills that I've learnt again at IHP. I wouldn't have a clue how to write all these things up before, but then going through that and thinking back what I've done at uni, it really helped me a lot …" [28 Indigenous student]

We see here in Marcus' story a belief that this non-traditional academic pathway was at the heart of the IHPs ability to produce Indigenous leaders across the health system. He describes the IHP as taking a risk on Indigenous students who had yet to demonstrate their academic capabilities, but in building their confidence, students went on to "do something". His journey from one of poor academic achievement to that of discipline lead in Indigenous health within an Australian university as a Medical Practitioner is certainly a strong testament to that.

Marcus' Story: Creating Leaders versus Graduates

Marcus moved to Brisbane as a high-school leaver from a regional coastal town in Queensland. He wasn't a strong academic performer at school and his OP score of 17 would not get him selected in most university courses however fortunately for him, the IHP entry was not based exclusively upon that one academic measure. A career in health was initially meant to be a back-up for his sporting career in which he had been awarded a scholarship for while studying.

With few family members having undertaken university study and being isolated in the big city, Marcus insists that if it weren't for the IHP family, he would have moved back home. IHP gave him a family but it also gave him a focus. As a young person he soon learnt about '***the historical aspects of my own history and culture that my own family didn't talk about and that we didn't learn about at school, so I became really passionate about that***'.

Marcus says the biggest challenge was learning how to write, use email and computers and he recalls the late nights in the computer room because he just didn't have access to a computer back at the Aboriginal hostel where he stayed. But it was the passion that he and the other students shared, along with the support of academic staff within IHP that sustained him during these years and inspired him to aim higher.

After graduating from IHP, Marcus went on to study medicine and start a family. Since becoming a medical doctor, he has enjoyed varying roles working in busy city hospitals and AMSs both at home and across Queensland. He is now the discipline lead for Indigenous health within a medical school at an Australian University helping churn out the next crop of changemakers in Indigenous health.

He credits IHP for developing a strong cohort of developed leaders who were nurtured to develop the "***confidence to go on and do more and aim for more, because it gave a bunch of people a whole bunch of skills to do something***". In comparing IHP to the current strategy of developing Indigenous health professionals he states:

"***The difference is from that program to what we're doing [today] in programs like medicine is we're cherry picking people that would have been successful anyway. What the IHP did was it took a risk. It brought people from a long way away that didn't have the academic capability, but they put a lot of work in developing these people. It's through that hard work and the challenges that you get leaders and you develop leadership. You can't develop leadership by just going through the motions of things***".

Building leaders through building on Indigenous capabilities

Importantly, IHP students did not enter the program as empty vessels ready to be moulded into health professionals. Most students came to the program with a strong desire to improve the lives of Aboriginal and Torres Strait Islander peoples' not only from a health perspective but also a social justice perspective. Some discussed being witness to early morbidity and mortality within their families and communities and talked about experiences of mistreatment and injustices being a driver to influence change.

> *"We had a lot of very younger Elders passing away. So, my passion was really around health and health inequality. This is way before Close the Gap came in. You could see it, but you couldn't necessarily articulate what was happening in our communities, which is why I went into the Indigenous Health Program. And, I learnt all about all of everything that I had been seeing, which was great." [13 Indigenous student]*

Some said it was self-motivation that led them to enrol in the IHP, others talked about being influenced by friends or family, particularly past or current IHP students, or those already working

in health. A few spoke of encouragement and support from their employers to undertake this course. For some students, their journey into IHP was following a long tradition within their own families of a career in health or as healers within their community. Many students spoke of being motivated to learn about health to foster change within their community. We also found student and staff stories of transformative learning experiences which arose from the student's own lived experiences, wisdom and knowledge. Participants described the IHP cohort as a diverse group whose cultures, ages, experiences and knowledges were valued, and enriched the shared learning environment.

> *"… you had so many people with different beliefs and their different – come from the communities and things like that, you were taught ways of how people lived and talked and language and what was ethical, what wasn't. … But the concentration of rich cultures and people, it was really quick learning experience for me, so I thought it was awesome." [13 Indigenous student]*

Students spoke of the importance of being in a predominantly Indigenous learning environment, which for many, staff and students alike, was a new encounter, but integral to the success of the program. Both IHP students and educators talked about the benefits of an Indigenous cohort and the safety in knowing "the mob's got your back". This course appeared to empower students as it validated their lived experiences and they were learning together with people with similar experiences that they could relate to. The IHP design recognised the collective knowledges and wisdom of students resulting in a united and empowered cohort.

> *"And so, here I was in this black space five days a week all day every day, and I loved it. The yarns you could have and to be affirmed and – and what we were studying was not look at how bad black fellas are, it was like how do we change the system to make things better for our mob. And, that was so exciting to me." [02 Indigenous student]*

We see how via the creation of a collective Indigenous learning environment, Indigenous identities and knowledges were affirmed, and students who once lacked confidence in the learning environment describe "having power" in these encounters. It is from that Indigenous leadership was fostered and indeed Eliza's story exemplifies a story of pre-existing capability which through the IHP resulted in personal transformation for herself and her community.

Eliza's Story: No longer watching people die

Eliza grew up in a remote Aboriginal community in far north Queensland. Her schooling years were difficult as she was presumed "***dumb***" and any evidence of academic excellence was assumed to be a result of her copying her classmates' work. Like most in her community, she was sent away for high school oft times feeling homesick, which was made worse with the loss of the matriarchs in her family during her absence. These senior women were influential in Eliza's life, shaping her interest in a career in health, particularly in following in their footsteps as nurses. Eliza trained and worked as an enrolled nurse but was frustrated because "***I was so restricted and wasn't allowed to do or give care to the old people the way I learnt***". While she was grateful for the opportunity to take care of the old people in her community, she didn't think being an enrolled nurse was "***enough, because I watched people die, I knew that there had to be something else that we could do to stop people from dying so young***".

Eliza found out about the IHP in Brisbane from a relative who was working at the University of Queensland at the time. Despite her previous educational experiences Eliza describes her time at IHP as "***the best time of my life being with the group that I was with, I actually found myself and who I really am…I was given the chance to actually grow and learn and have the space to do that***". The move to Brisbane and adapting to university life wasn't easy however, and Eliza was supported by several family members, financially, emotionally and physically. She says "***I am who I am today because of them…My drive to prove myself that I could do that and I think honouring my grandmothers and their stories and what they did to provide for us now kind of pushed me because I wanted to be like them***".

Eliza's educational journey did not stop with the IHP, and she continued on to undertake an Honours and Masters degree. She has enjoyed a long career working in health and health research across government and community-controlled sectors. She has since returned to working with remote communities in far north Queensland and the Cape, occupying a senior leadership role in an Indigenous organisation. She says, "***I think being here, I've put into practice what I've learnt back there at university, getting people's views on things and looking at evidence-based best practice***". While her work in facilitating social change is demanding and challenging Eliza is adamant for the need to do the hard work for the next generation. No longer watching her people die, Eliza describes her work as "***empowering community***".

"***Indigenous people have to be the ones to solve the problem because we know what the solutions are, so allow us to implement what we see as solutions to our own problems. This is the work that I do and I love. I don't think I can be anywhere else honestly***."

Transformative Learning Through Supportive Relationships

Participants told stories of the uniqueness of the IHP as an educational experience – that it was transformative, safe, welcoming, and personable, and relational. All participants described the importance of the relationships they enjoyed with fellow classmates, professional staff and academic staff throughout the program and beyond.

Indigenous Health Program students talked about staff (administration and educators) having an "open door policy" and providing non-judgemental support, mentorship and tutoring to students whenever needed.

> *"The small class sizes created a really close and collegial environment, one where the teaching staff and the other students became like family. We supported each other, and in many ways, I think it made us all better and more confident students. Doors were always open, you could always talk anything through, and this went well beyond just things related*

to our studies. Staff and students shared roles counselling each other … It was one of the many experiences that shaped my entire ability to identify and live as an Aboriginal person in a more complex and nuanced way, my experiences were no longer academic, I was immersed." [26 Indigenous student]

The support provided by staff extended beyond what was provided by the student support office and the impact it made was described as fundamental to student retention. Many students believed they would have failed if they had undertaken mainstream course. The environment was described as a safe space where people were cared for, assistance was given to help students navigate and manage within an often-inflexible university as can be evidenced in Melinda's Story.

Melinda's Story: Surviving an Education

Melinda was born in an Aboriginal reserve community in the 70s where she attended school until the age of 10 years old. She left her small community with her mother as a child moving around major cities and regional centres for school which she never particularly enjoyed as she had severe learning difficulties and she struggled to read and write. Her early working life was much like her childhood, trying out all kinds of jobs and courses moving through different professions. She describes her enrolment in IHP as "***being in the right place at the right time***" having met a friend who was a student who encouraged her to give it a go and encountering one of the teaching staff who had been a former teacher of hers at TAFE.

University wasn't a place that Melinda ever saw herself being at however. She recalls the first time she saw the old buildings of the University of Sydney as a child passing through on the bus and thinking that perhaps it was a castle where kings and queens live. She remembers classmates planning their university study and wishing that she had the same vision. This was not to say education wasn't important, in fact, her grandmother was a teacher aide back home on her community and would insist upon the grannies, "***For us to survive in this world, you need an education***".

Melinda is adamant that her ability to complete university study was due to the support from one of the professional staff. During her study, she had given birth to another child and a whole lot of stuff was going on in her life, but this particular staff member, she insists, taught her about being resilient, and being vulnerable and learning to accept help.

"***She took my son under her wing. Not even a week after he was born, I was in at IHP sitting an exam, I've got a baby hanging off my titty and then [she] would come in and when he was asleep, grab him and just like take him out so I could concentrate on what I had to achieve. That's why I'm always grateful. I always say to my family, 'You've got another mother that you need to meet one day, because she hasn't seen you since you were a baby'…he's 21 now***."

Melinda says that the IHP was not different to mainstream but that it was "***very complimentary of a learning style that allowed Aboriginal and Torres Strait Islander people to actually engage in an environment that can be seen as foreign to them***". Despite her learning difficulties and the foreignness of university she went on to complete an Honours degree achieving a high distinction and she is toying with the idea of undertaking a PhD. Not that she isn't busy enough, Melinda returned home several years back and today she holds one of the most senior executive management positions within the hospital and health service while still rearing up a big mob of kids.

The staff created a space for Aboriginal and Torres Strait Islander students to feel at home and minimised the amounts of energy students had to expend to deal with racism in order to focus more on their studies. When students were absent from class, it was known. Fellow students and staff would often follow up with the absent student to check if they were okay and to offer their support.

> *"So, as each year progressed for us, they brought on the next sort of group that came through. So, we went the second year, then they brought the first-year group in. So, we then sort of helped that group navigate their pathway, and they in turn then helped the next group that came after them. So, there was always that sort of notion of – and that was the responsibility that we took on as well in trying to provide support for not just our student group, but for the rest of the student group that were coming through." [01 Indigenous student]*

Indigenous Health Program students talked about the staff being culturally competent in that overall, they had knowledge and understanding of the needs of Aboriginal and Torres Strait Islander students. In comparison, mainstream courses were described as impersonal and unsupportive having lack of awareness or understanding of any specific needs, however, some IHP students said the program helped them to build resilience to cope with mainstream environments. Some referred to the IHP as refreshing in that it was not assumed that all Indigenous people are experts in all things Indigenous as they had been made to feel in mainstream courses.

> *"I wished I'd experienced a mainstream education program or learning space prior to IHP. I really didn't recognise the benefits, the strengths of IHP. I think having Indigenous staff teaching there and providing support, just how it was structured with the PBLs but also the other classes, for the sciences and technology, where the student numbers were quite low … and other support services. I think those were the benefits, having [staff] on site to provide the support immediately if needed. That was all beneficial. I think I really feel like I took that for granted, so when I went and did nursing, it was similar in that it was a smaller class, but for nursing I was stuck in an isolated campus, there was only one lecturer, and she didn't know what she was doing, so there was a lack of support. But because I developed those study skills during IHP, amongst all the other stuff that was happening, learning how to put an assessment together, learning how to cite, learning how to research, it was easy for me to actually just start nursing and get on with it, while a lot of my colleagues really struggled with getting started with thinking as a university student." [34 Indigenous student]*

A number of IHP students talked about the dichotomy between the Herston Campus where the IHP was largely delivered and the St Lucia Campus where they were required to attend lectures only in the latter part of the program. Herston was a small community where the IHP had its own designated area and IHP students gave a sense of pride and ownership of it. Isolation from the main campus at St Lucia was actually an advantage, students said they felt safe there and felt a sense of importance being part of the hospital campus. They also spoke of not only having access to educators but being together with them, all doing the same courses. In comparison, St Lucia was described as daunting and many believed they would have been lost or would have even failed the course if they were made to study there each day.

"I remember I had to do an elective and I had to go to St Lucia for it. I did one class and I freaked out. It was just too daunting. It was too academic. So, that was a real struggle, but luckily, I went back to the unit, I spoke to [educator]. I told him 'I can't do that. I'm going to fail. I can't sit in that classroom'. Because you're just a number. Where in that degree you're actually a person and they know your name and they say hello and they have a yarn to you. You feel like a family. But luckily [educator] was able to help me and he helped me with my elective, and I ended up doing one on one with him. So, it was really accommodating." [11 Non-Indigenous student]

Indigenous Health Program students appreciated the gradual integration into university life and the opportunity to get used to Herston before going to the main campus.

*"… pretty frightening sh*t going over there, man, I tell you. Yeah but I mean we were quite capable at that point." [13 Indigenous student]*

The IHP was described as a community, which gave a sense of family and belonging, for some right from the enrolment stage. There was an instant trust within the cohort and between students (across cohorts) and staff and many talked about being treated like a real person as people would say hello and yarn. Students said that this environment made it possible to live away from family, friends and community. Educators and staff commented that they also felt a part of this community.

"So we didn't get a sense that there was a hierarchy … we still respected everybody in the place. When I look back now, that's just like a community. It was a community for us. You have [program director] and an elderly woman in your class who's older than [program director], you still respect her … just the same or higher than [program director]. [Program director] knew. There wasn't an unbalance … it was just a comfortable place to be." [03 Indigenous student]

The sense of family and belonging that the IHP offered to students, learning within a predominantly Indigenous learning environment was also critical to the identity development of a number of students, particularly the high-school leavers. Strong lifelong friendships were formed and have continued throughout life after the IHP. Many talked about the importance of these connections and spoke of having increased cultural capital as a result. Mentor relationships have also continued within this network and have been drawn upon throughout their professional careers.

"So when I was working in [organisation], I came across [IHP Alumni] … there was sort of that reconnection at a professional level where they are now graduates working at policy level. So there was an established relationship, but I also developed an understanding of our role within health, and influences we could make, advising policy and program work that was state-wide. So there is a community, I think, that has gone through the IHP program that's out there and we're still connected. So connections I have now relate to connections that I had in IHP. It's unspoken, but there's a connection that was developed in that people just keep running into each other at particular times." [34 Indigenous student]

In Jermaine's story, we can witness how critical IHP was to his identity, the sense of family generated within the IHP learning environment and how this shaped him professionally in his work around the provision of culturally competent health services.

Jermaine's Story: Feeling like family and feeling right

Jermaine grew up in a regional town in far north Queensland raised by his white father, prohibited from knowing his Aboriginal family, despite the fact they lived just 15km up the road. Despite describing himself as an "***anxious, backward, upside down, dyslexic, slow learner***" Jermaine was school captain and prefect in high school. But it was at school that Jermaine connected with his own Blackness, when two new dark-skinned students turned up and claimed him as their cousin. For Jermaine, things started to make sense for him because "***before that you scrub your skin, you wear long sleeves, you put a hat on, you don't want to express that colour or natural beauty***".

Upon completing high school, Jermaine had his choice of apprenticeships and traineeships but "***it just didn't feel right***". He was accepted into a Bachelor of Science degree at another university with the hopes of becoming an allied health professional but a relative insisted that the IHP would be a better career choice to match his passion.

It was here in this new educational environment that Jermaine experienced a renewed sense of family and connection with his Indigeneity:

"***The education process was brilliant because it was interactive learning, then problem-based learnings…yarning it through, it gave you confidence to stand up in front of people. There was a lot of love in that room, there was a lot of laughs and we could all feel each other struggle because we could all understand that our families weren't perfect. We weren't from backgrounds that understood us or appreciated us. So it felt like family. It felt really good. It felt you could be yourself. You could shine, make a mistake, you have a laugh and that's life instead of being growled about it***".

While studying Jermaine also worked part-time as a community health worker locally and upon graduating, he returned home and took up a position as senior policy officer with government where he continued his cultural educational journey with his mother's family. Jermaine's cultural and educational journey have merged to form his work today in ensuring culturally competent health services for Indigenous peoples.

"***I want to see that clinical and cultural competency, be at the forefront, not at the back. [About cultural competency] If that was your brother, if that was your mother, if that was your uncle what would you do? You have to have a big heart. You have to wear it on your sleeve, don't be afraid and you've got to push that spirit, that energy…That's how we've always been taught or educated. If that was your family how would you talk? How would you do that assessment? How would you do it differently? Would you do it the same? So yeah, it's all about softness and it's all about being clear and never giving up. Never give up. We all learn differently but we should never give up on each other***".

Transformative Learning Through Innovating Indigenous Health

Participants attributed the transformative work of IHP to the innovative approach it took in regard to Indigenous health, and the skills, attributes and understandings it sought to imbue students with. This was often complemented by the knowledge and experiences of Indigenous students within the teaching and learning environment who actively engaged with and contested the knowledges being produced 'about' Indigenous peoples. Integral to this innovative approach to Indigenous health pedagogically, was the input from Indigenous community stakeholders in the design of the degree. Many people who were initially engaged with course were health workers, and IHP educators spoke of students continually informing the content of the course and championing health as a community experience, not as an individual concept making it culturally relevant.

"… So, I think the university sector has a lot to learn from the design of the Indigenous Primary Health Program and the teaching methods. Much more culturally relevant to our ways of learning. [14 Indigenous student]

The IHP took a strengths-based holistic approach to Indigenous health as opposed to replicating uncritically mainstream health sciences programs. IHP students were required to attend the course full-time i.e. Monday to Friday from 9am to 5pm most days, similar to full-time employment and IHP students talked about treating it like a job. Students also spoke highly of the staff and their suitability to this program and the engagement of appropriate guest lecturers with positive community support and input.

"Oh it was brilliant. The learning environment was just – you know, the people that worked there, the staff and the quality of people, like they – [program director] managed to find exactly the right mix of lectures and professors and real, quality staff. … Which you know, those people had a really good grasp of Aboriginal and Torres Strait Islander cultural issues and students and learning and the teachers and things like that. … I don't think you could get a better structure and system." [13 Indigenous student]

Indigenous Health Program students talked of acquiring a broad spectrum of tangible skills that created a series of paths rather than just one.

"I have been given the skills necessary to work in community and government settings. This has allowed me to have great diversity throughout my career …" [27 Non-Indigenous student]

The IHP was an active research centre where students gained foundational research skills and experience in communities. With research being strongly embedded into the program, IHP students spoke of their increased ability and confidence in conducting research and understood the importance and benefits of research within an Indigenous health context. Having this strong foundation in research assisted IHP students in their career journeys and some talked about developing a passion for research.

"Well, it was the research stuff. The initial kick-start for that was the research programs that we worked on. Because it was fairly research orientated, fairly action-research type orientated, that program. So it was about working with - and it wasn't coming in on the end of a research to finish a bit, or the initial start … you followed it through from the start to the finish. That included developing the design, the research design. It was the whole research process right to the start, to the very end … So we basically come out with those skills and then that you can apply to anything." [14 Indigenous student]

The majority of participants talked about the benefits of the PBL learning model of the IHP and how it became a skill for life. Its impact on students was profound and many IHP students talked about incorporating this method of problem solving into not only their workplaces but also their personal lives. Problem Based Learning was a method of learning that made the learning environment safe, accessible and engaging for a broad range of students with diverse skills sets and learning needs, as evidenced in Marlon's Story. For many it was what attracted them to the course, kept them engaged and continues to inform their approach to teaching and learning today.

Marlon's Story: A Community of Learners

Marlon never aspired to go to university. He grew up on Thursday Island, and as a young man he wanted to play footy or be a police officer, both of which he tried upon relocating to Brisbane. Unsuccessful, he returned back home to the Island and landed a job at the Hospital as a wards man after filling in a spare shift. Marlon's boss sent him to participate in the introductory course for the IHP. Not knowing much about it, he thought he would give it a go, at least it would be a two-week trip to Brisbane, where he could catch up with family. He didn't tell people he was going "***because I was ashamed I might fail, because I already failed high school, somebody will say to me 'how are you going to do uni when you can't even do high school?' that was my fear***".

Marlon had more than one reason to be afraid, he was concerned about his level of English given it wasn't his first language and computers it turned out, were something else altogether. Marlon deliberately turned up late and spent the train ride hoping it would break down in order to avoid the prospect of failure. That fear soon dissipated having met other students who were mature age who understood what he was trying to convey even when his English wasn't the best. The younger school leavers meanwhile helped him with those damn computers. But it was PBL that Marlon recalls as most impactful upon him both then and now.

"***We were introduced to PBL in that introductory course. For the first time I was engaging a lot, because I'm in Brisbane and I'm doing a course and then they mention a scenario for Torres Strait … (I thought wow!) you had people asking me about certain demographics of Torres Strait, I instantly feel like I'm included … It's because when we had another scenario about another community in Queensland, you had somebody who either worked there or was from there where we could use as reference too - we all sponged off that (it was better than reading from text books), It was the PBL of teaching and at the end of two weeks now I wasn't happy that it ended. I was excited now to see that there may be a good chance that I might be able to be accepted in university***".

To his surprise, he was offered a place and graduated from the IHP. He describes his educational experience:

"I was comfortable, the way, the methodology that they used in terms of teaching. I don't know if it's got something to do with the way the course is designed or the subject is designed, or it's a personal trait for them [lecturers] and how they lecture. You know, the way you were able to access them one-on-one if you had to. We had support everywhere, the admin staff there was helping us. Even [program director] was there all the time. So we didn't get a sense that there was a hierarchy … Because when I look back now, it was a community for us…Even though some of the lecturers were non-Indigenous we were still able to access them. How we responded to that was our relationship was as if we were all Indigenous. I am proud of my journey with IHP, it was truly life changing with lifelong friends!"

Problem based learning was valued because it promoted collaboration amongst students and it valued the existing knowledge of students. The PBL assessments were dependent on each student in the group contributing and the quick turnaround due dates were demanding on students. Indigenous Health Program educators described this model as cutting edge at the time and spoke of how the "flipped classroom" generated fierce yet healthy debates where students and educators alike challenged each other giving a rich context for active learning. Endearingly the acronym PBL was and continues to be used as a verb by IHP students i.e. "I PBL'd things at work". Through the PBL assessments, IHP students reported gaining skills and confidence in "talking back" and "speaking up".

"it's [PBL] introduced a learning technique that was a little unique but still got the same outcomes of what mainstream teachings are … from a little person that couldn't read or write to know I've got an honours degree". [20 Indigenous student]

Indigenous Health Program students talked of the field trips to Indigenous communities as being an enjoyable and memorable part of the program. For some the experience was described as "eye opening" as it was the first experience visiting and working within discrete remote Aboriginal and Torres Strait Islander communities. The field trips solidified and put into practice what they had learned giving them a practical skill set to assist in real life situations in their future workplaces. An educator commented that the field visits to Indigenous communities showed the audacity of the IHP and what it tried to achieve in that it was a bold endeavour particularly in the current climate of higher education.

"Hands-on. It was actually hands-on … so part of the qualification that differs from other universities was that, in this particular unit, for this next two months or whatever, it'll be an environmental health impact study … We went to Woorabinda and we lived in Woorabinda … and worked with the community to identify issues that are impacting the environment. Then we worked with the community to identify the areas and then we worked out how to address the areas … we worked out the project plans, the consultations for the community, the testing, any of the biology type stuff. We did those types of things on the community. Then we worked with Queensland Health to provide medications to address the issue within that particular problem … then that was all written up into programs. So that was developing - that's policy!" [14 Indigenous student]

Students typically described having developed a more complex and sophisticated understanding of Indigenous health, from biomedical understanding of health to a deeper understanding of the social and cultural determinants, the importance of mental health, individual and community notions of health and wellbeing and an understanding of the impact of colonisation on Aboriginal and Torres Strait Islander peoples' health. This holistic approach allowed greater consideration of the context of a person's life including their family and community as well as the issues they were experiencing rather than a rigid biomedical health behaviourist solution. This concept of health embedded in the IHP on a daily basis and IHP students were able to broaden their thinking around problem solving and strategies at a system and population level.

"…we were doing social determinants, looking at social determinants of health, and I just remember sitting in the computer room and looking at life expectancy … and thinking, "I don't understand that. Does that mean I'm going to die younger just because I'm Aboriginal?" Also then looking at things like housing and income, and it all kind of starting to fall into place around, "Oh, well, that's why." Like, I knew that we were different, or treated differently, I should say, but I'd never really thought about it. So the IHP gave the sort of insights, you know, actually laid it all out and gave a bit of foundation around the structural differences that we experience. And then the understanding that, well, actually, it doesn't have to be that way. We don't have to die … Yes, it really made me start to question and have a real interest in equity." [25 Indigenous student]

Students spoke not about becoming 'health professionals' but rather, critical thinkers. And while many students talked about leaving school without strong academic skills, they associated the IHP as integral to the development of a more sophisticated level of thinking. Indigenous Health

Program students recognised points of difference between learning environments based on deeper understands between students and educators.

> *"The most significant factor for the program for me was the design of the problem-based learning packages, because it makes you think critically about health systems, health structures, diseases, something that most courses don't do or are now starting to do, which is really looking at the problem through a clinical lens and cultural lens, and then being able to really research that collectively in small groups and working through health problems. … I still use that framework now in the work that I do, because they're often complex Aboriginal health issues, for example DV … and that's what they taught us a thinking framework. And, that's unique." [14 Indigenous student]*

Indigenous Health Program educators and students talked about a two-way learning environment where at times the educator and student lines were indistinct, and collective learning occurred with educators respectful of the wealth of knowledge students brought into the program. Educators spoke of transforming approaches to learning in other courses they taught thereafter. An appreciation of this experience was expressed by educators who felt they wanted to "give back" to students which is evident through the continued relationships they have with students today.

A Different Kind of Health Professional in a not so different Health System

> *"I think what the course did was it gave us the foundation knowledge around clinical care across primary health care, but then it also opened our eyes to the health system and essentially the negligence of the state federal and state departments in then supporting Aboriginal health." [14 Indigenous student]*

The program appeared to develop "a different kind of Aboriginal Health Worker" with participants often talking about how they felt better equipped to make tangible changes, with a community development and social determinants approach. It appeared to empower students, not just as 'health professionals' but it nurtured the development of advocates and activists within a health system still failing to adequately meet the needs of Indigenous peoples. Students often talked about their increased abilities to speak up, and being armed to deal with racist and hostile work environments.

The IHP was described as having had a significant impact on its graduates in terms of career trajectories. Individual stories of transformation experienced by students have been profound. Many graduates have taken up positions within the health system in roles including nurses, team leaders, executive managers, allied health professionals, doctors, CEOs, policy makers, and project managers across the Aboriginal community-controlled health sector, research and higher education, and the public and private health sectors.

> *"I think it's had a big impact in that there's now – I don't know how many – 70 graduates, majority of whom are Aboriginal/Torres Strait Islander, in positions of all types of different leadership. And at the time that the IHP was happening, it was really innovative, and maybe since there hasn't been either, but at that point in time, I don't think there was a course that was offering that type of qualification and have put through so many successful Aboriginal and Torres Strait Islander scholars. So it was very innovative and novel for its timing. Now, I mean, the world's changed significantly, I think, in that back then, to actually*

have foreseen what would be needed in the future, like there's no way I have this job, and now there's lots of sort of opportunities available for qualified, experienced Blackfellas and the IHP has definitely contributed to filling those positions. So the greater the number, the more influence we can have and I think that, yes, the IHP that started back then had seen that it was going to be something that would be needed in the future." [25 Indigenous student]

Undertaking further study after graduating from the IHP was common among students due to the empowering and inspiring learning environment and was often integral to the advancement of their careers as evidenced in David's story. For some it was vocational training at TAFE and some used the IHP as a stepping stone into medicine or other undergraduate courses that they were not eligible for when leaving school or they were inspired to move into a specialised discipline. Some who only intended to use the IHP as a stepping stone found a genuine interest in Indigenous health and embraced it. People said that the IHP was an enabler to subsequent tertiary education. Many went on to complete post-graduate qualifications such as Honours and Masters Degrees and Doctorates in Philosophy, however subsequent learning environments were typically not as accommodating and many, like David still attribute much of their success today to the foundation that the IHP provided.

David's Story: Knowledge and Networks as Enablers

David had a more direct pathway into the IHP than others, being raised in Brisbane, a high school leaver and a parent working within the health system who encouraged him to pursue a health career. Despite this, he was still one of the firsts in his family to go to university and he admits that his initial passion was in sports journalism rather than health.

Today, David enjoys a quite senior position within the health department and has worked in senior management positions within community-controlled health organisations as well as international public health postings. His career pathway was enabled by a range of supports which included; a health department undergraduate scholarship, completion of a Masters' degree, and a Graduate degree in management.

He attributes much of his success to the foundation of the IHP.

"I think it was a just a good fundamental understanding of health and well-being, it laid a platform. I was fortunate to do some post graduate study and other things since then, but I think the course certainly gave me a good understanding of health and social determinants of health and research methodology and things like, population health principles and it was probably the first real exposure to remote communities because I'd just grown up in Brisbane".

The other key enabler to his success has been the network of people which IHP was integral to developing:

"***The IHP built a good network of people to work with…It really helped to have a network of people, some of those people I'm still in contact with, work pretty closely with…among all cohorts, there's been some really influential people that are amongst those groups, medicine, administration and lots of different fields***".

Some who did not do further study expressed that they wished they had, while others still plan to undertake post-graduate studies but have found it too difficult to do whilst working.

While many students talked about the IHP exceeding expectations, likening it to a masters' level degree, some graduates faced challenges in the degree being recognised in its own right by employers. Those who had difficulties in getting the qualification recognised found that the positions they did land did not reflect the skills and experience gained through the IHP nor were these reflected in their wages. Some graduates progressed regardless but others were held back and it was their end point. The devaluing of the program had lasting impact on some graduate's careers as evidenced in Charlie's story. We see a failure of the degree to suitably recognise, but too we see a health system unable or unwilling to recognise the AHW structurally as health leaders in their own right.

> *"Because it wasn't recognised, that was another bear bug too. I just thought, everyone wanted you because you've just done this you beaut, you know – this course at UQ and we really want you to work for us. But then when you got there it was like … it didn't reflect the pay, it didn't reflect my experience, didn't reflect my skills that I had learnt in health, you know. I went from doing blood pressure and blood sugar levels in the community to being told, "Don't do that because you might tell the person the wrong thing." I wouldn't go back and work as a health worker and I'll probably be one foot in the ground by the time anything changes." [07 Indigenous student]*

Charlie's Story: Because no one listens to you

Charlie came to IHP in a roundabout sort of way. His schooling he undertook in a regional town and despite being school captain didn't have the grades to get him into uni. He repeated year 12 and was accepted into teacher's college and requiring him to move to Brisbane. Sorry business within the family soon saw him drop out of college and return home. He still had lots of choices career wise because of his divergent interests and outgoing personality. Some years later he came across information about an introductory workshop for the IHP and he moved to Brisbane the following year.

Like most IHP students, he wanted to put to work what he learnt back home with his own mob. Sadly when he graduated and returned home his degree saw him as 'too qualified' for the usual positions available within his community within Indigenous health. He eventually was successful in securing a Health Worker position however he couldn't advance any higher because the funding was not structured to support advancement. Rather than move up through the health system, Charlie moved around within AMSs in clinical and community development management roles as well as with government departments. He persisted because he knows how much harder life was for his parents and grandparents living underneath The Act. Charlie says it's this generation who need to keep this path going and to continue to knock the barriers out of the way.

It would be several years until Charlie found a job in which he had the type of autonomy that he had been seeking. He recalls being excited at the prospect of "***not having those restrictions, having full control, being an Indigenous person, designing for Indigenous people***" for the first time ever in his career. This position however was not within the health system.

Despite not offering him a direct pathway to his dream career, Charlie claims IHP had a profound influence on where he is today, from "***the problem-solving way of learning, the personalities of the lecturers, the support from staff, the trust, and the other mature aged students who brought their experience and stories, the Elders, uncles and aunties brought the guidance and direction for me during that time***".

His only regret is that he wished that he had studied harder…

> ***"Instead of studying just to pass, I should have studied harder so I can get that knowledge to have it ingrained in me and then expand on it as to put me in a position where I can talk from authority. I'm starting to get that hunger for going back to uni because I don't have letters in front of my name, I don't have letters behind my name. So I'm starting to think again, get back into study, because no one listens to you despite what you bring to the table***."

There was a sense that despite having a Bachelor of Applied Health Science degree, the career trajectories were not always clear. Many IHP graduates did not have specific career aspirations on commencement of the program but through their learning and development were able to identify and pursue career pathways most suited to their skill sets.

> *"I didn't have job or career aspirations at the start of the course but I did have job and career aspirations after I graduated, I wanted to work in a health organisation to support my people". [19 Indigenous student]*

Some of the IHP students said they would have benefited from receiving follow-up contact from IHP staff to assist them in identifying career opportunities. A few people did not gain employment in health and pursued other careers by choice, for others it was not by choice. Some non-Indigenous IHP graduates reported struggles in securing employment in Indigenous health due to most positions in the field being Indigenous identified. Lack of work experience in the field also contributed, however some reported being able to secure employment in Indigenous health through IHP networks.

"So, tried to get a job, which was a bit of a struggle I guess because a lot of the jobs are identified, and I had no experience either. So, those two combined was a bit of a struggle." [11 Non-Indigenous student]

A few IHP students expressed feeling unready to work in communities upon graduating from the IHP and felt they needed to gain additional skills and life experience before feeling equipped. They said that they valued real life skills and experience just as much as the degree, if not more. A number of IHP graduates talked about utilising the skills learned and gathered to move into policy making roles. Entering into cadetships was another pathway for some IHP graduates which enabled them to gain confidence and experience in work environments before entering the workforce.

Indigenous Health Program students who entered the program as AHWs found that the degree did not enable career progression within their workplaces. Reasons discussed included the political climate at the time being opposed to community-controlled health sector and AHW education and the role not being systemically valued. Many AHWs eventually left their roles to uptake other positions either within the same organisations, or with other employers. Some IHP graduates who then became AHWs found themselves having to complete the minimum certificate qualifications in Aboriginal and Torres Strait Islander Primary Health Care to gain employment as an AHW despite having an undergraduate degree in Applied Health Science. The fact that this degree was not recognised by certain employers, proved it to be an unsuccessful career progression pathway for AHWs contrary to what was previously believed. Some AHWs expressed feelings of frustration and insult that their scope of practice was limited as they were not nurses and believed they were better equipped to work in community health than nurses through their training in the IHP.

"So, my appointment was as a 003 Aboriginal health worker. So, it's operational level with a degree and this great GPA, super star student, and they actually made a point of letting me know that they increased the level, because it used to be 002, the trainee level, but they made it 003 for me given I had a degree. And, what was so funny was that the lady who cleaned my office got paid more than what I did. And so, I was like wow, that degree was really worth it! That being said, the skills that I had gained during that program, I was a very different kind of Aboriginal health worker, and I think that I was able to do some really good stuff out there as a health worker both in client support but more so doing community development type approach to health promotion, and do it differently and work in a very kind of ground up approach." [02 Indigenous student]

Indigenous Health Program graduates cited both structural and interpersonal racism as further barriers to recognising this new kind of Indigenous health professional. The relationship between discrimination and stifling Indigenous leadership was also discussed, as well as the need for support at a systems level to foster Indigenous leadership.

"… systems need to be set up to sort of cultivate leaders and – for any particular workforce I think it's having those systems set up. I know there's a lot of work happening around it … but I think, because of discrimination and things like that … it still holds back that Indigenous leadership path, it restricts it I think." [13 Indigenous student]

A Different Kind of Leadership

While the goal of the IHP was to develop Aboriginal and Torres Strait Islander leadership through a highly skilled AHW workforce, it also proved to be an enabler of non-Indigenous leadership for both staff and students. For instance, some non-Indigenous IHP students discussed challenges experienced as non-Indigenous employees working in Indigenous health. A few talked about being exposed to racist comments made by other non-Indigenous staff who assumed it was a safe space to do so. Others found themselves defending Aboriginal and Torres Strait Islander people in the workplace and educating other non-Indigenous staff in better understanding the needs of Aboriginal and Torres Strait Islander people.

> *"… I've never had dramas from clients, so I must be doing something right if they're not whinging about me being white … it was just other staff members. Because you do get white people that work in indigenous health that don't have a clue, that are so insensitive and just say stuff that's inappropriate. That's why I think if you get white people working in Aboriginal health, they must have experience working with Murri's … Constantly having to educate white people of that, trying to understand from an Aboriginal perspective as much as I can give, talking about the history and the trauma. I hate it, because they just presume because I'm white I think like them, where I don't. I see it so often, and I see other workers mistreating or talking down to Aboriginal women I work with, the clients. So, I always put in complaints. I pull them up. It still happens today, mistreatment. So, yeah, still on my bandwagon." [11 Non-Indigenous student]*

Some non-Indigenous educators, when reflecting on what they have taken with them from their involvement in the IHP, spoke about awareness of their own whiteness and frequently questioning themselves about what their role and contribution to Indigenous health should look like. One educator spoke of this being an ongoing struggle, in that whilst they considered it important to contribute to growing the capacity of Aboriginal and Torres Strait Islander people working in health, they also acknowledged an existing and increasingly skilled and capable Indigenous workforce and did not want to be seen as a colonial overseer.

> *"I didn't want to be seen to be one of those white people tagging along and benefitting from Indigenous stuff to some extent, and it's still something that I find a little bit challenging. …with the emergence through that program of a lot of strong black Indigenous researchers, educators, clinicians and so on, and seeing that space grow so much, you know I guess it made me think even more 'what's the role of a white person within this kind of context?' … I'm acutely aware of my own whiteness and the need not to be in a leading role because there's a lot of leading Indigenous people who can do stuff for themselves. I don't need to be trying to lead anything in that space and I really respect that … You know, I don't want to be the old colonial holding down some Indigenous person's role. I still ask myself that same question sometimes." [09 Non-Indigenous educator]*

For Indigenous students, a new kind of leadership emerged of which their own Indigeneity was central. Many students discussed how the IHP helped them connect with and/or affirmed their cultural identity. Through its pedagogical approach, Indigenous students were able to bring their Indigeneity into the classroom, whether drawing from their lived experience, relating to the case studies or communities visited, or bringing Indigenous knowledges to solve the problems raised within PBLs. Indigenous students could see their identity affirmed through engagement with a predominantly Indigenous community of learners as well as via the curriculum.

*“Well, one thing that sticks in my head is always around that being authentic. So when you've got a whole lot of black fellas in the room you just can't bullsh*t each other. People either know your family, who you're from, how you're connected to someone or whatever, right. So you've just got to be truthful about it. Those sort of things - so that's the first thing around that course.” [15 Indigenous student]*

The students articulated a particular kind of leadership in reflecting upon their journeys and that of their classmates. Participants described leadership as relational rather than hierarchical, emphasising one’s Indigeneity and accountability to community. Many acknowledged the paths of those before them who had paved the way and the responsibility they have not only to them but also to current and future generations. People talked about the responsibility of returning to their home communities and giving back as well as the additional pressures associated with that.

“Personally, it’s made a dramatic change up [home community], because I suppose they look at me as if I’m a doctor big noting myself and all that stuff, because I’m studying health and – they would come to me for advice. ‘What’s the impact if I do this,’ and blah, blah, blah. At first, I was a bit ashamed because I left my community, and when I went back up there I thought this would happen. But then after a while they realised that I was doing something for a reason. ‘He is helping out more – bringing what he’s learned from up there’.” [24 Indigenous student]

Participants spoke of leadership and success in a collective rather than individual sense with many not only proud of their own achievements but also the collective achievements of the cohort. Although highly valued, participants didn’t see university qualifications, as a measure of success, and many acknowledged the importance of the roles of everyone working across the health system and the achievements of all. Some participants who had not graduated or who did not take up senior roles within the health system would typically be dismissive of, or downplay their own role as leader, yet in their accounts we could still observe their role as leaders in their own family and community.

“I think if it [doing IHP] wasn’t for anything else, for me it was for my kids, to pass on to them that they can do anything they put their minds to”. [17 Indigenous student]

Nellie's Story: Being a knower and being the example

Nellie entered the IHP as a mature age student and health worker originally from north Queensland. One of her friends was undertaking the course and encouraged her to apply. She had been a carer for her invalid mother much of her life and at the time of undertaking study, she was raising small children with fairly modest goals. Having worked in the health system as an Aboriginal Health Worker she had experienced the "***domination***" of nurses over her day to day practice. She states "***basically I felt myself, I needed to get more behind me, like that paper, a degree so that we can turn around and say to them 'well you can't talk to us like that anymore, we're professionals in our own right', so that was my whole purpose of it***".

Nellie admits that she really surprised herself with her overall GPA and upon graduating, she worked in various roles in research and project management with a few attempts at postgraduate studies. On reflection, Nellie muses what would have been had she been better supported in terms of career guidance post-graduation, and with stronger local community networks outside of IHP, however she remains proud of her own achievements and that of others.

Nellie describes the impact of IHP upon her as a person, as becoming more empathetic and looking at things from a different lens "***I'm an empathetic person, but it kind of made me more empathetic to different groups of people…the course was able to open my mind up to different ways of thinking"***. Graduating from IHP has also, Nellie believes, opened her children's minds to undertaking tertiary studies, with one achieving first class honours and another on track to undertake a PhD. "***I'm pretty sure seeing their mother was able to do a course I think inspired them***". Nellie insists that university study isn't the be all and end all, stating "***You can only just be an example and encourage people if they want to do extra study***". Today Nellie is continuing to be a carer and continuing to take the lessons from IHP into her daily life in her role.

"***I see paediatricians all the time, so I'm talking to health professionals. So when these health professionals don't think I know what they're talking about, I just interject with something and they're like 'Oh, she knows something'. They assume we don't know anything, so I like that fact that I can talk to them about health stuff, especially on behalf of these little ones***".

Many participants reflected upon the impact of the IHP on the health system and the influential roles that graduates had:

> *"I believe the impact that the IHP cohort has had on the health system has been immense because some students went onto further study and became doctors, achieved doctorates, became researchers, Aboriginal health practitioners, nurses, project officers, contributed to their communities and made a difference in their own communities and the broader community." [19 Indigenous student]*

Typically, neither students nor staff conceptualised leadership in a hierarchical sense with everyone seen as a leader. Participants acknowledged that leadership wasn't solely about producing doctors, CEOs and Executive Directors, but influencing and raising up their own families and communities was seen just as, if not more important. The type of leadership that was emphasised and valued centred around "making a difference" and the responsibility to the community to act. Regardless of the location of IHP graduates as a workforce within or outside of the health system, we observed time and time again stories of advocates and change makers within their family, community, workplace, and discipline while remaining grounded and aware of who they were and their accountability and responsibilities towards their communities.

> *"…what I've noticed is that there's some Indigenous academics that are out there that have become too colonised and too accustomed to the lifestyle that they've accustomed to. But*

they neglect that fact that, well, there was ancestors that actually got you to this point, they fought for those opportunities for you to have, you've completed. So, it's about time that you now take the baton and actually start to test the system, start to work with community and grassroots people … I just don't want to be that type of person. [04 Indigenous student]

Perhaps due to the inclusion of research throughout each year of the IHP, many graduates had been involved in Indigenous health research upon completion of their degree, as research officers and/or in undertaking research higher degrees. In doing so, the IHP contributed to building the Indigenous health teaching and research workforce to train the next health workforce generation and contribute to the production of new knowledge about Indigenous peoples' health. We witness in these accounts, not just a transformation of individual Indigenous peoples' lives, as evidenced in Janice's story, but we too get a sense of the transformative nature of Indigenous peoples' presence within the very apparatus within which they were trained, enabling a new kind of critical Indigenous health leadership to emerge, which remains committed to the principles of the IHP.

Janice's Story: An Army of Critical Black Thinkers

Janice was born and raised in Brisbane and entered IHP as a young high school leaver. Her pathway into IHP is best described as a series of fortunate events. Graduating from year 12, her academic results were quite poor, and she came from a family that not only did not have strong university aspirations, but she had a parent who was quite unsupportive of her decision to study. Her application to university was a result of a high school policy whereby students graduating with an OP (regardless of the score) were required to submit a QTAC application. It was the word 'Indigenous' in the title that saw her elect to enrol in the IHP. Upon entering the IHP, Janice excelled academically and went on to Honours and PhD pathways collecting awards for academic excellence along the way.

She attributes this transformation to a number of factors, but in particular to the critical consciousness it developed which helped her make sense of her location in the world.

"I certainly had an awareness in high school of being black and of being poor, and I was a bit angry about that during high school and I didn't have the language to understand it or to think about it. What we were studying [at IHP] was not look at how bad black fellas are, it was like how do we change the system to make things better for our mob. And, that was so exciting to me".

The distinctly 'Black learning environment' that IHP seemed to foster was the critical foundation to much of her work today as a senior health researcher in a higher educational institute.

"I've come from a learning background where you speak up and you can count on other black fellas to be in the room to have your back.. so I now really appreciate how privileged that learning environment was, that we had power in the classroom … the way the class was taught was that it encouraged critical dialogues".

The reconfiguring of power and Blackness from 'bad' to 'good' has transformed the intellectual work she undertakes today as a health researcher which she insists has enabled her to "***ask very different questions***".

In describing IHP, Janice says:

"So, we all have been well trained. And, we talk here when we teach about how people are disciplined by the disciplines…We get disciplined to be a certain kind of way, that the institution produces these kinds of graduates. This cohort [IHP] produced a particular kind of graduate, and not in the disciplinary way that the disciplines typically do to us. It really armoured up a mob of black fellas to go out and do some really awesome things...It's really cool to think that this little program with such a small number of people has created this little army that's out there doing some really awesome stuff. They built an army. And, that was only a small number, and I think if we had more of that, I wonder what the landscape would look like. If we did more of this stuff of getting likeminded people together, particularly black fellas, and create this space where we can grow these kind of quite independent thinkers who could take on the world, then imagine what could happen".

Discussion

It's tempting to think of education and health workforce issues among Indigenous peoples as fundamentally a mechanical question of numbers - numbers recruited, numbers retained, numbers who 'move beyond the frontline'. These are indeed important numbers, about which institutions need to be held to account. However, our findings transform those numbers into human stories which tell us so much more about the experiences of a remarkable group of students who, as a collective, provide a unique window of understanding into the contours of power which shape the opportunities and the experiences of 'the counted'. There are back stories here of experiences of education and workforce prior to undertaking study at the IHP, as well as the stories of the educational value of the degree and all that has ensued since. There's diversity in the stories, of course, but together they frame a larger picture of the workings of power which underpin educational and career opportunity. These types of stories are relatively rare within the available literature but offer new ways of thinking about an Indigenous health workforce agenda. Below we draw together a number of these 'power' issues as they contest a dominant discourse which has become bogged down in a field of 'lifting aspirations', 'building capacity', 'creating pathways' and 'providing support'.

We elicited a new way of thinking about the Indigenous health workforce, because we spoke with a different kind of workforce; not different because of the diverse type of workforce produced by the IHP (e.g. health workers, community workers, policy officers, researchers, doctors, nurses, CEOs etc.), but different by virtue of the shared articulation of the **power of one's Indigeneity** across their educational and career pathways. Indigeneity was described as a driver and an enabler to academic and career success rather than a barrier, and in fact was typically the hinge factor in career decision-making, which didn't adhere to structured career pathways and pipelines through the health system. The centrality of Indigeneity as an asset remains marginal to the existing Indigenous health workforce literature which instead centres culture in a broad sense but ultimately views Indigeneity in a numerical sense. At present we observe an Indigenous health workforce agenda which emphasises population parity and implies that better representation across the health system will result in better health outcomes; or that the capacity to attract an increasing number of Indigenous health professionals indicates increasing capability to meet the health needs of Indigenous peoples. How exactly such transformation will be generated is unclear and under-theorised, in part because the centrality of Indigeneity has been overlooked. Among the IHP cohort we observed countless transformative stories associated with their presence; though it was not in their numbers that this change occurred, but through the strength of and commitment to their Indigeneity.

Here we are forced to rethink the Indigenous in an Indigenous health workforce agenda, not in terms of authentic or acceptable Indigenous identities but instead recognising **the centrality of Indigeneity to an Indigenous health workforce capable of transforming a health system**. We recognise that there are any number of Indigenous peoples who have career aspirations which are not bound up in an Indigenous identity or with a specific Indigenous health application in mind who, rightly remain beneficiaries of an Indigenous health workforce agenda of equity and inclusion. We also recognise, through the IHP cohort, that there is too an Indigenous health workforce whose Indigeneity is the driver of their work in ways that are transformative individually, collectively and structurally within and beyond the health system. Rigney described the emergence of Indigenous researchers who, by their presence are reforming Indigenous knowledge production away from Aboriginalism to Indigenism. According to Rigney, Indigenism refers to "a distinct Indigenous Australian academic body of knowledge that seeks to disrupt the

socially constructed identity of the 'archetypal Aborigine' as a controlled and oppressed being … [and which can] advocate a research compatibility with Indigenous realities, interests and aspirations" (Rigney, 36). Through Rigney's Indigenist framework, we can see from the IHP cohort, an articulation of what an Indigenist health workforce agenda might look like. We are not suggesting this replace existing efforts, or that there is only one way to be Indigenous within such an agenda; **we simply wish to expand the possibilities for Indigeneity within the health system in a workforce context, centring Indigenous sovereignty as opposed to Indigenous equity**. We thus analyse the learnings offered by this cohort through the key Indigenist principles as defined by Rigney.

Resistance as the emancipatory imperative [an alternative to the aspiration recruitment strategy]
The principle of resistance as an emancipatory imperative is one which "emphasises liberation from colonial domination" and attends to the physical, cultural and emotional oppressions Indigenous peoples have and continue to experience. Rather than render Indigenous peoples victims, resistance calls for the development of "a robust Indigenist intelligentsia for the revision of existing arrangements" (Rigney, 2006, 39-40). Such an approach seeks a conscious and deliberate commitment to the redistribution of power for Indigenous peoples, something which the parity and pipeline approaches to health workforce have failed to attend to, encouraging instead Indigenous resilience to the flawed health and education systems they are navigating. The existing 'capacity building' approach to Indigenous health workforce also undermines an Indigenist approach which consciously resists reproducing the idea that Indigenous peoples are inferior, intellectually, culturally, or physically.

Among the IHP cohort, we witnessed a group of Indigenous peoples who, not waiting to have their aspirations built, instead had an existing commitment to the **redistribution of power within the health system**, in such a way that they would no longer have to watch their people die, or watch the hospital morgue fill up. We found a workforce highly aspirational about transforming the health system but uncertain as to the best place from which to undertake such work. Interestingly, Indigenous peoples were not looking to the health system to save their communities, nor did we find career trajectories guided by individual desires to get to the top of one's profession; rather they tended to be narrated around the struggle of finding the best location within the health system in order to effect change. This stands in stark contrast to the attribution of the ongoing under-representation of Indigenous peoples in various health professions to a lack of aspiration and/or lack of academic preparedness, which typically avoids the structural barriers to Indigenous access to higher education. Ironically, the students from the IHP would struggle to be accepted into a mainstream health science program under present conditions, yet it is clear from the career outcomes from this relatively small cohort, that this was never a 'remedial' cohort.

Political Integrity [Fostering community of practice as retention strategy]
Rigney (2006, 40) describes political integrity as 'Indigenous ontological and epistemological views about the world that directly translate to Indigenous philosophies, languages, cultural and spiritual values and beliefs". Political integrity is enabled, according to Rigney by work undertaken by Indigenous peoples themselves, determining their own priorities and capacity building mechanisms on their own terms. It does not call for the exclusion of non-Indigenous peoples but seeks to resist the monopoly non-Indigenous people hold and continue to hold in Indigenous affairs. It was evident from the IHP degree program that the political integrity of the learning environment was a critical factor in retention stories.

We observed in the IHP Alumni stories a clear articulation of the **power of being part of an Indigenous cohort**. More than a matter of safety in numbers, a distinctly Indigenous community was created which was inclusive of non-Indigenous staff and students, while centring Indigenous ontological and epistemological views about health and Indigeneity. This was enabled through the problem-based learning approach and the **power of a predominantly Indigenous intellectual space** in which students could identify, critique and rehearse a distinctly Indigenous articulation of health, offering a deeper criticality than any of the mainstream health courses that students went on to take. In this space, non-Indigenous staff and students talked about learning to be allies and the value of shared knowledge, of Indigenous knowledge, and becoming aware of their own positioning within white institutions. All talked about being enriched by this experience. Among the IHP Alumni, the value of an Indigenous cohort offered a supportive intellectual community that was critical to student retention, but it was through this community that students too spoke of the importance of a sense of belonging, and social support navigating life and foreign university systems. Unfortunately, current Indigenous retention efforts are typically centred around individual academic tutoring and/or fostering a sense of community in terms of its social and cultural value, often overlooking the intellectual value of an Indigenous community of practice. It was clear that **the development of a critical Indigenous consciousness was the key enabler to transforming the health system, which is only made possible through the creation of spaces which enable Indigenous peoples to come together intellectually**.

Privileging Indigenous Voices

The privileging of Indigenous voices in Indigenist research "gives voice to the voiceless" (Rigney, 2006, 42) to ensure that Indigenous peoples can determine their own agendas. Rigney acknowledges that the minds of Indigenous peoples are not "free of the propensity for acting out in colonial hegemonic ways as a result of colonialist psychic and cultural internalisations," but insists that it is still more politically appropriate for Indigenous peoples to be given the opportunity to speak through Indigenous researchers. Unfortunately within existing Indigenous health workforce discourse, Indigenous voices remain marginalised, and despite offering the first and most **powerful critical insights of the health system's failings and the value of an Indigenous health workforce**, it is the voices of the Aboriginal and Torres Strait Islander health worker that appears to have been ignored the longest. Indeed it is revealing that some 20 years after a degree program established to build the capacities of an AHW workforce, the health system still fails to recognise their skills and expertise, with limited to no formal career structure.

Most IHP Alumni spoke of moving out of the health system and out of the health worker role in order to occupy a leadership role that had any semblance of power, of being listened to, in order to effect change within the system. Though regardless of where one was situated hierarchically within the health system, participants spoke of the health system's unwillingness to see them as leaders, as knowers, and/or legitimate health professionals in their own right. These daily navigations of the health system for an Indigenous health workforce are a glaring omission from Indigenous health workforce research and policy frameworks. And herein lies the real irony; the assumption that the same institutions which continue to fail in improving the health of Indigenous people are well positioned to apply their long experience in this failure to addressing workforce inequalities. There's no sense in the usual shopping list of 'recruitment, retention and career advancement' strategies of privileging Indigenous voices, maintaining political integrity or centring resistance as the emancipatory imperative for an Indigenous health workforce. Yet without this shift, not only do Aboriginal and Torres Strait Islander people miss out on career paths where they can make change to a failing system, incredibly the failing system manages to avoid all responsibility.

Conclusion

Through the life stories and career trajectories of a small cohort of primarily Indigenous health professionals we offer a reformed and transformative health workforce agenda. Drawing from the intellectual work of Rigney, we suggest an **Indigenist health workforce agenda** centres Indigenous sovereignty rather than a notion of equity measured by population parity. Such an approach demands a reconfiguration of existing strategies, and success measures, each of which necessitate a radical rethink of Indigeneity.

The facilitation of an Indigenist health workforce agenda is one which needs to be defined by Indigenous peoples and it is not our goal to set the parameters for such an agenda. Rather than impose yet another agenda upon Indigenous people, we have centred the experiences of IHP Alumni to poses a raft of challenges to both health and education systems committed to building an Indigenous health workforce capable of transforming health outcomes for Indigenous peoples:

- What might a strength-based approach to Indigenous student recruitment and retention in higher education look like?
- How might we reconfigure our gaze upon possibilities rather than pipelines, celebrating and enabling existing Indigenous capabilities, leadership and transformative aspirations?
- How can interdisciplinary Indigenous intellectual spaces be cultivated to support the collective interests of Indigenous peoples and expand Indigenous leadership?
- How might Indigenous health workforce success be measured beyond keeping account of how many Indigenous peoples enter mainstream services and professions?
- How might we imagine Indigenous health workforce in terms of the transformative change of communities/services/systems rather than only attending to occupational aspirations of individuals and building resilience to a resistant health system?
- What is the capacity for the health system to interrogate its own aspirations for and expectations of Indigenous people, including its resistance to addressing the unfinished business of the AHW career structure?
- How might peak and advocacy bodies (both Indigenous and mainstream) best support this proposed re-purposed agenda?

Appendices

Appendix A – IHP Symposium Flyer

2 MARCH 2018

IHP HEALTH WORKFORCE SYMPOSIUM

A gathering of Graduates, Academics and Community Stakeholders of the Indigenous Health Program, The University of Queensland 1994-2005

Registration for the Symposium is essential and can occur at the following Eventbrite site

Venue: Rydges Fortitude Valley Brisbane

601 Gregory Tce, Bowen Hills, Brisbane.

10am to 4pm

IHP Alumni and Staff are invited to bring and share memorabilia from the Indigenous Health Program

POCHE CENTRE FOR INDIGENOUS HEALTH

Email: poche@uq.edu.au

Phone: (07) 3443 1678

www.poche.centre.uq.edu.au

Appendix B – IHP Symposium Schedule

IHP Symposium Schedule
Friday 2 March 2018

TIME	SESSION
9.00 am	**Registration Opens** *Tea and Coffee on arrival*
9.45 am	*Morning Tea*
10.15 am	**Acknowledgement of Country and Welcome to IHP Symposium** *Mrs Jenny Allie, Mr Condy Canuto and Dr Chelsea Bond*
10.30 am	**Keynote Presentation** *Emeritus Professor Cindy Shannon*
11.30 am	**Presentation of IHP Painting** **In Memorial** *A/Prof Jon Willis*
12:00 pm	*Lunch at Six Acres Restaurant*
1.00 pm	**Staff Reflection Panel** *Chair: A/Prof Mark Brough* *Panel: A/Prof Jon Willis, Prof Melissa Haswell, Dr Leonie Cox*
1.30 pm	**Beyond the frontline: About the research project** *Mr Condy Canuto and Dr Chelsea Bond*
2.00 pm	*Afternoon tea*
2.30 pm	**First in Family: Transformation through Higher Education** *Chair: Dr Odette Pearson* *Panel: Mr Julian Hunt, Ms Audrey Deemal, Mr Richard Abednego*
3.00 pm	**Innovating Indigenous Health** *Chair: Dr Shannon Springer* *Panel: Mrs Louise Sanderson and Mr Tony Kiessler*
3.30 pm	**Indigenous Health Leaders and Leadership** *Chair: Mrs Wyomie Robertson* *Panel: Mr Kenny Bedford, Ms Samantha Wild, Mr Condy Canuto*
4.00pm	**Closing Remarks** *Dr Chelsea Bond and Mr Condy Canuto*
4.30 pm	**After-event function** *Canapés and drinks at Paddock Bar Deck*

Appendix C – IHP Symposium Twitter Activity

UQ Poche Centre for Indigenous He...
@UQPoche

What a beautiful day of reunions here at our #Indigenous Health Workforce Symposium as we celebrate the program that produced #UQ's largest cohort of Aboriginal and Torres Strait Islander graduates @uqalumni #UQIHP2018 #IHPalumni

1:49 PM - 2 Mar 2018

14 Retweets 23 Likes

1 14 23

Health at UQ
@UQHealth
Following

Full details on today's #Indigenous Health Workforce Symposium, hosted by @UQPoche, bringing together alumni from the #UQ Indigenous #Health Program that was offered between 1994 and 2005: bit.ly/2oB3IDx

#IHPalumni #UQIHP2018

11:28 AM - 2 Mar 2018

4 Retweets 10 Likes

4 10

UQ Poche Centre for Indigenous He...
@UQPoche

#sorrynotsorry for all the #IHPreunion spam. Talking about Indigenous leadership, innovation and transformation at #UQIHP2018

2:54 PM - 2 Mar 2018

5 Retweets 9 Likes

5 9

UQ Poche Centre for Indigenous He...
@UQPoche

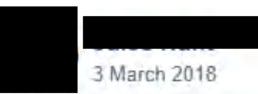
Dr Chelsea Bond @drcbond talking about the legacy of the #UQ #Indigenous Health Program (1994 - 2005) @UQHealth @uqalumni @LowitjaInstitut #UQIHP2018

UQ News @UQ_News
#UQ Indigenous alumni close the gap as leaders in health. More than 70 graduates celebrate. @UQPoche, @drcbond
tinyurl.com/ydbwaate

3:53 PM - 2 Mar 2018

6 Retweets 17 Likes

6 17



3 March 2018

Thanks Chelsea Watego Bond for a great day out and my wife and I loved it! Was great to see many familiar faces and hear all the stories and get to give a snapshot of mine. For me this course was life changing. Helped me develop into a world I knew nothing about in a culturally safe environment. All my mob have benefited and have gained uni degrees or currently finishing one off. I am so glad the course was delivered the way it was and even though I suppose for the first year at least I wasn't too big on what email was I overcame this fear and lack of understanding of technology I progressively gained enough courage to understand what was required. Being a mature aged student I felt a responsibility to appear to know what I was doing so having the younger ones in with older ones was a really good mix and in the group setting with lots of support worked great. Anyway I could go on but just wanted to say thank you for all your hard work and to hear the stories really was a healing experience... look forward what happens next...

Chelsea Watego and 18 others 1 comment Seen by 49

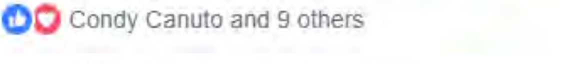
Like Comment

Deadly bro.

Like · Reply · 1y 1

3 March 2018

Wow what a great day it was to see so many familiar face and listen to the great stories we shared, it was truly inspiring and it also showed how this really was TWO WAY learning, also a BIG THANKYOU for all the hard work Chelsea Watego Bond, Condy Canuto and your team for putting this event together, so look forward to the next one 😊



Condy Canuto and 9 others Seen by 46

shared a photo.

3 March 2018

Old song only better as the years passed slowly by ...

was with and 2 others.

2 March 2018

Chelsea Watego and 9 others Seen by 45

Appendix D – *UQ Indigenous alumni close the gap as leaders*, The University of Queensland, Faculty of Health and Behavioural Sciences, 2 March 2018

UQ Indigenous alumni close the gap as leaders in health

2 March 2018

The achievements of leading doctors, scholars, executives and policy makers in Indigenous health will be celebrated at a University of Queenslandsymposium.

The Indigenous Health Workforce Symposium hosted by UQ's Poche Centre for Indigenous Health on Friday 2 March will bring together alumni from the UQ Indigenous Health Program (IHP) that was offered between 1994 and 2005.

Dr Chelsea Bond, who was part of the largest cohort of Aboriginal and Torres Strait Islander students to graduate from UQ, said the symposium was an opportunity for alumni and staff to reflect upon the legacy and impact of the program.

"In just over a decade, more than 70 students graduated from the program, under the leadership of Emeritus Professor Cindy Shannon," Dr Bond said.

"A significant number of graduates are now making a difference in the health field in their own way, in their own communities.

"Some used the course as a stepping stone to specialised roles such as nurses, nurse academics, doctors, researchers and social workers, to name a few.

"Most have taken the learnings from this program for the betterment of their own communities, both within and outside of the health system."

Funded by The Lowitja Institute, the benefits of the program are currently being examined by a team of health researchers led by Dr Bond, as part of a 20 year retrospective cohort study of career trajectories of former graduates.

"The participants, in reflecting upon the program, will help inform a deeper understanding of the enablers to Indigenous health workforce leadership across the health system as well as the transformative nature of their presence within it," Dr Bond said.

Appendix E – National Conference on Indigenous Health Workforce Leadership Flyer

NATIONAL CONFERENCE ON INDIGENOUS HEALTH WORKFORCE LEADERSHIP

2 November 2018
8:30am - 5pm
5-6pm Post-conference drinks and canapés
Hotel Grand Chancellor, Spring Hill, Brisbane

Featuring Keynote Speaker
PROF CINDY SHANNON
QUT

ANNOUNCING NEW KEYNOTE SPEAKER
DR KRISTOPHER RALLAH-BAKER
AIDA

AND NEW SPEAKER
NATASHA LEE
UQ

and Key Thought Leaders

ROMLIE MOKAK – The Lowitja Institute
PROF SHAUN EWEN – Uni of Melb
PROF GREGORY PHILLIPS – ABSTARR Consulting/Griffith Uni
PROF ROIANNE WEST – Griffith Uni
A/PROF RAYMOND LOVETT – ANU
A/PROF SHANNON SPRINGER – Bond Uni
NEIL WILLMETT – QAIHC
DONNA MURRAY – IAHA
KARL BRISCOE – NATSIHWA
JANINE MOHAMED – CATSINaM
SAMANTHA WILD – QMHC

PROFESSIONAL $100
STUDENTS $60
TICKETS LIMITED.
REGISTER NOW AT
www.poche.centre.uq.edu.au/events
email poche@uq.edu.au

CHANGEMAKERS: BUILDING AN INDIGENOUS HEALTH WORKFORCE
Identifying success factors enabling Indigenous health leadership

UNFINISHED BUSINESS: THE ABORIGINAL HEALTH WORKER WORKFORCE
Re-centering the past, present and future role of the Aboriginal Health Worker

REIMAGINING THE INDIGENOUS WORKFORCE: MOVING BEYOND THE FRONTLINE
Strong Indigenous health leadership traversing new landscapes in Indigenous health

THE LOWITJA INSTITUTE: INDIGENOUS HEALTH WORKFORCE RESEARCH

A review and analysis of progress in building the Aboriginal and Torres Strait Islander health researcher workforce since 2000: Project Forum – DR TESS RYAN & DR CHRIS PLATANIA-PHUNG (UNI OF MELB)

Career pathways for Aboriginal and Torres Strait Islander health professionals – KARRINA DEMASI (AMSANT) & JAMIE NEWMAN (OAMS)

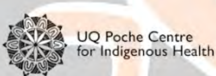
Working well: Tailoring a workforce development model to deliver sustained improvements in community controlled healthcare – A/PROF JANYA MCCALMAN & DR SANDY CAMPBELL (CQU)

Understanding stress and staying strong in the Aboriginal and Torres Strait Islander health and human services workforce – DR GOKHAN AYTURK (AHCSA)

First Response: Integrating trauma-informed care within primary healthcare for Aboriginal and Torres Strait Islander women experiencing violence – KEZIAH BENNETT-BROOK & MARLENE LONGBOTTOM (THE GEORGE INSTITUTE)

Wujal Wujal NDIS Workforce Pilot: #ProperStrongWay – EILEEN DEEMAL-HALL (WUJAL WUJAL ASC) & DR DEB SELWAY (NDS)

Moving beyond the front line: A 20-year retrospective cohort study of career trajectories from the Indigenous Health Program at UQ – DR CHELSEA BOND & JANET STAJIC (UQ)



Appendix F – National Conference on Indigenous Health Workforce Leadership Program

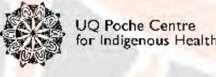
NATIONAL CONFERENCE ON INDIGENOUS HEALTH WORKFORCE LEADERSHIP

#MovingBeyondTheFrontline

PROGRAM

Friday 2 November 2018
Hotel Grand Chancellor
Spring Hill, Brisbane

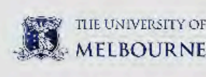
TIME	SESSION
8.30am	REGISTRATIONS OPEN Tea and coffee on arrival
9.00am	ACKNOWLEDGEMENT OF COUNTRY Opening and welcome
9:15am	KEYNOTE PLENARY The Honourable Ken Wyatt AM, MP Minister for Indigenous Health, Minister for Senior Australians and Aged Care Professor Cindy Shannon Professor of Indigenous Health, Queensland University of Technology Dr Kristopher Rallah-Baker President, Australian Indigenous Doctors' Association
10:30am	MORNING TEA
	THE LOWITJA INSTITUTE: INDIGENOUS HEALTH WORKFORCE RESEARCH CONCURRENT SESSIONS
Roma Room	SESSION 1 TRANSFORMING THE STORY & PATHWAY CHAIR ROMLIE MOKAK (THE LOWITJA INSTITUTE)
10:50am	A review and analysis of progress in building the Aboriginal and Torres Strait Islander health researcher workforce since 2000: Project Forum Dr Tess Ryan & Dr Chris Platania-Phung (Uni Melb)
11.20am	Moving beyond the frontline: A 20-year retrospective cohort study of career trajectories from the Indigenous Health Program at UQ Dr Chelsea Bond & Janet Stajic (UQ)
11.35am	Reframing discourse and changing the narrative of Aboriginal and Torres Strait Islander health and wellbeing: An analysis Benny Wilson (ANU)
11.50am	Career pathways for Aboriginal and Torres Strait Islander health professionals Karrina DeMasi (AMSANT) & Jamie Newman (OAMS)
12.05pm	Question and Answers
Terrace Room	SESSION 2 BUILDING ON STRENGTHS CHAIR ASSOCIATE PROFESSOR JON WILLIS (UQ)
10:50am	Working well: Tailoring a workforce development model to deliver sustained improvements in community controlled healthcare Associate Professor Janya McCalman & Dr Sandy Campbell (CQU)
11.05am	Understanding stress and staying strong in the Aboriginal and Torres Strait Islander health and human services workforce Robert Dann & Dr Gabriela Zizzo (AHCSA)
11.20am	First Response: Integrating trauma-informed care within primary healthcare for Aboriginal and Torres Strait Islander women experiencing violence Keziah Bennett-Brook (The George Institute) & Marlene Longbottom (UOW)

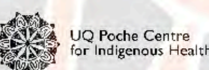


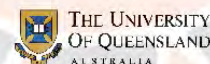
NATIONAL CONFERENCE ON INDIGENOUS HEALTH WORKFORCE LEADERSHIP

#MovingBeyondTheFrontline

11:35am	Wujal Wujal NDIS Workforce Pilot: #ProperStrongWay Eileen Deemal-Hall (Wujal Wujal ASC) & Dr Deb Selway (NDS)
11:50am	Deadly Choices: Growing our future Aboriginal and Torres Strait Islander health workforce Donisha Duff (IUIH)
12.05pm	Question and Answers
12:30pm	LUNCH
1:15pm	CHANGEMAKERS: BUILDING AN INDIGENOUS HEALTH WORKFORCE Chair: Professor Shaun Ewen (Uni Melb) Panel: Associate Professor Shannon Springer (Bond Uni), Janine Mohamed (CATSINaM), Donna Murray (IAHA) and Natasha Lee (UQ) This panel considers the success factors for building an Indigenous health workforce, including supporting the training of Indigenous health professionals, the usefulness of cohorts and the enablers for Indigenous leadership within the health system and beyond.
2:15pm	UNFINISHED BUSINESS: THE ABORIGINAL HEALTH WORKER WORKFORCE Chair: Neil Willmett (QAIHC) Panel: Karl Briscoe (NATSIHWA), Tarita Fisher (DDHHS, QLD Health) and Tyson Morris (Galambila AHS) The Aboriginal Health Worker remains central to the health system's ability to provide comprehensive, culturally safe and clinically competent care, yet they remain one of the least recognised occupational groups. This panel considers the past, present and future role of the AHW in community, clinical, government and non-government contexts across the country.
3:15pm	AFTERNOON TEA
3:45pm	REIMAGINING THE INDIGENOUS WORKFORCE: MOVING BEYOND THE FRONTLINE Chair: Professor Gregory Phillips (ABSTARR Consulting/Griffith Uni) Panel: Professor Roianne West (Griffith Uni), Associate Professor Ray Lovett (ANU) and Eddie Mulholland (Miwatj Health AC) From parity across the health professions to radically transformed health service provision, this panel considers what a strong Indigenous health workforce looks like and what new territory can be traversed in advancing Indigenous health outcomes.
4:45pm	CLOSING REMARKS Dr David Singh (UQ) Dr Chelsea Bond and Condy Canuto (UQ)
5:00pm	AFTER-EVENT FUNCTION







Appendix G – IndigenousX Articles

Chelsea Bond, Moving Beyond the Frontline: The power and promise of an Indigenous Health Workforce, IndigenousX, 29 October 2018

@INDIGENOUSX

Home About Topics Contact

SUPPORT INDEPENDENT INDIGENOUS MEDIA ON PATREON

Share this:

Facebook

Twitter

More 281

Author:

Chelsea Bond

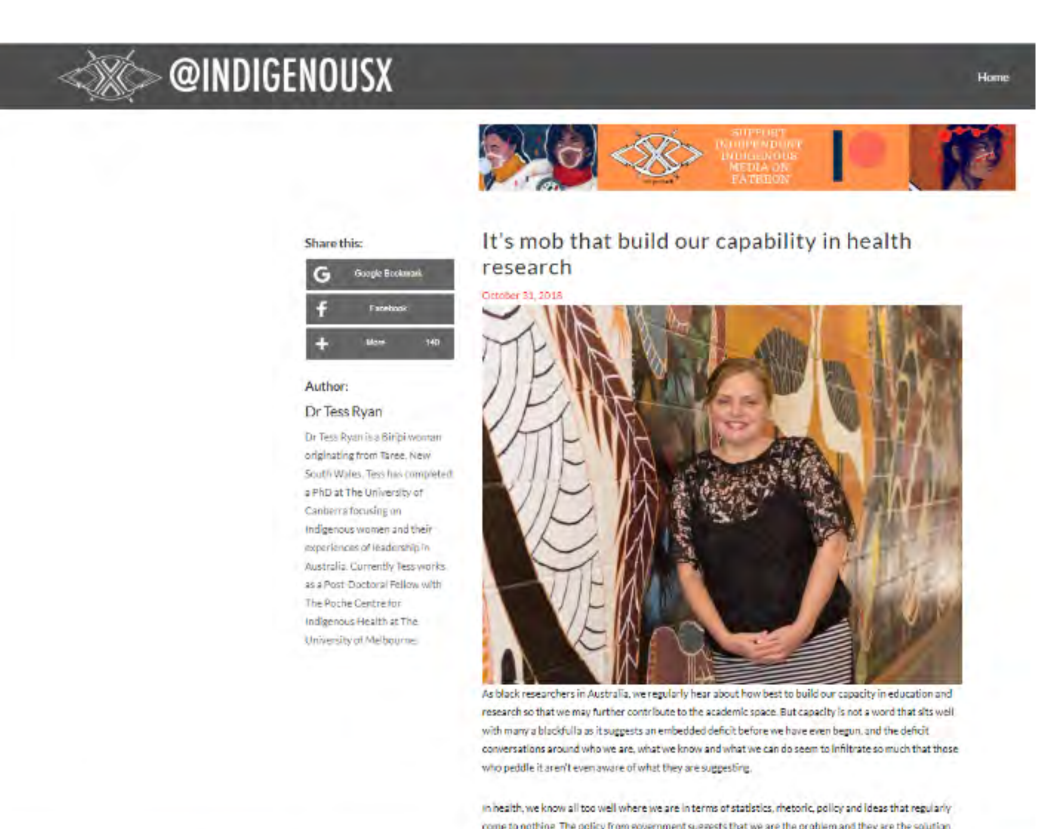
Dr Chelsea Bond, is a Senior Research Fellow at The University of Queensland and one half of the #WildBlackWomen program (with Angelina Hurley) on Brisbane's 98.9FM Let's Talk every Friday from 9am-10am EST @drcbond

Moving Beyond the Frontline: The power and promise of an Indigenous Health Workforce

October 29, 2018

If you have worked in Indigenous health you would be all too familiar with the discourses of 'Closing the Gap' and 'compliance' which remind us that the Black body is to be regulated and remedied by the health system. In more recent decades, these Black bodies have been co-opted into the same system and in fact the same agenda, not as clients but as clinicians; as members of the health workforce who will supposedly remedy the ills created by a system that wilfully refused to provide care to our people for generations.

Tess Ryan, It's Mob That Build Our Capacity in Health Research, IndigenousX, 31 October 2018



@INDIGENOUSX

Home

SUPPORT INDEPENDENT INDIGENOUS MEDIA ON PATREON

Share this:

Google Bookmark

Facebook

More 140

Author:

Dr Tess Ryan

Dr Tess Ryan is a Biripi woman originating from Taree, New South Wales. Tess has completed a PhD at The University of Canberra focusing on Indigenous women and their experiences of leadership in Australia. Currently Tess works as a Post-Doctoral Fellow with The Poche Centre for Indigenous Health at The University of Melbourne.

It's mob that build our capability in health research

October 31, 2018

As black researchers in Australia, we regularly hear about how best to build our capacity in education and research so that we may further contribute to the academic space. But capacity is not a word that sits well with many a blackfulla as it suggests an embedded deficit before we have even begun, and the deficit conversations around who we are, what we know and what we can do seem to infiltrate so much that those who peddle it aren't even aware of what they are suggesting.

In health, we know all too well where we are in terms of statistics, rhetoric, policy and ideas that regularly come to nothing. The policy from government suggests that we are the problem and they are the solution.

Appendix H – Croakey Article

David Singh and Melissa Sweet, RANZCO urged to apologise to first Indigenous ophthalmologist – and more news from #MovingBeyondTheFrontline, Croakey, 8 November 2018

RANZCO urged to apologise to first Indigenous ophthalmologist – and more news from #MovingBeyondTheFrontline

(This article was updated on 14 November – see additions at end).

Introduction by Croakey: Leaders in Indigenous health from Australia and New Zealand have called on the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) to make "an unreserved apology" to Australia's first Indigenous ophthalmologist, Dr Kris Rallah-Baker, "for its callous disregard of his experiences of racism and bullying".

The call is published in this open letter to the College. It follows the College's response to an article by Rallah-Baker, president of the Australian Indigenous Doctors' Association (AIDA), describing his experiences of "direct and unashamed racism" during his training.

Professor Gregory Phillips, Dr Chelsea Bond, AIDA, members of the Leaders in Indigenous Medical Education (LIME) Network and other signatories to the open letter call on the College to engage in an independently facilitated discussion with Rallah-Baker to review and meaningfully address the concerns he has raised.

They also want the College to outline specific strategies in place to safely support its members in reporting discrimination, harassment and bullying; and to advise what it will do to ensure staff, board and members have a sufficient practical and theoretical understanding of what constitutes a culturally safe ophthalmology as experienced by the providers of care as well as its recipients.

The College's response to Rallah-Baker was published on the eve of the National Conference on Indigenous Health Workforce Leadership convened in Brisbane last week. It generated much discussion about how illustrative it was of the experiences of Aboriginal and Torres Strait Islander health professionals, according to the article below by Dr David Singh from the University of Queensland's Poche Centre.

Appendix I – National Conference Twitter

chelsea bond @drcbond · Following

Our #UQMob #PublicHealth #WildBlackWomen #MovingBeyondTheFrontline

3:54 PM - 2 Nov 2018

6 Retweets 34 Likes

Tyson Morris @TysonMorris16 · Follow

Love wot u do and u won't work a day in your life #AHW #Aboriginalhealth #IndigenousHealthWorkforce #movingbeyondthefrontline

2:38 PM - 5 Nov 2018

Romlie Mokak @RMokak · Following

Great to catch up with researcher partners Sandy Campbell, @JanyaMcCalman and of course @drcbond, with @LowitjaInstitut Alex Zurawski #MovingBeyondTheFrontLine @croakeyblog

4:50 PM - 2 Nov 2018

9 Retweets 21 Likes

Bronwyn Fredericks @BronFredericks · Following

I'm so proud of these @UQ_News stars!!! ⭐ They did a fabulous job organising & coordinating everything to make today's #UQ @UQPoche National Conference on Indigenous Health Workforce Leadership a success! ⭐ Thank you! ⭐ #MovingBeyondTheFrontline ⭐⭐⭐⭐⭐⭐⭐⭐⭐⭐⭐⭐⭐⭐⭐

UQ Poche Centre for Indigenous Health @UQPoche
Our amazing team that made today a huge success #MovingBeyondTheFrontline

6:49 PM - 2 Nov 2018

7 Retweets 30 Likes

1 · 7 · 30

IndigenousX Pty Ltd and 8 others liked

DrTess Ryan @TessRyan1 · 2 Nov 2018

Was great to be a part of the UQPoche conference today. I know this battle is long & hard, but as an army we must look out for each other. #movingbeyondthefrontline

12 · 24

Shannon Springer @SpringShannon · Following

#movingbeyondthefrontline Prof West: building the cultural capability of the non-Indigenous should not be at the detriment of building the #Indigenous #health #workforce

4:00 PM - 2 Nov 2018

17 Retweets 32 Likes

Appendix J – Vodcasts

Indigenous Health Workforce Priorities

Odette Best's story

Audrey Deemal's story

Eddie Bulli's story

Travis Shorey's story

Odette Pearson's story

Kenny Bedford's story

Bibliography

Abbott, P., Gordon, E., & Davison, J. (2007). Expanding roles of Aboriginal Health Workers in the Primary Care Setting: Seeking Recognition. *Contemporary Nurse, 26*(1), 66-73.

Aboriginal and Torres Strait Islander Health Workforce Working Group. (2015). Annual Report to the Health Workforce Principal Committee. (Australian Health Ministers' Advisory Council: Canberra).

Aboriginal and Torres Strait Islander Health Workforce Working Group. (2017). National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2023. (Australian Health Ministers' Advisory Council: Canberra).

Adams, M., Aylward, P., Heyne, N., Hull, C., Misan, G., Taylor, J., & Walker-Jeffreys, M. (2005). Integrated support for Aboriginal tertiary students in health-related courses: the Pika Wiya Learning Centre. *Australian Health Review, 29*(4), 482-488.

Anderson, C., Bunda, T., & Walter, M. (2008). Indigenous Higher Education: The Role of Universities in Releasing the Potential. *Australian Journal of Indigenous Education*, *37*, 1-8

Anderson, I. (2011) *Indigenous pathways into the professions*. Canberra, Australia: Department of Health, Australian Government.

Anderson, I. P. S., Ewen, S. C., & Knoche, D. A. (2009). Indigenous medical workforce development: current status and future directions. *Medical Journal of Australia, 190*(10), 580-581.

Australian Bureau of Statistics (ABS). (2017). 2016 Census shows growing Aboriginal and Torres Strait Islander population. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/MediaRealesesByCatalogue/02D50FAA9987D6B7CA25814800087E03

Australian Institute for Health and Welfare. (2019). *National Health Workforce Datasets*. Retrieved from https://www.aihw.gov.au/about-our-data/our-data-collections/national-health-workforce-dataset

Bailey, J., Veitch, C., Crossland, L., & Preston, R. (2006). Developing research capacity building for Aboriginal & Torres Strait Islander health workers in health service settings. *Rural and Remote Health,* 6(4), 556.

Bessarab, D., & Ng'andu, B. (2010). Yarning about yarning as a legitimate method in Indigenous research. *International Journal of Critical Indigenous Studies, 3*(1), 37-50.

Best, O. (2014) The cultural safety journey: An Australian nursing context. In O. Best & B. Fredericks. (Eds.), *Yatdjuligin: Aboriginal and Torres Strait Islander Nursing & Midwifery Care* (pp. 51-79).

Bond, C. (2007). *"When you're black, they look at you harder": Narrating Aboriginality within Public Health*. (Doctoral dissertation, University of Queensland, Brisbane, Australia). Retrieved from: https://espace.library.uq.edu.au/view/UQ:158618.

Browne, J., Thorpe, S., Tunny, N., Adams, K., & Palermo, C. (2013). A qualitative evaluation of a mentoring program for Aboriginal health workers and allied health professionals. *Australian and New Zealand Journal of Public Health, 37*(5), 457-462.

Browne, K., D'Amico, E., Thorpe, S., & Mitchell, C. (2014). Feltman: evaluating the acceptability of a diabetes education tool for Aboriginal health workers. *Australian Journal of Primary Health, 20(*4), 319-322. doi: 10.1071/PY14040

Buzzacott, C. (2018, October 19). I said 'I'm in labour' but no one listened. *IndigenousX.* Retrieved from https://indigenousx.com.au/i-said-im-in-labour-but-no-one-listened/

Cameron, L. (2010). Supporting Indigenous nursing students. *Australian Nursing Journal, 18*(6), 39.

Cameron, S., & Robinson, K. (2013). The Experiences of Indigenous Australian Psychologists at University. *Australian Psychologist, 49*(1), 54-62.

Cannady, M., Greenwald, E., & Harris, K. (2014). Problematizing the STEM Pipeline Metaphor: Is the STEM Pipeline Metaphor Serving our Students and the STEM Workforce? *Science Education Policy, 98*(3)*,* 443-460.

Chesters, J. (2009). Footprints Forwards Blocked by a Failure Discourse: Issues in Providing Advice about Medicine and other Health Science Careers to Indigenous Secondary School Students. *Australian Journal of Career Development, 18*(1), 26-35.

Chur-Hansen, A., Herbert, P., Caruso, J., & Barrett, R. (2008). Indigenous Students Entering a Course in the

Health Professions: A Qualitative Study of their Aspirations and Expectations. *Aboriginal and Islander Health Worker Journal, 32*(5), 19-24.

Curtis, E., Reid, P., & Jones, R. (2014). Decolonising the Academy: The process of re-presenting Indigenous health in tertiary teaching and learning. *Diversity in Higher Education, 15*, 147-165.

Curtis, E., Wikaire, E., Stokes, K., & Reid, P. (2012). Addressing Indigenous health workforce inequities: A literature review exploring 'best' practice for recruitment into tertiary health programmes. *International Journal for Equity in Health, 11*, 13. doi: 10.1186/1475-9276-11-13

Curtis, E., Wikaire, E., Kool, B., Honey, M., Kelly, F., Poole, P., Barrow, M., Airini, Ewen, S., & Reid, P. (2014). What helps and hinders Indigenous student success in higher education health programmes: a qualitative study using the Critical Incident Technique. *Higher Education Research & Development, 34*(3), 486-500.

D'Antoine, N., & Paul, D. (2006). Pre-medicine and Pre-dentistry Program: Creating Opportunity for Indigenous Students. *Aboriginal and Islander Health Workers Journal, 30*(3), 6-8.

Dawson, A. P., Cargo, M., Stewart, H., Chong, A., & Daniel, M. (2012). Aboriginal health workers experience multilevel barriers to quitting smoking: a qualitative study. *International Journal for Equity in Health, 11*, 27.

Dawson, A. P., Cargo, M., Stewart, H., Chong, A., & Daniel, M. (2012) "I know it's bad for me and yet I do it": exploring the factors that perpetuate smoking in Aboriginal Health Workers – a qualitative study. *BMC Health Services Research, 12*(1), 102.

Department of Health. (2014). *Aboriginal and Torres Strait Islander Health Curriculum Framework*. Canberra: Australian Government.

Department of Prime Minister and Cabinet. (2014). *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report.* Retrieved from https://www.pmc.gov.au/sites/default/files/publications/indigenous/Health-Performance-Framework-2014/tier-3-health-system-performance/312-aboriginal-and-torres-strait-islander-people-health-workforce.html

Deshmukh, T., Abbott, P., & Reath, J. (2014). 'It's got to be another approach': An Aboriginal health worker perspective on cardiovascular risk screening and education. *Australian Family Physician, 43*(7), 475-478.

DiTomaso, N., Post, C., & Parks-Yancy, R. (2007) Workforce Diversity and Inequality: Power, Status, and Numbers. *Annual Review of Sociology, 33*, 473-501.

Ellender, I., Drysdale, M., Chesters, J., Faulkner, S., Kelly, H., & Turnbull, L. (2008). When a Dream Becomes a Nightmare: Why Do Indigenous Australian Medical Students Withdraw from Their Courses? *Australian Journal of Indigenous Education, 37,* 40-47.

Felton-Busch, C. M., Solomon, S. D., McBain, K. E., & De La Rue, S. (2009). Barriers to Advanced Education for Indigenous Australian Health Workers: An Exploratory Study. *Education for Health*, 22(2), 187.

Felton-Busch, C., Maza, K., Ghee, M., Mills, F., Mills, J., Hitchins, M., Park, T., & Chamberlain-Salaun, J. (2013). Using mentoring circles to support Aboriginal and Torres Strait Islander nursing students: Guidelines for sharing and learning. *Contemporary Nurse*, **46**(1), 135-138. doi: 10.5172/conu.2013.46.1.135

Fredericks, B. (2009). 'Getting a job': Aboriginal Women's Issues and Experiences in the Health Sector. *International Journal of Critical Indigenous Studies, 2*(1), 24-35.

Fredericks, B., Adams, M., Walker, M., Peacock, C., Duthie, D., Best, O., & Mills, K. (2011). Talkin' Up Our Doctoral Research. *Aboriginal and Islander Health Worker Journal,* 35(6), 27.

Freeman, T., Edwards, T., Baum, F., Lawless, A., Jolley, G., Javanparast, S., & Francis, T. (2014). Cultural Respect Strategies in Australian Aboriginal Primary Health Care Services: Beyond Education and Training of Practitioners. *Australian and New Zealand Journal of Public Health, 38*, 355-361.

Garvey, G., Rolfe, I. E., Pearson, S. A., & Treloar, C. (2009). Indigenous Australian medical students' perceptions of their medical school training. *Medical Education, 43*(11), 1047-1055.

Gilroy, J., Dew, A., Lincoln, M., & Hines, M. (2017). Need for an Australian Indigenous disability workforce strategy: review of the literature. *Disability and Rehabilitation 39*(16), 1664-1673. doi: 10.1080/09638288.2016.1201151

Goold, S. (2006) 'Getting Em n Keepin Em': Indigenous Issues in Nursing Education. *Australian Aboriginal Studies, 2*, 57-61.

Grimes, D. A., & Schulz, K. F. (2002). Cohort studies: Marching towards outcomes. *The Lancet, 359*(9303), 341-345.

Gwynne, K., & Lincoln, M. (2017). Developing the rural health workforce to improve Australian Aboriginal and Torres Strait Islander health outcomes: a systematic review. *Australian Health Review, 41*:234-238.

Haas, P. M. (1992). Introduction: epistemic communities and international policy coordination. *International Organization, 46*(1), 1-35.

Harris, A., & Robinson, G. (2007). The Aboriginal Mental Health Worker Program: The Challenge of Supporting Aboriginal Involvement in Mental Health Care in the Remote Community Context. *Australian e-Journal for the Advancement of Mental Health, 6*(1), 15-25.

Hecker, R. (1997). Participatory action research as a strategy for empowering Aboriginal health workers. *Australian and New Zealand Journal of Public Health,* 21(7), 784-788.

Hill, K., Harvey, N., Felton-Busch, C., Hoskins, J., Rasalam, R., Malouf, P., & Knight, S. (2018). The Road to Registration: Aboriginal and Torres Strait Islander Health Practitioner Training in North Queensland. *Rural and Remote Health, 18*, 3899. doi: 10.22605/RRH3899.

Hill, P. S., Wakerman, J., Matthews, S., & Gibson, O. (2001). Tactics at the interface: Australian Aboriginal and Torres Strait Islander health managers. *Social Science & Medicine, 52*(3), 467-480.

Hinton, A., & Chirgwin, S. (2010). Nursing Education: Reducing Reality Shock for Graduate Indigenous Nurses – It's All About Time. *Australian Journal of Advanced Nursing, 28*(1), 60-66.

Humphreys, J., Wakerman, J., Wells, R., Kuipers, P., Jones, J., & Entwistle, P. (2008). "Beyond Workforce": A systemic solution for health service provision in small rural and remote communities. *Medical Journal of Australia,* 188(8) S77-S80.

Jakamarra, K., & Peile, A. (1977). Across Australia… from Health Worker to Health Worker. *Aboriginal and Islander Health Worker Journal 1*(2), 19-21.

Johnston, E. (1991). Royal Commission into the Aboriginal Deaths in Custody: National Report. Canberra: Australian Government Printing Services.

Jonsen, K., Tatli, A., Ozbilgin, M., & Bell, M. (2013). The Tragedy of the Uncommons: Reframing workforce diversity. *Human Relations, 66*(2), 271-294.

Jowsey, T., Yen, L., Ward, N., McNab, J., Aspin, C., & Usherwood, T. (2012). It hinges on the door: Time, spaces and identity in Australian Aboriginal Health services. *Health Sociology Review, 21*(2), 196-207

Kelaher, M., Sabanovic, H., La Brooy, C., Lock, M., Lusher, D., & Brown, L. (2014). Does more equitable governance lead to more equitable health care? A case study based on the implementation of health reform in Aboriginal health Australia. *Social Science and Medicine,* 123, 278-286, doi: 10.1016/j.socscimed.2014.07.032.

Kelly, H., Robinson, A., Drysdale, M., Chesters, J., Faulkner, S., Ellender, I., & Turner, L. (2009). "It's not about me, it's about the community": Culturally relevant health career promotion for Indigenous students in Australia. *Australian Journal of Indigenous Education,* 38, 19-26.

Kippen, S., Ward, B., & Warren, L. (2006). Enhancing Indigenous Participation in Higher Education Health Courses in Rural Victoria. *Australian Journal of Indigenous Education, 35*, 1-10.

Kuipers, P., Harvey, D., Lindeman, M., & Stothers, K. (2014). Aboriginal and Torres Strait Islander health practitioners in rural areas: credentialing, context and capacity building. *Rural and Remote Health, 14,* 2897.

Lawson, K. A., Armstrong, R. M., & Van Der Weyden, M. B. (2007). Training Indigenous doctors for Australia: shooting for goal. *Medical Journal of Australia, 186*(10), 547-550.

Leditschke, A., & Maher, P. (2011). Health Workforce Australia's Aboriginal and Torres Strait Islander Health Worker Project. *Aboriginal and Islander Health Worker Journal, 35*(1), 2.

MacIntyre, A. (2007). *After Virtue* (3rd ed.). London: Bloomsbury Academia.

Mackean, T., Mokak, R., Carmichael, A., Phillips, G. L., Prideaux, D., & Walters, T. R. (2007). Reform in Australian medical schools: a collaborative approach to realising Indigenous health potential. *Medical Journal of Australia, 186*(10), 544-546.

Mark, A., McLeod, I., Booker, J., & Ardler, C. (2005). Aboriginal Health Worker Smoking: A Barrier to Lower Community Smoking Rates? *Aboriginal and Islander Health Worker Journal, 29*(5), 22-26.

Martin, D. E., & Kipling, A. (2006). Factors shaping Aboriginal nursing students' experiences. *Nurse Education Today, 26*, 688-696.

McAdam, E. (2007). A Timeline History of NT Aboriginal Health Workers and Aboriginal Community Workers 1870-2007. *Aboriginal and Islander Health Worker Journal, 31*(3), 3-5.

McRae, M. Taylor, S. J., Swain, L., & Sheldrake, C. (2008) Evaluation of a pharmacist-led, medicines education program for Aboriginal Health Workers. *Rural and Remote Health,* 8(4), 946.

McRae, M., & Taylor, S. J. (2008). Medicines education for Aboriginal health workers: is there a role for the pharmacist? *Australian Pharmacist, 27*(6), 502-504, 506-507.

Mills, J., Felton-Busch, C., Park, T., Maza, K., Mills, F., Ghee, M., Hitchins, M., Chamberlain-Salaun, J., & Neuendorf, N. (2014). Supporting Australian Torres Strait Islander and Aboriginal nursing students using mentoring circles: an action research study. *Higher Education Research & Development, 33*(6), 1136-1149.

Mitchell, M., & Hussey, L. M. (2006). The Aboriginal health worker. *Medical Journal of Australia, 184*(10), 529-530.

Mununggguritj, N., Burray Purray, J., Gemuluwuy, D., Bara, P., & Mamarika, E. (1978) Our Social Environment: Views from Health Workers. *Aboriginal and Islander Health Worker Journal, 2*(1), 4-8.

Murray, R. B., & Wronski, I. (2006). When the tide goes out: health workforce in rural, remote and Indigenous communities. *Medical Journal of Australia, 185*(1), 37-38.

Nagel, T., & Thompson, C. (2006). Aboriginal Mental Health Workers and the Improving Indigenous Mental Health Service Delivery Model in the 'Top End'. *Australasian Psychiatry,* 14(3), 291-294.

National Aboriginal Health Strategy Working Party. (1989). *A National Aboriginal Health Strategy*. Canberra: National Aboriginal Health Strategy Working Party.

Nguyen, H. T., & Gardiner, A. (2008). Indigenous community members as teachers of Indigenous health. *Australian Family Physician, 37*(12), 1019-1021.

O'Kane, A., & Curry, B. (2003) Unveiling the secrets of the rural and remote allied health workforce. In: Proceedings, 7th National Rural Health Conference, Hobart, Australia, 1-4 March 2003.

Pacza, T., Steele, L, & Tennant, M. (2001). Development of oral health training for rural and remote Aboriginal health workers. *Australian Journal of Rural Health*, 9(3), 105-110.

Paul, D. (2012). Creating change: building the capacity of the medical workforce in Aboriginal health. *ANZ Journal of Surgery,* 83(1-2), 55-59.

Pham, X., Page, P., Sivamalai, S., & Woolley, T. (2012). The benefits of a tailor-made pilot primary health-care course for Indigenous high school students in remote Queensland. *Australian Journal of Rural Health, 20*(3), 113-118.

Queensland Health. (2016). *Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2026*. Brisbane: Queensland Government: Brisbane.

Rallah-Baker, K. (7 September 2018). Closing the gap from both sides. *Insight: Australia's newspaper of ophthalmic optics*. Retrieved from https://www.insightnews.com.au/Article3/1819/Closing-the-gap-from-both-sides

Reath, J., & Doolan, G. (2005). Progress in Aboriginal and Torres Strait Islander health training – an evaluation of the implementation of the GPET framework. *Australian Family Physician, 34*(S12), 23-26.

Rigney, L (2006) *Indigenist Research and Aboriginal Australia*, In Kunnie, J.E & Goduka, NI (eds), Indigenous People's Wisdom and Power: Affirming our Knowledge Through Narratives, 32-49.

Stamp, G., Champion, S., Anderson, G., Warren, B., Stuart-Butler, D., Doolan, J., Boles, C., Callaghan, L., Foale, A., & Muyambi C (2008) Aboriginal maternal and infant care workers: partners in caring for Aboriginal mothers and babies. *Rural and Remote Health, 8*(3), 883.

Stuart, L., & Gorman, D. (2015). The experiences of Indigenous health workers enrolled in a Bachelor of Nursing at a regional Australian university. *AlterNative: An International Journal of Indigenous Peoples, 11*(1), 29-44.

Stuart, L., & Nielsen, A. M. (2010). Two Aboriginal Registered Nurses Show Us Why Black Nurses Caring for Black Patients is Good Medicine. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 37(*1), 96-101.

Stuart, L., Nielsen, A.M., & Horner, V. E. (2010). Support strategies that graduate Indigenous nurses – a dreaming journey. *Journal of Australian Indigenous Issues, 13*(3), 95-100.

Swain, L., & Barclay, L. (2015).Medication reviews are useful, but the model needs to be changed: Perspectives on Aboriginal Health Service health professionals on Home Medicines Reviews. *BMC Health Services Research, 15*, 366.

Taylor, K. P., Thompson, S. C., Smith, J. S., Dimer, L., & Ali, M. (2009). Exploring the impact of an Aboriginal

Health Workers on hospitalised Aboriginal experiences: lessons from cardiology. *Australian Health Review, 33*(4), 549-557.

Taylor, K., & Guerin, P. (2010). *Health Care and Indigenous Australians: Cultural safety in practice.* Melbourne: Palgrave Macmillan.

Templeton, D. J., Tyson, B. A., Meharg, J. P., Habgood, K. E., Bullen, P. M., Malek, S., & McLean, R. (2010). Aboriginal health worker screening for sexually transmissible infections and blood-borne viruses in a rural Australian juvenile correctional facility. *Sexual Health, 7*(1), 44-48.

Thomas, D. P., Bainbridge, R., & Tsey, K. (2014). Changing discourses in Aboriginal and Torres Strait Islander health research, 1914-2014. *Medical Journal of Australia, 201*(1), S1-S4.

Thompson, M. (2010). A review of the barriers preventing Indigenous Health Workers delivering tobacco interventions to their communities. *Australian and New Zealand Journal of Public Health, 35*(1), 47-53.

Thompson, M. (2011). 'The best bang for our buck': Recommendations for the provision of training for tobacco action workers and Indigenous health workers. *Contemporary Nurse, 37*(1), 90-91.

Usher, K., Lindsay, D., & Mackay, W. (2005). An innovative nurse education program in the Torres Strait Islands. *Nurse Education Today*, 25(6), 437-441.

Usher, K., Lindsay, D., Miller, M., & Miller, A. (2005). Challenges faced by Indigenous nursing students and strategies that aided their progress in the course: A descriptive study. *Contemporary Nurse, 19*(1-2), 17-31.

Usher, K., Miller, M., Turale, S., & Goold, S. (2005). Meeting the challenges of recruitment and retention of Indigenous people into nursing: outcomes of the Indigenous Nurse Education Working Group. *Collegian, 12(*3), 27-31.

Vukic, A., Etowa, J., & Perley-Dutchner, L. (2014). The Socio-Political Impacts on Health Care that Effect Aboriginal Nurses Working in Aboriginal Communities. *International Journal of Nursing 1*(2), 79-101.

Vukic, A., Jesty, C., Mathews, V., & Etowa, J. (2012). Understanding race and racism in nursing: Insights from Aboriginal nurses. *ISRN Nursing.* doi: 10.5402/2012/196437

Wainwright, J., Gridley, H., & Sampson, E. (2012). Facing a world of NO: How accessible is a career in psychology for Aboriginal and Torres Strait Islander Australians? *The Australian Community Psychologist, 24*(2), 143-151.

Walker, M., Fredericks, B., & Anderson, D. (2014). "Yarning" as a method for community-based health research with Indigenous women: the Indigenous Women's Wellness Research Program. *Health Care for Women International*, *35*(10), 1216-1226.

Walter, M., Taylor, S., & Habibis, D. (2011). How White is Social Work in Australia? *Australian Social Work, 64*(1), 6-19.

Watson, K., Young, J., & Barnes, M. (2012). What constitutes 'support' for the role of the Aboriginal and Torres Strait Islander child health workforce? *Australian Health Review, 37*(1), 112-116.

Watts, L., Ampt, A., Sherwood, J., & Keenan, T. '*When they give you the nod, they give you the confidence' – Indigenous medical students perceptions of the Pre-Medicine Program.* Paper presented at the 11th National Rural Health Conference.

West, R., Usher, K., & Foster, K. (2010). Increased numbers of Australian Indigenous nurses would make a significant contribution to 'closing the gap' in Indigenous health: What is getting in the way? *Contemporary Nurse 36*(1-2), 121-130.

West, R., Usher, K., Foster, K., & Stewart, L. (2014). Academic Staff Perceptions of Factors Underlying Program Completion by Australian Indigenous Nursing Students. *The Qualitative Report, 19*(12), 1-19.

West, R., West, L., West, K., & Usher, K. (2011). Tjirtamai – 'To care for': A nursing education model designed to increase the number of Aboriginal nurses in a rural and remote Queensland community. *Contemporary Nurse*, 37(1), 39-48.

Whiteside, M., Tsey, K., Cadet-James, Y., & Wilson, A. (2006) Empowerment as a Framework for Indigenous Workforce Development and Organisational Change. *Australian Social Work, 59*(4) 422-434.

Wilkey, J., & Fagan, P. (2008). Finally, a Qualification Pathway for Aboriginal and Torres Strait Islander Sexual Health Workers in Queensland. *Aboriginal and Islander Health Worker Journal, 32*(6), 9-11.

Williams, S. (2001). The Indigenous Australian Health Worker: Can Research Enhance Their Development as Health and Community Development Professionals? *Aboriginal and Islander Health Worker Journal 25*(1), 9-15.

Wollin, J., Cannon, C., Douglas, H., Fairweather, C., Perrett, S., Ingamells, A., & Purcell, C. (2006). Attracting and retaining Indigenous students to university for nursing education. *Australian vocational education review, 13*(1), 1-5.

Wright, A., Briscoe, K., & Lovett, R. (2019). A National Profile of Aboriginal and Torres Strait Islander Health Workers, 2000-2016. *Australian and New Zealand Journal of Public Health, 43*(1), 24-26.

Young, J., Stupans, I., Scutter, S., & Smith, L. (2007). Retaining Indigenous Students within Health Sciences Courses at the University of South Australia. *Focus on Health Professional Education: A Multi-Disciplinary Journal, 9*(1), 33-43.

Zhao, Y., Russell, D., Gutheridge, S., Ramjan, M., Jones, M., Humphreys, J., Carey, T., & Wakerman, J. (2017). Long-term trends in supply and sustainability of the health workforce in remote Aboriginal communities in the Northern Territory of Australia. *BMC Health Services Research, 17*, 836.