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COVID-19 and Indigenous knowledge and leadership: (Re)centring public health curricula to address inequities

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In Aotearoa New Zealand, Māori (the Indigenous peoples) have a national treaty negotiated with the colonising British Crown. The treaty, Te Tiriti o Waitangi, guarantees continued Māori sovereignty, protects Māori interests, promotes Māori wellbeing, and guaranteed the Crown limited *kāwanatanga* (governance). Currently, Māori make up a significant proportion of the population, at 15%, and similar to other Indigenous peoples who have been colonised, Māori continue to carry a disproportionate burden of disease compared with the settler population.^{1,2} Te Tiriti o Waitangi is central to ethical public health and health promotion practice and is a legislative, policy and professional imperative.³ Health promotion in Aotearoa New Zealand has a longstanding commitment to moving beyond rhetoric and legalistic interpretations, to fulfilling the spirit and aspirations of Te Tiriti o Waitangi relationships, Māori autonomy and equitable outcomes.⁴ Aotearoa New Zealand competency frameworks require health promoters and public health workers to be proficient in Te Tiriti o Waitangi application, understand the ongoing effects of our colonial history, be familiar with Māori models of health, and know how to engage with Māori communities.⁵⁻⁷

Came et al.³ have argued that despite these stated good intentions, there is variable application of Te Tiriti o Waitangi in practice and there is room for further development throughout the wider field of public health. With the renewed interest in public health due to COVID-19, it is timely to reconsider the ways that we can re-centre Te Tiriti o Waitangi and Indigenous knowledge in our curricula to build our own and our students' critical

consciousness and reduce the significant and increasing health disparities between Māori and non-Māori. This aspiration sits within broader global calls in health promotion to "make space for and privilege Indigenous peoples' voices and Indigenous knowledges".⁸ Throughout the COVID-19 period, we have watched public health in action. In Aotearoa New Zealand, we have seen the mobilisation of effective Māori-led public health responses such as road checkpoints into isolated predominantly Māori communities. We have also seen conventional top-down government public health action that we can critically examine in regard to impact on Māori health and in the context of Te Tiriti o Waitangi obligations. These examples provide us new prospects to assist us in decolonising our curricula through elevating critical Indigenous perspectives.

Decolonising our curricula means becoming reflective of the forms of knowledge that we use. Through our teaching, we advertently demonstrate the knowledge we value and our world views. We must work with integrity in creating space for students to deepen their critical consciousness and become champions of Indigenous solutions and Te Tiriti o Waitangi-based practice. As educators, we must commit to our ongoing critical reflection and ask ourselves: How do our graduate profiles reflect Indigenous aspirations? How do our learning outcomes uphold Indigenous ways of knowing? Using the COVID-19 pandemic response examples creates potential to realign the largely Euro-centric discipline of public health. Using critical pedagogies enables us to ask: Which public health responses are valued? What are the multiple perspectives we can use to

analyse public health action in pandemic response? Whose voices are privileged and authoritative, and whose are marginalised and silenced? How can we recognise colonial structures, challenge these and work in Te Tiriti o Waitangi-led ways? As Charles^{9(p24)} states, "In critically re-examining what is included in the curriculum – the voices, narratives and different sources of knowledge – education could be transformative of both the individual (staff and/or student) and the impact this might have on the subject discipline and society".

Māori health promotion

Ratima¹⁰ describes Māori health promotion as the process of enabling Māori to increase control over the determinants of health and strengthen identity as Māori, and thereby improve the health and position of Māori in society. A key model of Māori health promotion, Te Pae Mahutonga, guides practice that is consistent with Māori concepts of health, values and ways of working.^{11,12} Te Pae Mahutonga is a constellation of stars used as a navigational tool by Māori, otherwise known as the Southern Cross. The four central whetu (stars) represent the four key tasks of health promotion: Mauri ora (cultural identity), Waiora (physical environment), Toiora (healthy lifestyles), and Te Oranga (participation in society). These tasks are facilitated by the two pointer stars: Te Mana Whakahaere (autonomy) and Ngā Manukura (community leadership), which we discuss here in relation to COVID-19.

Te Mana Whakahaere is about enhancing wellbeing through increasing Māori participation.¹¹ Ratima¹² describes Te Mana Whakahaere as a community action approach, founded in community ownership and control of health promotion initiatives. During COVID-19, many iwi (tribes) self-initiated local safety protocols based on Māori concepts of tapu (prohibited or restricted), noa (free from restriction) and rāhui (temporary restriction), including road checkpoints, and restrictions on access to beaches, rivers and forests. The road checkpoints set up by iwi throughout rural areas with large Māori populations illustrate community ownership in identifying public health risks and holding knowledge about the needs and priorities of Māori. The checkpoints

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were a health protection strategy developed by iwi to restrict movement through these areas to protect the wellbeing of all residents, Māori and non-Māori. These communities are particularly vulnerable to COVID-19 due to isolation, chronic health issues, low immunity and limited access to health services. The checkpoints reflected community leadership and Māori autonomy and relied on community resources to reduce unnecessary travel and potential spread of the virus. The checkpoints were not without public criticism and were met with racist political discourse. For example, some commentators questioned the legality of the community-led checkpoints, despite them being endorsed by the Police Commissioner.¹³ In many cases, the community responses highlighted the need for active and responsive Te Tiriti o Waitangi relationships between iwi, Police, Civil Defence, local authorities, government agencies and community organisations working collaboratively. It is a useful example to show students the need to “actively support the continuation and restoration of Indigenous control and authority”.¹⁴ The Māori-led approaches show how the strengths, resources and values within Te Ao Māori, Māori whānau and communities are critical to public health action in Aotearoa New Zealand, particularly if we are to reduce and prevent inequities. “Regardless of what the intervention is, if Māori feel that they are not in control of, or party to the process, then the likelihood of success is diminished. Working ‘with’ these communities, rather than ‘on’ them, will ensure authentic relationships are maintained and nurtured and increase the likelihood of good outcomes.”¹⁵

Ngā Manukura refers to Māori leadership in health promotion.^{11,12} Effective health promotion requires Indigenous expertise and participation in decision making to achieve positive outcomes and equity. Māori leadership championed an improvement to funeral restrictions to better acknowledge Māori capability to manage public health at large gatherings and enable Māori to grieve and practice beliefs associated with death and dying. For example, initial government restrictions on funerals centred on strict constraints around funeral homes housing the deceased, viewing restrictions and significantly limiting the numbers of the bereaved. This effectively disregarded marae (cultural community centres) as culturally appropriate spaces for mourning with expertise in appropriately managing large

gatherings such as tangihanga (funerals). It also disregarded Māori beliefs and practices associated with death and dying. After sustained campaigning by Māori leadership, some restrictions were improved to enable larger numbers of the bereaved to attend tangihanga, and for iwi to determine their protocol for tangihanga on marae.

The New Zealand Government has been criticised for not proactively including Māori in COVID-19 planning and decision-making, thereby not upholding Te Tiriti o Waitangi partnership obligation.¹⁶ Jones¹⁷ describes the exclusion of Māori from core decision making spaces as reflecting the institutional racism of the health and disability system, with inherent risks to equity. While Māori have been active contributors to the COVID-19 response, the colonising ‘intellectual authority’ of epidemiology and infectious disease experts have been centred: Western scientific knowledge privileged over Indigenous knowledge. There has been little acknowledgement of Indigenous values, priorities and frameworks.¹⁸ Successful Māori responses are often criticised and over-scrutinised, with central government support slow or non-existent. Our future public health practitioners must be adept in building proactive alliances, competently building trust and cooperation at cultural interfaces. Using critical pedagogies enables us to ask: Who is making the plan and leading the response? Whose skills and knowledge can be drawn on? Who has access to information and resources to allow a coordination of effort? How can we ensure that data is collected, analysed, interpreted and translated in line with Indigenous world views? Incorporating work-integrated learning into curricula is a key way to prepare students to practically support the prioritising of Indigenous-led public health action. Through engagement with communities, students can practise building relationships, critically self-reflect, apply their learning of Te Tiriti o Waitangi and advocate for Māori-led approaches in real-world settings.

In public health, we need to be aware of the assumptions and theoretical underpinnings of our practice. Similarly, our teaching and learning is not neutral: which public health challenges we identify, what information we use and how, and the solutions we propose are political processes. We must grow our students to ask: Whose interests are being prioritised? Health promotion is individuals and communities being able

to make their own choices and realise their full potential. As Berghan et al.^{5(p44)} state, “the work of decolonisation, and the systematic disinvestment of colonial power, fits comfortably within the scope of health promotion. Decolonisation is about shifting power and resources to enable Indigenous control”. Decolonisation is a process, and the COVID-19 pandemic provides a specific point in time where we may consider the values reflected and lessons learned. Conveniently, during the week Aotearoa went into lockdown, public health activists had organised an online anti-racism conference: Te Tiriti Based Futures: Anti-racism 2020. This event attracted thousands of participants, including many from the health sector who were keen to learn more about racism, Te Tiriti o Waitangi and decolonisation. The YouTube channel developed from the event contains more than 50 open-access webinars available for educators to use across the world. We live in a global village, and it is timely to review our public health curricula to identify which knowledges we value and to broaden perspectives, particularly with the resurgence in the Black Lives Matter movement. In Aotearoa, Te Tiriti o Waitangi and continued health inequities necessitate that our teaching and learning does not perpetuate colonisation, but is active in decolonisation, to reflect and engage with Indigenous responses and practice in public health and rebalance voices.

In Aotearoa New Zealand, those working in public health must recognise Māori as Tāngata Whenua (Indigenous people of the land), and acknowledge Te Tiriti o Waitangi responsibilities, working to eliminate ethnic health inequities.¹⁴ The COVID-19 pandemic response has provided discussion about how we can ensure our public health actions and outcomes reflect the realities and aspirations of Māori. Like the Ottawa Charter, which is about the relationships between individuals, communities and governments, Te Tiriti o Waitangi is also about relationships, especially the Crown’s relationship with Māori, the balance between state control and autonomy, and the opportunity for cooperative action so that mutual collective benefits might be realised.

Will our current health promotion pedagogies equip us with a workforce competent in decolonisation, able to support meaningful relationships with communities and Indigenous peoples, and ready to do political and anti-racism work?⁵ The challenge for us

as teachers is to disrupt the longstanding traditions of public health that focus on Eurocentric methodologies and that limit our ability to achieve equity. We must have courageous conversations with each other and our students about how racism and colonisation continue to shape both our past and present.

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