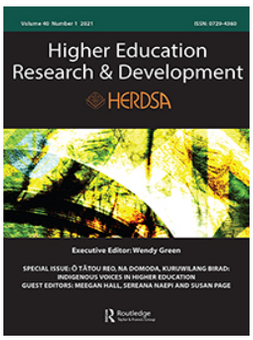

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Amplifying Indigenous voice and curriculum within the public health academy – the emergence of Indigenous sovereign leadership in public health education

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ABSTRACT

In April 2019, educators from around Aotearoa (New Zealand) and Australia came together to share their experiences of teaching Indigenous public health. The inaugural International Indigenous Public Health Education Leadership Symposium provided an opportunity to (i) discuss the range of challenges of this work, and (ii) to affirm a collective aspiration to strengthen the contribution of public health education to improved Indigenous outcomes. Talking across the borders of individual institutions, distinct cultures and nations enabled a rich conversation about the interface of health and Indigenous education. We explored the twin agendas of decolonisation and indigenisation, meeting the respective needs of Indigenous and non-Indigenous students, and how to best mobilise Indigenous public health leadership. This article will outline the discussion that unfolded and that led to the establishment of an inclusive Australia/Aotearoa/South Pacific Indigenous public health education entity and network.

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Introduction

The pursuit of collective health and wellbeing is an enduring priority of many of the 370 million Indigenous peoples across the planet (Anderson et al., 2016). These aspirations have been obstructed and challenged by the ongoing legacies of settler government policies of colonisation and forced assimilation, which have undermined the infrastructure of Indigenous health and the balance of Mother Earth (King et al., 2009).

By taking an upstream focus on the cultural, social, political and historical determinants of health rather than focussing on the treatment of ill health and injury, public health as a discipline has been uniquely placed to contribute to strengthening Indigenous health. Through applying the ethical values of social justice, equity and anti-racism, public health practitioners have consistently advocated for healthy public policy and the redistribution of wealth and health (Marmot, 2005). Indigenous practitioners and educators have been at the forefront of this work leading efforts to decolonise health practice (Smith, 1999).

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Written on the occasion of the first international Indigenous public health educators symposium hosted in Aotearoa, this article canvasses the broad-ranging discussion that ensued. The authors, all public health educators, comprise of two Indigenous and one non-Indigenous person. We begin by tracing a brief history of Indigenous public health education within Aotearoa and Australia, before reflecting on the unique challenges of teaching public health to students and practitioners to ensure effectiveness with respect to Indigenous health. This entails exploring the composition of the Indigenous public health educator community, the unique needs of the learners we are engaging, and the focus and form of our curricula. Based on the collective discussion of participants and informed by literature, we developed three pou (pillars) of a decolonised public health curriculum. We conclude by discussing the opportunity and challenges in operationalising our fledgling network to strengthen Indigenous public health education.

History of Indigenous public health education in Australia and in Aotearoa

Aotearoa

Mātauranga (Māori knowledge) has traditionally been passed on through wānanga, or fora of higher learning. Māori philosophers maintain that knowledge was originally derived from three kete (baskets). These were te kete tuatea, which contained 'ancestral knowledge' of warfare and agriculture, te kete tuauri, encompassing 'sacred knowledge' of realms beyond the natural world, and te kete aronui, containing 'life's knowledge', practices that would benefit the Earth and all living things (Kāretu, 2008). Collectively these kete included knowledge of tikanga (Māori customs), codes of behaviour governed by the application of tapu (that which is sacred), noa (unrestricted), and rāhui (restrictions). In terms of 'public health' application, tikanga was used to minimise disease and protect water supplies, food sources and the safety of people (Ratima & Ratima, 2003). More recent expressions of Māori public health have drawn on both Māori and western public health knowledges. Sir Maui Pōmare and Sir Te Rangi Hīroa, for instance, were pioneering Māori leaders who worked with communities to address the emerging threats of introduced diseases. They linked poor health with socio-economic adversity, advocated for a political commitment to health and were actively involved in trying to secure the return of confiscated lands.

Contemporary Māori public health action (Ratima et al., 2015) continues to involve engagement with kaumātua and kuia (elders) and assumes Māori needs, preferences and aspirations lie at the centre of practice. Collective wellbeing is seen as inseparable from wider Māori social, economic, political and cultural realities. Māori models of health emphasise the importance of culture, the interconnectedness of emotional and physical health, the importance of whānau (extended family) and wairua (spirit).

Within tertiary education, Māori health papers first emerged in the 1980s as elective papers within health curricula, and since then undergraduate and postgraduate Māori (public) health majors have been established (Brunton, 2011). There have been various efforts across western universities in Aotearoa to integrate Māori content across health curricula (Curtis et al., 2014). Whare wānanga (Māori universities) such as Te

Wānanga o Raukawa, continue to lead the integration of Māori world views into curriculum, teaching and all levels of university life.

As a workforce (of which Māori public health educators are a part), the formal public health community in Aotearoa remains small and unregulated. We, however, remain united through our voluntary commitment to a public health ethical code of practice, and familiarity and engagement with the generic public health competencies.

Australia

Collective public health measures are evident throughout history and across various societies (Baum, 2015; Scally, 2014). However, it was not until the 1800s when public health challenges such as cholera became epidemic throughout Britain, that the British developed a public health response that was shared throughout the colonies. All Australian colonies passed Public Health Acts modelled on the British Public Health Acts in the last two decades of the nineteenth century (Baum, 2015). Around the same time, a Diploma of Public Health was introduced in Britain, which allowed doctors to influence sanitary, food and hygiene public health reforms (Scally, 2014).

Accounts from early contact with European explorers paint a picture of largely disease-free, fit and healthy people (Fredericks et al., 2015). Colonisation had a profound impact on Aboriginal and Torres Strait Islander (Indigenous Australian) people, via the destruction of cultures and lifestyles, and an influx of infectious diseases that nearly eradicated Aboriginal populations (Fredericks et al., 2015). The colonial response to public health disease control for Aboriginal people (incarceration) was considerably different to that for non-Indigenous people (in-community treatment), a remnant of 1800s Britain (Lovett et al., 2019).

The impact of oppressive policies and the suppression of sovereignty of Indigenous Australian people has resulted in successive governments working to address poor Indigenous health systemically (Fredericks et al., 2015). The National Aboriginal Health Strategy Working Party was established in 1987, resulting in the development of the *National Aboriginal Health Strategy* (NAHS) (Lovett et al., 2019). The NAHS was an important milestone, as the first time that Commonwealth and State levels of government had worked with Indigenous communities on national policy, and for its incorporation of an holistic and cyclic Indigenous Australian concept of health (Fredericks et al., 2015). The NAHS concept of health aligned Indigenous Australian views with determinants-focused public health practice and remains key in the development of public health curricula content: a necessity to educate the public health workforce about Indigenous health.

In 1987, the Public Health Education and Research Program (PHERP) was established, and following a review in 2005, a recommendation was made for a set of 'foundation competencies for judgement-safe public health practitioners' to be developed (Lee et al., 2014). This led to the development of specific Indigenous public health core competencies, under the leadership of Professor Ian Anderson, and the publication of the Indigenous core competencies by the Australia Network of Academic Public Health Institutions (ANAPHI). The Indigenous Public Health Curriculum Network was formed as part of the PHERP-funded Indigenous Public Health Capacity Building Project (Lee et al., 2017). In 2009 following a name change, this Network became the

Public Health Indigenous Leadership in Education network (PHILE), with the focus of building capacity in Indigenous public health pedagogy, university-level teaching and learning programmes nationally. As a collaboration of Indigenous and non-Indigenous academics, PHILE has been responsible for developing an Indigenous public health curriculum, auditing curricula of Australian universities, and growing the next generation of Indigenous public health leaders and academics (Lee et al., 2017; Coombe et al., 2019). Having completed these significant initiatives in Australia, partnering with Indigenous educators from other nations was a logical next step. In early 2019 PHILE members and Māori and Pasifika public health educators gathered together for the first time, to consider a cross-nation collaboration.

Indigenous public health educators – who are we?

A key reason for the symposium was to build a community for Indigenous public health curricula. An Indigenous public health educator network did not exist in Aotearoa. Māori and Pasifika public health educators gather together either in largely practitioner-focused conferences, broader health research communities, or respective content-focused communities; we have been without an Indigenous public health education 'home'. Indigenous Australians wanted to share their public health pedagogy experience with other First Nations people, in order to learn from each other.

In gathering together for the first time, the diversity in our international collective was apparent. We fell into two main groupings. The first were Indigenous and non-Indigenous teachers of Indigenous content in public health/health sciences. That is, educators working within a western-dominated discipline, more likely teaching non-Indigenous learners. The second were teachers of hauora (Māori health) in Māori and Indigenous studies and Indigenous health for the Australian context. That is, those working within an Indigenous academic discipline, more likely teaching Indigenous learners.

Each group faces their own unique challenges. For instance, public health educators teaching Indigenous health within health sciences may find themselves working in isolation within a Eurocentric discipline, potentially objectified in the learning environment (Bond, 2014). Battiste (2004) asserts that this positioning likely compromises their effectiveness in terms of supporting Indigenous student outcomes. Conversely, they may have more success than non-health educators in integrating Indigenous content throughout such programmes, potentially effecting transformation from within.

Indigenous health educators teaching within the Indigenous Studies discipline are working from a position of self-determination. Studying within such a context can be very powerful for Indigenous and non-Indigenous students; offering critical, decolonial and in-depth exploration of public health centred in Indigenous experiences and providing direct contact and immersion within an Indigenous (academic) community. Potentially, however, teaching from outside a public health programme may lead to the perception of Indigenous content as 'added on' and may limit integration (Coombe et al., 2017).

Rather than conceptualising a single 'cultural interface', namely western/Indigenous, the Indigenous studies/public health delineation suggests multiple and multi-level interfaces. For instance, with regards to Indigenous educators, the interface with Indigenous communities is also critical (Phillips et al., 2007). Indigenous public health occupies a

position of 'double marginality' (Dewachi, 2009); situated as somewhat marginal in a field/discipline deemed marginal to other health sciences, e.g., medicine or nursing. In addition, the spread across at least two academic disciplines reflects the present 'disjointed and fragmented state' of Indigenous Humanities emphasised by Battiste (2004). This predicament was expressed by one symposium attendee as 'silos [that] have split and divided us'. In spite of being 'each at different points in our journey', our marginality, fragmentation and lack of number provided an impetus to cohere together.

Pedagogy I: the Indigenous public health education project

Attendees identified several aspects of an ideal public health curriculum from an Indigenous perspective. These were inclusion of Indigenous knowledge, cultural responsiveness, preparing students to work effectively with Indigenous communities, a focus on equity, and consideration of institutional racism.

Equity has been a significant focus in public health for decades (World Health Organization, 1978) and a key feature of government policy (Ministry of Health, 2018). Equity therefore forms a significant part of public health discourses and is a typical feature in public health programmes (Pentecost et al., 2018). Ford and Airhihenbuwa (2010) suggest, while racial hierarchies remain uncontested and racism under-theorised in public health, the capacity to effect equity is considerably compromised. Indeed, it is a mistake to presume that merely promoting equity obviates inequity.

These observations herald the need for a different type of teaching and learning, alluded to by symposium attendees in discussion of the importance of decolonising and/or indigenising the pedagogy of public health. Does decolonising prepare the ground for indigenising? Is decolonisation achieved through indigenisation? Is indigenising without decolonising a form of tokenism? (Dudgeon et al., 2016). What are the respective roles of Indigenous and non-Indigenous public health educators in both types of curriculum reform?

The need for decolonisation & decoloniality

In Australia and Aotearoa, the ongoing adverse effects of colonisation and dispossession on Indigenous peoples continue to be felt, perpetuated by structural inequity and institutional racism (Paradies, 2016). Colonial mindsets persist in the formal and informal institutions of the settler state as well as in everyday discourse and practice (Reid et al., 2017). These have prompted calls for decolonisation and decoloniality – to bring an end not only to the coloniality of power but also the coloniality of being (Maldonado-Torres, 2007) and knowledge (Mignolo, 2007). Here the distinction is between political and economic subordination and the resulting ways of thinking, living, working, authority and relationships that survive colonialism and extend the subordination of the Indigenous 'Other' (Maldonado-Torres, 2007). It is in the realms of knowledge and being – culture, labour, intersubjective relations and knowledge production – that Indigenous educators today contend with the legacy of colonialism.

Historically, education systems have formed a key part of the colonial infrastructure, espousing, transmitting, and assimilating learners into dominant cultural narratives

(Hutchings & Lee, 2016). Science and the health disciplines have been complicit in the subjugation of Indigenous ways of knowing and knowledge production, and the creation and maintenance of a fabricated, racialised hierarchy of humankind (Reid et al., 2019). Accordingly, health science and public health curricula have traditionally inculcated students in western biomedical models of care (Ford & Airhihenbuwa, 2018). The inclusion of indigenous health papers in public health programmes in recent decades have gone some way to rebalancing this focus. Approaches to decolonisation have only continued to evolve within these papers, supported by the momentum of cultural safety, cultural competence and anti-racist theorising and pedagogical developments.

Smith (1999, p. 98) refers to decolonisation as 'a long-term process involving the bureaucratic, cultural, linguistic and psychology divesting of colonial power', and Jackson (1989) similarly talks about the need to [decolonise] one's mind from colonial subjugation. The notion of decoloniality involving both un-learning and re-learning is promulgated in the Freirean (1970) concept of conscientisation – the process of developing a critical awareness of one's social reality through reflection and action. Came (2012, p. 78) explains

> Decolonisation is both an individual and collective process of revealing and actively analysing the historic and contemporary impact of colonisation, monoculturalism and institutional racism combined with political movement towards the recognition of sovereignty.

Darlaston-Jones et al. (2014, p. 96) emphasise

> Decolonisation and conscientisation requires an awareness, acknowledgement and shift on the part of the dominant group – repositioning both the dominant and Indigenous groups in ways that result in epistemological equivalence.

The pedagogical implications of these definitions are clear – decolonising or decolonial learning must be active and personal, grounded in the 'here and now' as well as the historical, with cognisance of the distinct challenges for dominant and Indigenous learners.

A decolonised public health curriculum

Pentecost et al. (2018) identified several critical orientations for humanising and decolonising education. With some reconfiguration and synthesis, the authors have formed these into pou that much of the decolonisation literature maps onto and that usefully address the central problems posed by coloniality. Each pou encompasses ways of knowing, ways of being and ways of doing (Martin & Mirraboopa, 2003).

Pou One – challenging knowledge hierarchies – epistemological decolonisation

The first pou seeks to address the unquestioned privileging and dominance of western and positivist knowledge (for instance, the evidence hierarchy), and the marginalisation of lived-experiential, qualitative and Indigenous knowledge in health sciences and public health. It does this through foregrounding the social construction of knowledge (Ford & Airhihenbuwa, 2018). Accordingly, topics are approached from multiple perspectives and ways of knowing, those perspectives equivalent rather than defined against each other, reviewed against the kinds of questions they can answer (Pentecost et al., 2018). This pou involves introducing research methods training where students undertake their own research to experientially deepen their understandings of knowledge

production (Pentecost et al., 2018). It can also involve incorporating critical approaches (for instance, critical race praxis) and asking students to apply these by challenging their initial understandings, 'questioning the question', and undertaking self-critique. Epistemological decolonisation also involves giving voice to and privileging the perspectives of marginalised communities (Ford & Airhihenbuwa, 2018).

Pou Two – an integrated understanding of history and social context

This second pou requires engagement with the traumatic history of colonialism, and also with a contemporary social system that continues to reproduce inequality (Hojjati et al., 2018). In doing so, the dominant cultural narratives relating to colonial history are challenged/countered, and the endurance of coloniality is highlighted. For Reid et al. (2019), this pou upholds the right of Indigenous peoples to 'truth telling' about colonisation and its effects, a necessary part of healing.

According to Huygens (2011), this re-telling of history provides dominant culture members with necessary 'alternative knowledges' about the colonial past, putting emphasis on the experience of Indigenous people, but also unsettling beliefs in the benign benevolence of the colonisers. Huygens posits that the teaching of this content must be led by members of the settler coloniser group. As fellow beneficiaries of colonisation they are ideally placed to support the emotions that may be aroused for non-Indigenous students.

A second component aims to build a sophisticated understanding of political economy and the structural/commercial/political determinants of health and health inequities, and to embed public health practice within these (Pentecost et al., 2018). This focus is less about adding courses on history or political economy, and more about training health professionals to be sensitive to their social context, including accepting a moral responsibility to uphold human dignity and advocate for social justice.

Pou Three – challenging the image of the health professional (cultivating relational practice)

A third pou combines a reconceptualisation of the public health practitioner and learning in order to achieve reflective practice (Pentecost et al., 2018). This pou involves seeing public health practitioners as people who deal with people, advocates, carers and healers as much as 'scientist'. Such an expanded conceptualisation entails reflecting on professional identity and values, and recognising that respectful interaction is also a core component of professional competence and health outcomes. This is supported by embedding relationality in health practice and seeing *care* as an essential aspect of public health.

Building on the content of Pou One and Two, students need to be able to demonstrate how a critical health focus applies in their lives, education and practice. For all public health students, this requires recognition of how professional practices reflect and potentially reinforce systems, and what active steps might be taken to resist and dismantle these structures (Hojjati et al., 2018). For non-Indigenous students, this may involve deconstructing their own cultural situatedness, identifying unearned white privilege associated with being part of the dominant group and reflecting on their own attitudes and beliefs about Indigenous peoples (Darlaston-Jones et al., 2014). Cross-Townsend (2011) notes that critical learning relationships can only be developed through immersive practices of 'democratic discussion' where mentoring and learning from each other is facilitated.

Nakata et al. (2012) favour non-personalised confrontation, supporting students to remain open to thinking, reflecting and learning rather than insisting on a 'decolonial' endpoint within the confines of a single course. A deep understanding of the type of learning involved (Coombe et al., 2016) is important here – accepting that this learning takes time, involves considerable thinking and reflection, grappling with difficult questions and may involve 'slippage' back to entrenched logic.

Language and analytical tools from Pou One (e.g., critical theories) may help students to explore contemporary complexities at the western/Indigenous cultural interface, rather than 'a rehearsed politics of difference' (Nakata, 2018). The complexities of interactions at the cultural interface and the difficulties of achieving cross-cultural understandings and acquiring cultural competences should also be conveyed to students (Wepa, 2015).

This pou attracted a significant amount of discussion among symposium attendees. The importance of reconstituting healthy relationships and engaging with community on the basis of relatedness and interrelatedness was noted specifically, as was the notion of students as future health professionals and advocates. High quality cultural supervision and cultural responsiveness as determined by whānau were cited as key mechanisms for producing professionally and culturally effective practitioners.

An indigenised public health curriculum

There are several points in the pou outlined above that allude to 'Indigenous inputs'. Indeed, Dudgeon et al. (2016, p. 115) argue for an Indigenous perspective that is 'grounded in decolonisation, the struggle for social justice, cultural reclamation and the development of Indigenous knowledges'. Nakata et al. (2012) call for knowledge-making that draws in concepts and meanings from both Indigenous knowledge and colonial systems of thought and experience. In the area of medical education, Jones et al. (2019, p. 514) argue for decolonisation 'hand in hand with a process of 'indigenising'. To 'indigenise' means to subject to native or Indigenous influence; noted by symposium attendees as a necessity for public health teaching.

As Cross-Townsend (2011, p. 72) notes, 'indigenisation' has been 'a catch-cry for Indigenous Studies, where the strategy is to inject authentic Indigenous content across the disciplines of the academy'. However, she, and several others express concern about incorporating Indigenous content and perspectives uncritically. Content presented in a single lecture by an Indigenous guest speaker may appear tokenistic. A focus on 'exotic elements' may unintentionally reinforce romanticised notions of Indigenous people (Fredericks & Bargallie, 2016). Or an 'impoverished' version of Indigenous pedagogy, and distorted understandings of Indigenous knowledge may result (Nakata, 2004). A further risk is that of highlighting social, economic and health disadvantage without accompanying Indigenous resilience or resistance narratives, thereby reinforcing a deficit perspective (Fredericks & Bargallie, 2016).

Indigenous knowledge and experience, including history, language and ways of knowing, must be foregrounded rather than conceptualised through a 'western scientific filter where it is disembodied from its people' (Nakata, 2007). It must be incorporated as valid, holistic knowledge that is also diverse and relevant for contemporary contexts. This entails not presenting Indigenous knowledge only as 'traditional' or 'community', or in

solely ancestral and spiritual terms. Nor should Indigenous and emancipatory knowledge be positioned as 'practical' against 'theoretical' western and colonial knowledge, 'cultural' against academic teaching (Curtis et al., 2014). Furthermore, critically reflexive rather than authoritarian teaching of Indigenous knowledge is essential to mitigate the reification of colonial 'Indigenous versus western' boundaries (Nakata, 2018, p. 5).

It is important that Indigenous perspectives critique, deconstruct and analyse dominant culture hegemonic ideologies and power relations as well as constructions of 'aboriginality' (Williamson & Dalal, 2007, p. 52). However, 'deeply critical' deconstruction and analysis of dominant culture from Indigenous standpoints can threaten and alienate dominate culture learners (Choules, 2006), calling for a carefully managed approach.

Consulting with local communities about how to incorporate Indigenous knowledge and perspectives will ensure appropriate, mandated expertise and input, specific to the local context (Pentecost et al., 2018, p. 211). The views of Indigenous communities make a valuable contribution. Firstly, Indigenous views of the 'shared situation' provide someone for non-Indigenous students to respond to. This can stimulate motivated learners to seek new ways to facilitate change (Huygens, 2011). Secondly, the retelling of history according to an Indigenous perspective portrays Indigenous agency rather than victimhood, an important part of any colonial counter-narrative (Fredericks & Bargallie, 2016).

In considering their role in decolonising public health curricula, symposium attendees discussed the disproportionate workload and additional cultural demands (Torepe & Manning, 2018) that arise from being Indigenous educators, and the need for support from non-Indigenous colleagues. In a bid to mitigate the burden, one attendee called for a recognition of indigeneity that does not rely on off-site cultural immersion such as noho marae (staying overnight at a meeting house). Attendees expressed a desire for opportunities and time to reflect on and discuss Indigenous public health pedagogy, as well as tikanga support from kaumātua, in order to strengthen their teaching practice and facilitate thinking beyond the status quo. One symposium attendee shared an example of the utility of indigenous values in this regard – respect, reciprocity and relationship – to guide teaching across decolonising and indigenising activities.

Pedagogy II: our learners

An additional pedagogical challenge was discussed at the symposium; that of meeting the diverse needs of public health learners. Given that non-Indigenous students comprise the majority of enrolments, and were identified as those most in need of decolonisation in order to not perpetuate harm to Indigenous people, several attendees admitted a tendency to focus on their needs, perhaps at the expense of Indigenous learners. While educators felt their approaches were successful in meeting non-Indigenous needs, they recognised that critical counter-narratives and talking *about* Indigenous peoples seemed to generate some awkwardness for Indigenous learners. Questions raised included 'how do we create a safe (non-colonising) environment for Indigenous students?', 'why are Indigenous students entering our programmes and not graduating?', and 'are we ready for kura kaupapa (Māori immersion school) and Indigenous Australian students enrolling in public health?'. There was a strong feeling that the unique needs of

all Indigenous students deserve more attention in the public health curriculum going forward.

Rather than assuming a singular way to teach Indigenous public health, these discussions highlight the need to tailor approaches and methods (Jones et al., 2019; Lee et al., 2017). As Huygens (2011, p. 75) emphasises, this content has very different meaning and implications for Indigenous and non-Indigenous students:

> The cultural implications of revisiting history are different for settler colonisers and Indigenous people. Addressing the oppressed, Martin-Baro (1994, p. 218) explains that recovery of historical memory means 'recovering … a tradition and a culture … Revisiting history challenges a settler coloniser's internalised self-attributions of decency and fairness, and gives a sense of urgency to reviewing their cultural inheritance.

As numbers of Indigenous students increase in public health programmes and classrooms, the need to 'caucus' (Came et al., 2019) students to enable safe, free-flowing and in-depth discussion, as practiced in *te Tiriti o Waitangi* education and anti-racist teaching pedagogy, may be warranted. Furthermore, with the entrance of a cohort of bilingual, bicultural and confident Indigenous students, the critical counter-narrative, no matter how much weight it gives to Indigenous agency, may feel deficient, out of step and 'inauthentic'.

Such a cohort of empowered Indigenous learners may also feel within their bounds to challenge Indigenous educators with regards to their authenticity and expertise. One symposium attendee cited the mobilisation and opposition of such students to new 'flipped classroom' (Reidsema et al., 2017) teaching methods that required their more active engagement, and the uncomfortable situation that ensued. Time to consider the different needs of the next generation of Indigenous learners (and indeed emerging Indigenous leaders), and a reorientation and sophistication of the critical counter-narrative developed in public health curricula are needed; these are areas in which Indigenous Studies has much to offer.

Points raised in the symposium discussion are simultaneously supported and challenged by Nakata (2018, p. 5), who discusses the problematic consequences of a shared classroom in which there is 'tacit acceptance of teaching designed to affirm Indigenous students, while teaching to challenge and unsettle non-Indigenous students'. In his view, this may lead to the avoidance of difficult or emotional discussions, the placement of sensitive issues 'out of bounds', 'skipping over complex entanglements', and the reproduction of a politics of difference. Nakata appears to support the exposure of each group of students to this difficult middle ground, thus rendering considered and expert teaching/facilitation essential. A forum in which these issues are able to be discussed and debated deeply, as they apply specifically to public health, is essential. Further, all teachers need to engage in a process of deep learning, of Indigenous issues and knowledge, to enable them to engage in comprehensive curricula reform (Coombe et al., 2016).

Indigenous public health graduate competencies

Producing a public health workforce equipped to address health inequities and promote Indigenous wellbeing is one of the imperatives of an Indigenous educator collective. The pou of a decolonised/indigenised public health curriculum presented here draw

important connections between the causes of inequities and poor health (Curtis et al., 2019) and provide students with some tools to counter these. Pou Two accounts for historical trauma and institutional racism in the establishment of poor determinants of health. Pou One provides the epistemological foundation for this counter-narrative and also centres Indigenous ways of being and knowing. Pou Three requires the student to reflect on their situatedness in their colonial context, *and* in relation to Indigenous peoples and health, as a critical foundation for mitigating cultural incompetence. These curriculum pou thereby relate to the ongoing debate in Indigenous health education regarding cultural safety/critical consciousness versus cultural competency, coming down on the side of the former. However, although cultural competency has been challenged for not translating into improved health outcomes for Indigenous peoples (Curtis et al., 2019), the language of competency has been central to the Indigenous public health project.

Public health competencies have been developed in both Australia and Aotearoa, inclusive of Indigenous health standards. In Aotearoa these are differentiated into Māori and *te Tiriti o Waitangi* standards, incorporated within distinct health promotion and public health competencies. These competencies encompass knowledge, action and skills to guide effective practice with respect to health outcomes, combining elements of a transcultural/cultural awareness approach with a socio-political/social determinants of health lens. Adherence to these competencies is neither enforced nor accredited, however, and the link to education is not clearly made or monitored (Ahuriri-Driscoll, 2019). Questions raised about existing competencies at the symposium included 'what do we have? Who uses them? How are they used, and how are they evaluated?' Individual members reported drawing on the competencies in different ways in their curricula, as well as adhering to university-specific bicultural/Treaty-based frameworks. However, it was noted that there was no 'clear set of cultural competencies measures … measurable and signed off by someone credible'. A further question included 'whether, because the competencies are set at a basic level, they are sufficient to look after our people?'

In contrast, in Australia, foundation and Aboriginal and Torres Strait Islander core competencies for Master of Public Health (MPH) graduates have been developed (Lee et al., 2017) and evaluated (Coombe et al., 2019). Furthermore, a clear link to curriculum has been drawn through consideration of how Indigenous health competencies might be integrated into public health teaching and learning in terms of content and pedagogy (Lee et al., 2017), and through horizontal and/or vertical curricula integration strategies (Coombe et al., 2017). The inclusion of Indigenous alongside non-Indigenous content/material has been an important step in decolonising/indigenising the public health curriculum (Coombe et al., 2019).

The Indigenous public health core competencies developed by PHILE are comprehensive, and map to both decolonising and indigenising elements of the curriculum pou (see Table 1). A particularly valuable added aspect of the Indigenous Australian competencies is the emphasis on (economic) evaluation – a 'western' form of knowing decolonised and reoriented to promote Indigenous outcomes (Lee et al., 2017). Such a skillset moves students beyond symbolic or ceremonial means of redress, to substantive, structural, material and redistributive equity-oriented action. Thus, while Indigenous Studies might provide insights regarding the nuances, depths and tensions of indigenising 'at the interface', public health offers some valuable tools and areas of practice to effect

Table 1. Pou of a decolonised/indigenised public health curriculum, mapped against PHILE Indigenous public health competencies.

Curriculum pou	Relevant Indigenous public health competencies (PHILE)
Pou One: Challenging knowledge hierarchies – epistemological decolonisation • Understanding knowledge as socially constructed • Giving equal weight to qualitative, experiential and community-based indicators	• Analyse key comparative health indicators for Aboriginal and Torres Strait Islander (ATSI) peoples • Analyse key comparative indicators regarding the social determinants of health for ATSI peoples • *Burden and prevalence of chronic disease and infectious disease, social and emotional wellbeing and mental health, national key performance indicators, ATSI identification*
Pou Two: An integrated understanding of history and social context • Engaging with colonial history, its ongoing effects and complicity • Awareness and critical analysis of health within a wider social context • Accepting a moral responsibility to uphold human dignity and advocate for social justice	• Describe ATSI health in historical context and analyse the impact of colonial processes on health outcomes • Critically evaluate Indigenous public health policy or programmes • Apply the principles of economic evaluation to ATSI programmes with a particular focus of the allocation of resources relative to need • *The reproduction of ATSI disadvantage, ATSI initiatives in health, key institutional structures in ATSI health, ATSI health, economics and equity, human rights, self-determination and decolonising practices, cultural dimensions of ATSI health, colonisation and health, ATSI initiatives and approaches to health*
Pou Three: Challenging the image of the health professional – cultivating relational practice • Reconceptualising public health practitioner as advocate, care, healer • Reflection on professional identity and values, cultural situatedness • Preparedness to take action	• Demonstrate a reflexive public health practice for ATSI health contexts • *Ethical ATSI health practice, understanding factors shaping own cultural standpoint, nature of evidence and ways to access knowledge from ATSI perspectives, appreciating existence of local protocols, awareness of cultural safety, and ATSI learning styles, ATSI identification*

decolonial outcomes. There is significant value therefore in realising the complementarity and synergies of both disciplines in indigenous public health education, led by indigenous public health educators and their allies.

Implications/conclusion: operationalising Indigenous public health educational leadership

The discussion outlined above demonstrates the considerable work that might be undertaken by an indigenous public health educator collective (for example, instituting accreditation according to Indigenous public health competencies). Being able to operationalise Indigenous public health educational leadership is critical, and this was the subject of much discussion. How a cross-nation Indigenous public health educator network might be structured and sustained, building from existing entities to represent Indigenous interests appropriately, will be the focus of continuing deliberations. However, and whatever unfolds, Indigenous leadership – 'nothing for us without us' – is a core principle.

Through documenting and building on our discussions as a collective of educators in indigenous public health, this article canvasses the broad range of issues and considerations involved. The enduring challenges of our marginality, number and distribution

have been recognised, together with the strengths of our collectivity and diversity. The twin objectives of decolonising and indigenising public health pedagogy and curricula, shaped in and around several pou, have been outlined. We propose that this work will provide a valuable basis for further and future discussions.

Returning to our workplaces, we are confronted with the realities of the constrained capacity of Indigenous academics to implement this important curriculum and teaching and learning leadership in addition to existing workloads and demands. Recent research shows that Māori make up less than 5% of the total academic workforce in Aotearoa (McAllister et al., 2019), and Indigenous Australians comprise less than 1% of the total academic workforce in Australia (Department of Education Australian Government, 2018). The challenge, therefore is to not only recruit and retain Indigenous public health students, but for the Academy to look after its own and recruit and retain Indigenous academics. The curriculum needs to be Indigenised and decolonised but ultimately so does the Academy itself.

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