"It's about Rights": The Bunya Project's Indigenous Australian Voices on Health Care Curricula and Practice

DANIELLE MANTON, MEGAN WILLIAMS, AND ANDREW HAYEN

Abstract

Indigenous community-controlled health care organizations provide timely, sustained, and culturally safe care. However, their expertise is often excluded from health professional education. This limits the transfer of knowledges and protocols to future practitioners—those positioned to shape health care systems and practices that could achieve the health rights of Indigenous people and reduce health and social inequities. In Australia, despite national government commitments to transforming curricula, services, and systems related to Indigenous health, health care training organizations such as universities generally have low numbers of Indigenous staff and few strategies to engage Indigenous experts. The authors of this paper are part of the Bunya Project, an Indigenous-led participatory action research effort designed to support non-Indigenous university staff and curriculum development through partnerships with Indigenous community-controlled organizations. We conducted 24 interviews with Indigenous individuals to ascertain recommendations for health care curricula. Three themes emerged: (1) role-modeling and leadership of Indigenous-controlled health organizations; (2) specific learnings for health professionals; and (3) achieving human rights in practice. Interviews also highlighted the need for health professionals' extension beyond clinical caregiving, and staff and students' development of knowledge, skills, and actions regarding client self-determination in order to promote clients' rights across all aspects of their health care. Critical self-reflection by health professionals is a foundational individual-level skill necessary for cultural safety.

DANIELLE MANTON is a PhD candidate and senior lecturer in Indigenous teaching and learning at the University of Technology Sydney, Australia.

MEGAN WILLIAMS, PhD, is a professor of Indigenous health at the University of Technology Sydney, Australia.

ANDREW HAYEN, PhD, is a professor of biostatistics at the University of Technology Sydney, Australia.

Please address correspondence to Danielle Manton. Email: Danielle.Manton@uts.edu.au.

Competing interests: None declared.

Introduction

The right to health and Indigenous rights

Indigenous peoples' right to health is affirmed in international conventions and declarations pertaining to health, human rights, and the specific rights of Indigenous peoples. The United Nations Declaration on the Rights of Indigenous Peoples identifies conditions necessary to achieve the right to health and social justice, including self-determination, maintaining traditional health practices, protection from vulnerabilities, and improved social conditions and determinants of health.[1] The right to culturally appropriate health care is affirmed in General Comment 14 of the United Nations Committee on Economic, Social and Cultural Rights, and cultural dimensions of health are recognizable in the Declaration on the Rights of Indigenous Peoples' provisions on the right to maintain traditional knowledge, including medicines and knowledge of the properties of fauna and flora.[2]

Indigenous peoples' right to health is affirmed in legal and policy documents in the local jurisdictions of Indigenous peoples across the world.[3] These documents highlight the key principles of cultural safety in health care, access to land and resources, and accountability through legal recourse when violations of the right to health occur.

Statements in legal and policy documents frequently reflect the holistic worldview of Indigenous people—that health is not just physical well-being but also social, emotional, spiritual, mental, and environmental well-being.[4] These dimensions of health are affected and influenced by experiences across generations, particularly the influences of colonization, colonialism, racism, and multitudinous forms of social exclusion.

Self-determination

Self-determination in health care is articulated in human rights instruments.[5] Indigenous peoples have the right to self-determination, including in health care.[6] Nonetheless, many health care systems have been identified as structurally racist, with clear examples of interpersonal racism in health care settings.[7] In Australia, the health care system and processes are seen as an instrument of colonization that continues to suppress Aboriginal and Torres Strait Islander peoples.[8] The recent framework to address health inequity in Australia, entitled *Closing the Gap*, involves federal, state, and local governments. The framework was first developed in 2008 with minimal consultation with Indigenous peoples or organizations; a majority of the inequities to be addressed worsened over the following decade.[9] A policy refresh occurred in 2018 with input from Aboriginal and Torres Strait Islander peoples and organizations, and in 2020 the Australian government formed a partnership with the Coalition of Aboriginal and Torres Strait Islander Peak Organisations to shift the approach to include self-determination.[10]

Working in partnership with Indigenous communities is a key strategy for improving self-determination, health care quality, and the potential for cultural safety.[11] Health professionals receive little training on how to work in partnership with Indigenous communities or on key concepts of cultural safety, Indigenous rights, and specific Indigenous content underlying general evidence-based practices.[12] Overwhelmingly, health care education focuses on the ill health of Indigenous peoples, with limited exposure to Indigenous perspectives on holistic health care models.[13] Without this knowledge, health care providers risk continuing to devalue Indigenous models of health care by rendering them invisible.[14]

Cultural safety

Culturally safe practice is defined by the Australia Health Practitioner Regulation Agency and National Boards as "the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practicing behaviours and power differentials in delivering safe, accessible and responsive health care free from racism."[15]

There is growing pressure in the Australian health sector to demonstrate culturally safe practice. Indeed, cultural safety is one of the objectives of the Australian Health Practitioner Regulation National Law.[16]

However, there have been too few strategies to teach cultural safety in practice.[17] In 2014, the Australian government developed the Aboriginal and Torres Strait Islander Health Curriculum Framework consisting of nine capabilities, including respect, relationships, and partnerships.[18] These capabilities are often not well modeled at the university level.[19] Additionally, capabilities valued by Indigenous peoples—such as respect, communication, advocacy, and reflection—are rarely explicitly developed or measured.

Aboriginal community-controlled health organizations workforce and leadership

The 145-plus Aboriginal community-controlled health organizations (ACCHOs) in Australia demonstrate leadership in delivering culturally safe holistic health care.[20] ACCHOs are the largest employers of the Indigenous workforce in Australia.[21] Their staff enter a health care career wanting to achieve systemic change and positive outcomes for their families and communities.[22] ACCHOs are well placed to facilitate partnerships with universities to build the Indigenous workforce.[23]

Education

Universities play a key role in perpetuating and reinforcing structures of inequality and oppression. They have very few partnerships with ACCHOs to develop curricula or strategies to work with Indigenous peoples.[24]

Graduates are typically underprepared to work with Indigenous peoples and have little understanding of the burden of colonial contexts, histories, and ongoing trauma.[25] Coupled with assumptions, stereotyping, and lack of reflective insight, this perpetuates an inequitable power dynamic.[26]

Inclusion in health care education is limited to observation *about* Indigenous peoples rather than *with* Indigenous peoples. Indigenous Australians frequently report experiences of racism as part of their daily life and in the health system.[27]

Universities produce graduates who immediately have positions of power in relation to Indigenous peoples.[28] Recent graduates play an important role in how Indigenous patients engage with the health care system.[29] If recent graduates are equipped with the appropriate knowledge, skills, and strategies, they can become proactive agents in promoting and providing space for Indigenous leadership and in identifying and addressing racism.

Health curricula often include first-person accounts of lived experience to bridge theory and practice in health care.[30] The Indigenous-led participatory action research project, the Bunya Project, was designed to support non-Indigenous university staff and curriculum development through partnerships with Indigenous community-controlled organizations and strategic opportunities to share firsthand accounts of health needs and recommendations.[31]

Methodology

The Bunya Project is centered in an Aboriginal worldview, recognizing the value of the knowledge held with Indigenous peoples for millennia and its importance and relevance in today's context. This project is grounded in the centering and privileging of Indigenous ways of knowing (epistemologies), being (ontology), and doing (axiology).[32] The design of the Bunya Project has been described in full elsewhere; here, we provide only a short overview and a focus on the qualitative research component pertaining to this paper.[33]

Methods

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

Interviews, conducted in a relaxed setting known as Kapati Time, emphasized storytelling and knowledge sharing, reflecting the project's cen-

trality of Indigenous expertise and methodologies.[34]

The structured interviews focused on Indigenous self-determination in health care education and asking participants what they thought mainstream health students should incorporate into their professional practice.[35]

While the interviews were semi-structured, based on Kapati Time and yarning principles, guiding questions were provided to all invited participants. The interview duration ranged from 15 to 60 minutes and was determined by the participants and the conversation.

Ethical approval

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

Recruitment

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

Analysis

The first author conducted all interviews, collecting firsthand data, including context, non-verbal behaviors, and participants' voices.[36] After reading all transcripts without annotation, we created codes from emerging themes through active coding, leading to the identification of overarching themes.[37] We then refined these themes, emphasizing rights as a driver of analysis, through focused coding, resulting in three key findings with 12 subthemes.[38] Feedback from participating organizations and individuals ensured the reflective nature of the findings.

Findings

Accessing Indigenous voices is crucial for integrating Indigenous perspectives into curricula. The diverse stories gathered in the Bunya Project, while varied, share common themes, such as Indigenous people feeling unsafe in health services, being blamed, and feeling responsible for accessing services rather than services prioritizing accessibility for them.[39] The common message is the aspiration that health care practices in Australia will meet their basic human rights.

"What we show you": Self-determination of Indigenous-controlled health organizations to create culturally safe health care

The participants conveyed that Aboriginal peoples have immense expertise and experience that mainstream health services could learn from—not only with regard to cultural knowledge but also concerning flexible and multifaceted ways to make health care accessible. Access to health services and the right to the highest attainable standard of health are fundamental human rights, as is Indigenous people's right to self-determine programs and services that affect their well-being.[40] For Aunty Ivy, a respected Gamillaroi Elder, culturally safe access to health care services meant an understanding of indigeneity:

> I use an Aboriginal Medical Service because I don't have to explain.

When Aboriginal people use Aboriginal services or see Aboriginal health care providers, they often do not have to explain the experiences that Aboriginal people have with, for example, colonization, racism, and complex family and community relationships,

which non-Indigenous people tend not to know about.[41] One participant, Kaurna Elder Aunty Lily-Jo, outlined the benefit of removing barriers such as anxiety related to attending appointments with set times.[42] In her words:

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

Unlike mainstream health organizations and hospitals, ACCHOs offer preventive health care.[43] They also address the needs of the whole community across the lifespan and proactively develop relationships within the community.[44] Aunty Lily-Jo continued:

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

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

Advocacy and empowerment. Alinta, a Biripi woman in her mid-20s, spoke of the importance of advocacy within the health care environment, empowering her to the benefit of herself and her community. Indigenous people globally have connected individually and collectively to become active in advocating for human rights.[45] As Alinta explained:

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

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

> I don't know if it's me as a person who establishes those boundaries and I have that willpower and I guess that confidence to say, "This is where I'm at. You need to tell me the point of difference. You need

to tell me what I need to do." But they were willing to listen and learn from what I needed for my eyecare.

"What you need to know": Health care free from discrimination, and learnings for health professionals

Mainstream health care professionals and education providers have much to learn about how to work with Indigenous peoples.[46] In Australia, policies and regulations are beginning to hold health care practitioners and education providers accountable to this learning, but there is still much ambiguity about how to approach learning and what curriculum content should be.[47] The participants in this study identified points that they felt were important for health care practitioners to understand when working with Aboriginal peoples. These reflect the United Nations' work on health professional education from a human rights-based approach, which includes providing information and skills to address and prevent bias and discrimination.[48]

Legacy of colonization. The interviews suggest the importance of understanding the ongoing legacy of colonization and how past policies and power relations continue to impact Aboriginal peoples. Exclusionary practices—especially assumptions, stereotyping, and oppression—are in the fabric and culture of Australian health care systems and structures.[49]

Uncle Rex, a Gandangara man, reflected on this through his own experiences and journey:

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

Alinta recognized the ongoing impact of colonization and the continued negative impact of introduced food sources:

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

Health practitioners play a vital role in recognizing the ongoing impact of colonization on health and health care. Aunty Joy, a Kuku Yalanji and Kuku Thaypan Elder, shared her story interacting with health professionals:

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

Riley spoke of a similar experience featuring a constant expectation and pressure to know ancestorial medical details:

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

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

Racism and distrust. Many Indigenous peoples face racism as a daily reality, despite racism being illegal in many nations, including Australia, and a breach of human rights.[50] Aboriginal peoples experience frequent racism in health settings, leading to a profound distrust of the system.[51] Nulla, a Gamilaraay woman in her early 30s, spoke of her experience with interpersonal racism, being told that

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

Uncle Jim, a respected Wiradjuri Elder, spoke of his experience with his daughter, first to justify her Aboriginality based on her "white" appearance and then to challenge stereotyping and assumptions—devoid of clinical reasoning—based on her cultural identity. Uncle Jim described the experience:

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

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

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

As a result of these experiences, participants noted that they felt distrust and apprehension toward accessing health services and working with non-Indigenous health professionals.

Tidam, an Aboriginal man from the east coast of Australia in his mid-30s, spoke of wanting to know specific information about the health care professional who was treating him:

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

Jarrah, an Aboriginal and Māori man in his mid-20s, spoke of the legacy of the past and how it continues to influence Indigenous peoples' attitudes and approaches to health care:

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

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

> That could have been a very different pathway for

her if her parents didn't have the skills to be able to navigate through that system.

Cultural load. Cultural load refers to the extra responsibility placed on Indigenous individuals in personal and professional settings whereby these individuals are expected to educate, provide insight, and offer support on topics perceived as "Indigenous."[52] In Australia, it is against the law to discriminate against someone based on race or culture, and operating in ways that lead one's culture to result in differential practices is discriminatory.[53]

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

"Oh, what's CTG [Closing the Gap]?" Then you are the one who has got to educate them.

Nulla continued:

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

Stereotypes and assumptions. Stereotyping and assumptions relate to power, race, and positionality.

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

Just because someone's from that community, you don't want to label them as everyone's got the same problem, as well.

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

"Are you Indigenous? Do you have diabetes?"

Aunty Tahnee, a respected Wonnarua Elder, spoke of a similar experience in which health professionals made assumptions without clinical reasoning or diagnostic testing:

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

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

Nulla described the reality of this:

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

Uncle Jim identified the potent influence of bias and assumptions about indigeneity, as well as the importance of critical self-reflection to challenge them:

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

Ed, a Noongar man in his 40s, emphasized the significance of critical self-reflection, urging health practitioners to engage in community-centered work and understand the issues affecting all community members, recognizing their strengths, to challenge preconceived assumptions. He provided clear advice:

I think knowing that community and knowing the problems in the community. I think also people in general, especially non-Aboriginal people, they paint a picture of Aboriginal people are very sick people. And I know a lot of Aboriginal people are very, very much switched on into their health and looking after themselves quite well. I think just

knowing the problems in the community maybe and trying to change that, it can help, but if you going for work research, I think it's a good idea, to know what those problems are, as well.

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

"What you need to show us": Quality health services and human rights in practice

Interview participants described many foundational skills and concepts that health care practitioners should demonstrate when working with Indigenous peoples. Cultural safety is now legislated for in Australia, as discussed below.

Cultural safety. Participants were able to remember health practitioners who had demonstrated culturally safe practice.

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

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

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

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

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

They found a lot of things that were underlying with me. And they were very good with our people and culture and that there. They've got a good understanding. They were actually pretty good there.

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

Security of person and relationships. When Indigenous peoples require health care, they often find themselves in vulnerable positions—for several reasons outlined above and because they must navigate uneven power dynamics—which can compromise their rights to physical and mental integrity, as well as security of person.[54] Establishing relationships is crucial in addressing these power dynamics and fostering feelings of safety, which are core components of cultural safety. This involves practitioners prioritizing communication, respect, and the creation of safe relationships that value each client as a person.[55]

In Kahi's words:

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

Aunty Lily-Jo added to this concept by describing aspirations for her own health care:

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

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

Forming that relationship, the same as what we do, who we are, where we're from, which breaks down a lot of barriers. I think, those first initial barriers.

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

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

While developing relationships takes time, it is an investment in the ongoing care of the patient.

Communication. Communication in health care is a fundamental quality standard in patient and workforce safety and a fundamental human right (the right to be able to seek, receive, and impart information).[56] Uncle Rex identified the importance of communication in establishing relationships and trust:

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

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

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

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

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

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

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

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

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

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

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

Steven's broader reflections also explain his perspective that communication is foundational to relationships in communities and that health care providers' willingness and ability to develop relationships in the community helps Indigenous people feel more comfortable accessing and complying with health care.

Interpersonal skills. Interpersonal skills such as communication style are often subjective, hard to articulate, and difficult to teach and assess.[57] These skills, however, can have a beneficial impact on patients, often leading to a positive experience and improved adherence and outcomes.[58] The interpersonal skills of a health professional support all peoples' right to access health services, as well as the right to maintain the highest attainable standard of health.

Monti, who lives in regional New South Wales, spoke fondly of the interpersonal skills of a local pharmacist:

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

The ongoing impact of colonization, oppression, and racism compels Indigenous peoples to adopt defensive mechanisms, which increases the need for strong interpersonal skills among health professionals. Uncle Warrin, a Worimi man, issued a warning for current and future health care practitioners working with Aboriginal people:

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

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

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

Riley spoke about the difference between community experiences and expectations, on the one hand, and practitioners' experiences and expectations, on the other. He reflected that it is important for health practitioners to know that difference is not wrong.[59] Riley emphasized the importance of respect as a demonstration of authenticity and the need for practitioners to understand the complexities of the local context and be respectful. He said:

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

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

It's just having respect. Respect and education.

Discussion

This research among 24 Aboriginal people explored their health care experiences, uncovering positive and negative examples within mainstream and Indigenous-led services. Participants provided recommendations for university health care curriculum development, in keeping with the Bunya Project's purpose to positively influence university staff, support them in transforming and evaluating their curricula, and in training health students to be more culturally appropriate and respect the rights of Indigenous peoples. The health care curriculum is only a starting point, and as participants explained, practitioners also benefit from learning within and from Aboriginal communities during and after graduation. Participants highlighted the importance of educators equipping future health professionals with the skills and knowledge needed to promote human rights, emphasizing active listening, respect, trust-based relationships, and empowering Indigenous people to self-determine solutions to complex health issues.[60] They called on health professionals to understand the social context, particularly of the local Aboriginal communities, because it influences health, well-being, and rights; Aboriginal community life is a cultural determinant of health.[61]

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

Subjugation embedded in the health care system perpetuates systemic racism, necessitating critical reflection to shift the narrative from blaming Indigenous peoples to recognizing systemic problems. By equipping health students with skills to become culturally capable clinicians, the burden on Indigenous peoples as educators can be reduced. Partnering with ACCHOs offers universities opportunities to improve health curricula and practices collaboratively and respectfully.[62]

Conclusion

Australia's health sector has the largest Indigenous workforce of all sectors, largely because this is a priority area where Indigenous people feel they can make the most impact to the benefit of their communities.[63] By partnering with Indigenous community-controlled organizations, universities can develop health curricula that involve Indigenous health care providers and users. Through these partnerships, universities can also feasibly and valuably contribute to Indigenous communities and engage more deeply with local cultures. Finally, including Indigenous knowledges and community members in the teaching of health care practice creates potential for intergenerational change—not only among Indigenous people but among health care providers and educators—and for fulfilling human rights.

References

1. United Nations Declaration on the Rights of Indigenous Peoples, G.A., Res 61/295 (2007); J. Gilbert and C. Lennox, "Towards New Development Paradigms: The United Nations Declaration on the Rights of Indigenous Peoples as a Tool to Support Self-Determined Development," *International Journal of Human Rights* 23/1–2 (2019).

2. Committee on Economic, Social and Cultural Rights, General Comment No. 14, UN Doc. E/C.12/2000/4 (2000); United Nations Declaration on the Rights of Indigenous Peoples (see note 1), art. 31.

3. A. Moscoso, C. Piñones-Rivera, R. Arancibia, and B. Quenaya, "The Right to Health Care Viewed from the Indigenous Research Paradigm: Violations of the Rights of an Aymara Warmi in Chile's Tarapacá Region," *Health and Human Rights Journal* 25/1 (2023).

4. L. Jackson Pulver, M. Williams, and S. Fitzpatrick, "Social Determinants of Australia's First Peoples' Health: A Multi-level Empowerment Perspective," in P. Liamputtong (ed), *Social Determinants of Health* (Oxford: Oxford University Press, 2019).

5. Gilbert and Lennox (see note 1).

6. Committee on Economic, Social and Cultural Rights (see note 2); United Nations Declaration on the Rights of Indigenous Peoples (see note 1), arts. 3, 24.

7. C. Watego, D. Singh, and A. Macoun, "Partnership for Justice in Health: Scoping Paper on Race, Racism and the Australian Health System," Lowitja Institute Discussion Paper (2021); C. Parter, D. Murray, J. Mohamed, et al., "Talking about the 'R' Word: A Right to a Health System That Is Free of Racism," *Public Health Research and Practice* 31/1 (2021); Y. Paradies and J. Cunningham, "Experiences of Racism among Urban Indigenous Australians: Findings from the DRUID Study," *Ethnic and Racial Studies* 32/3 (2009).

8. W. M. Foucault, *Archaeology of Knowledge and the Discourse on Language* (1972, trans. A. M. Sheridan Smith), p. 49; P. Wolfe, "Settler Colonialism and the Elimination of the Native," *Journal of Genocide Research* 8/4 (2006); Parter et al. (see note 7).

9. C. Holland, *A Ten-Year Review: The Closing the Gap Strategy and Recommendations for Reset* (Close the Gap Campaign Steering Committee, 2018).

10. Council of Australian Governments, *COAG Statement on the Closing the Gap Refresh* (December 12, 2018); Coalition of Peaks and Australian Governments, "National Agreement on Closing the Gap" (2020), https://www.coalitionofpeaks.org.au/national-agreement-on-closing-the-gap.

11. C. Sheila, B. J. Smith, A. Possamai-Inesedy, and A. M. N. Renzaho, "Exploring the Role of Community Engagement in Improving the Health of Disadvantaged Populations: A Systematic Review," *Global Health Action* 8/1 (2015); M. Wright, D. Getta, O. Green, et al., "Co-designing Health Service Evaluation Tools That Foreground First Nation Worldviews for Better Mental Health and Wellbeing Outcomes," *International Journal of Environmental Research and Public Health* 18/16 (2021).

12. D. Manton and M. Williams, "Strengthening Indigenous Australian Perspectives in Allied Health Education: A Critical Reflection," *International Journal of Indigenous Health* 16/1 (2021).

13. Jackson Pulver et al. (see note 4); National Aboriginal Health Strategy Working Party, *A National Aboriginal Health Strategy* (Canberra: National Aboriginal Health Strategy Working Party, 1989); D. Manton, M. Williams, and A. Hayen, "The Bunya Project: Protocol for a Mixed-Methods Approach to Developing a Culturally Informed Curriculum," *JMIR Research Protocols* 12/1 (2023).

14. Manton et al. (see note 13).

15. Australian Health Practitioner Regulation Agency and National Boards, *The National Scheme's Aboriginal and*

Torres Strait Islander Health and Cultural Safety Strategy 2020–2025 (Australian Health Practitioner Regulation Agency and National Boards, 2020), p. 9.

16. Ibid.; Australian Health Practitioner Regulation Agency and National Boards, *Regulatory Guide* (Australian Health Practitioner Regulation Agency and National Boards, 2022).

17. Manton and Williams (see note 12).

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

19. R. Delbridge, L. Garvey and J. Mackelprang, et al., "Working at a Cultural Interface: Co-creating Aboriginal Health Curriculum for Health Professions," *Higher Education Research and Development* 41/5 (2022).

20. Manton et al. (see note 13).

21. National Aboriginal Community Controlled Health Organisation, "NACCHO Members" (August 11, 2023), https://www.naccho.org.au/naccho-members.

22. J. Bailey, I. Blignault, C. Carriage, et al., *We Are Working for Our People: Growing and Strengthening the Aboriginal and Torres Strait Islander Health Workforce; Career Pathways Project Report* (Melbourne: Lowitja Institute, 2020).

23. M. Davis, "Community Control and the Work of the National Aboriginal Community Controlled Health Organisation: Putting Meat on the Bones of the UNDRIP," *Indigenous Law Bulletin* 8/11 (2013).

24. D. Saxe and J. Gale, "Unsettling the 'White University': Undermining Color-Blindness through Critical Race Theory and Testimonio," *Journal for Critical Education Policy Studies* 19/3 (2022); B. M. Brayboy, H. R. Gough, B. Leonard, et al., "Reclaiming Scholarship: Critical Indigenous Research Methodologies," in S. D. Lapan, M. T. Quartaroli, and F. Riemer (eds), *Qualitative Research: An Introduction to Methods and Designs* (San Francisco: Jossey-Bass, 2012).

25. Manton and Williams (see note 12).

26. J. Marcelin, S. Dawd, R. Siraj, et al., "The Impact of Unconscious Bias in Healthcare: How to Recognize and Mitigate It," *Journal of Infectious Diseases* 220/2 (2019).

27. Parter et al. (see note 7); Reconciliation Australia, *2020 Australian Reconciliation Barometer* (Parkes: Reconciliation Australia, 2020).

28. Manton and Williams (see note 12); Manton et al. (see note 13).

29. Y. S. Poon, Y. P. Lin, P. Griffiths, et al., "A Global Overview of Healthcare Workers' Turnover Intention amid COVID-19 Pandemic: A Systematic Review with Future Directions," *Human Resources for Health* 20/1 (2022).

30. T. Parnell, K. Fiske, K. Stastny, et al., "Lived Experience Narratives in Health Professional Education: Educators' Perspectives of a Co-designed, Online Mental Health Education Resource," *BMC Medical Education* 23/1 (2023).

31. Manton et al. (see note 13).

32. S. Wilson, "What Is Indigenous Research Methodology?," *Canadian Journal of Native Education* 25/2 (2001).

33. Manton et al. (see note 13).

34. R. Ober, "Kapati Time: Storytelling as a Data Collection Method in Indigenous Research," *International Journal of Learning in Social Contexts* 22/1 (2017).

35. Ibid.

36. K. Charmaz, *Constructing Grounded Theory* (London: Sage Publishing, 2014), p. 111.

37. Ibid., p. 115.

38. Ibid.

39. G. Bodkin-Andrews, S. Page, and M. Trudgett, "Shaming the Silences: Indigenous Graduate Attributes and the Privileging of Aboriginal and Torres Strait Islander Voices," *Critical Studies in Education* 63/1 (2022); S. Topp, A. Edelman, and S. Taylor, "'We Are Everything to Everyone': A Systematic Review of Factors Influencing the Accountability Relationships of Aboriginal and Torres Strait Islander Health Workers (AHWs) in the Australian Health System," *International Journal for Equity in Health* 17/1 (2018).

40. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI) (1966); United Nations Declaration on the Rights of Indigenous Peoples (see note 1).

41. S. Fitzpatrick, *Inner Qualities versus Inequalities': A Case Study of Student Change Learning about Aboriginal Health Using Sequential, Explanatory Mixed Methods*, PhD thesis (UNSW, 2023).

42. S. Avery, *Culture Is Inclusion: A Narrative of Aboriginal and Torres Strait Islander People with Disability* (Sydney: First Peoples Disability Network Australia, 2018).

43. D. Coombs, "Future-Proofing Indigenous Self-Determination in Health: Goals, Tactics, and Achievements of Aboriginal Community Controlled Health Organisations in New South Wales, Australia," in N. Moodie and S. Maddison (eds), *Public Policy and Indigenous Futures* (Singapore: Springer Nature, 2023).

44. S. C. Thompson, E. Haynes, S. Shahid, et al., "Shedding Light or Fanning Flames?: A Consideration of the Challenges in Exploring the Relative Effectiveness of Aboriginal Community Controlled Health Services," *Quality in Primary Care* 23/3 (2015).

45. T. Calma and D. Dick, "Social Determinants and the Health of Indigenous Peoples in Australia: A Human Rights-Based Approach," (International Symposium on the Social Determinants of Indigenous Health, April 29–30, 2007), https://humanrights.gov.au/about/news/speeches/social-determinants-and-health-indigenous-peoples-australia-human-rights-based.

46. Manton and Williams (see note 12).

47. Ibid.

48. United Nations General Assembly, Interim Report of the Special Rapporteur on the Right of Everyone to the

Enjoyment of the Highest Attainable Standard of Physical and Mental Health, UN Doc. A/74/174 (2019).

49. Parter et al. (see note 7).

50. Ibid.; Australia, Racial Discrimination Act (1975); Human Rights Watch, "An Approach to Reparations" (July 19, 2001), https://www.hrw.org/legacy/campaigns/race/reparations.pdf.

51. Parter et al. (see note 7).

52. M. Gooda, "Aboriginal and Torres Strait Islander Social Justice Commissioner," *Social Justice and Aboriginal and Torres Strait Islander Peoples Access to Services* (2011).

53. Australia, Racial Discrimination Act (1975).

54. United Nations Declaration on the Rights of Indigenous Peoples (see note 1), art. 7.

55. L. Tynan, What Is Relationality? Indigenous Knowledges, Practices and Responsibilities with Kin," *Cultural Geographies* 28/4 (2021).

56. Australian Commission on Safety and Quality in Healthcare, "Communicating for safety standard" (August 11, 2023), https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard; S. McLeod, "Communication Rights: Fundamental Human Rights for All," *International Journal of Speech-Language Pathology* 20/1 (2018).

57. McLeod (see note 56).

58. V. Rosequist, *Mind Your Manners: An Investigation on Patient Perception of Bedside Manner and Its Effect on Their Visit*, master's capstone project (University of Tampa, 2023).

59. M. Wright, A. Lin, M. O'Connell, et al., "Understanding and Working with Different Worldviews to Co-design Cultural Security in Clinical Mental Health Settings to Engage with Aboriginal and Torres Strait Islander Clients," *Primary Health Care Research and Development* 22 (2021).

60. Australian Commission on Safety and Quality in Healthcare (see note 56).

61. Lowitja Institute, *Culture Is Key: Towards Cultural Determinants-Driven Health Policy* (Melbourne: Lowitja Institute, 2020).

62. S. Page, M. Trudgett, and G. Bodkin-Andrews., "Creating a Degree-Focused Pedagogical Framework to Guide Indigenous Graduate Attribute Curriculum Development," *Higher Education* 78 (2019); J. Cranney, C. Turnbull, S. C. Provost, et al., "Graduate Attributes of the 4-Year Australian Undergraduate Psychology Program," *Australian Psychologist* 44/4 (2009); O. Humberto, L. Konjarski, and S. Howe, "Does University Prepare Students for Employment?: Alignment between Graduate Attributes, Accreditation Requirements and Industry Employability Criteria," *Journal of Teaching and Learning for Graduate Employability* 10/1 (2019); L. Matson, C. Ng, M. Dockry, et al., "Transforming Research and Relationships through Collaborative Tribal-University Partnerships on Manoomin (Wild Rice)," *Environmental Science and Policy* 115 (2021); H. J. Mackey, D. Luecke, J. Robinson, et al., "Partnership through Story: Promising Practices for Meaningful Research," *Tribal College Journal of American Indian Higher Education* 33/2 (2021); V. Hiratsuka, S. Brown Trinidad, et al., "'You Actually View Us as the Experts in Our Own System': Indigenous–Academic Community Partnership," *Progress in Community Health Partnerships: Research, Education, and Action* 14/2 (2020).

63. Bailey et al. (see note 22).