What we do matters: Supporting anti-racism and decolonisation of public health teaching and practice through the development of Māori public health competencies

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Abstract

Objective: This research sought to expand on a set of core Māori hauora ā-iwi/public health competencies initially designed for teaching and to enable their use in workplaces.

Methods: The research used a kaupapa Māori methodology in four stages including the development of draft levels of competence for all core competencies, consultation hui (meetings), analysis of feedback and redrafting, and respondent validation.

Results: Key themes elicited in relation to the content of the competencies included increasing language expectations, the importance of strength-based approaches and self-determination, and the need for individual responsibility to address structural racism. Reflective practice was identified as a fundamental cross-cutting competency. Participants suggested planetary health and political ideologies be included as additional socio-political determinants of health with equity impacts. Key concerns related to the application of the competency document included the need for cultural safety and ensuring that all public health practitioners are 'seen'.

Conclusions: The Māori hauora ā-iwi/public health competencies have been published under a Creative Commons licence.

Implications for public health: The process of drafting a set of Māori public health competencies elicited key themes potentially relevant for public health practice in other countries and resulted in a competency document for use by universities and workplaces.

Key words: public health competencies, Māori, New Zealand, anti-racism, decolonisation

Background

In Aotearoa New Zealand, there are persisting health inequities between Māori and non-Māori.[1] For example, there are substantial disparities in the burden of morbidity for the vast majority of commonly diagnosed chronic conditions, with these conditions also manifesting at a younger age in Māori.[2] Māori also have poorer outcomes than non-Māori for 23 out of 24 of the most common cancers, with excess mortality ranging between 12% and 156%.[3] The need to accelerate progress in addressing inequities is most starkly illustrated by comparisons in life expectancy at birth and the concern that, with current trends, it could take well over another century for all Māori to achieve equity in life expectancy with those of European descent.[4]

The pursuit of equity is a fundamental component of public health practice[5], which requires practitioners to acknowledge and address the unequal distribution of the determinants of health, as well as the differential access to and through health and disability services resulting from colonisation and racism.[6] In Aotearoa New Zealand, decolonial transformation of the health sector is consistent with a commitment to te Tiriti o Waitangi (the founding document of Aotearoa New Zealand), in which Māori are guaranteed ongoing authority to manage their own affairs, chieftainship over all property including natural resources, and are assured the same rights and protections afforded to Pākehā (NZ Europeans).[7] As such, te Tiriti o Waitangi has been regarded as a 'foundation for good health'[8] and provides an instrument against which to monitor health policies and programmes.[9,10]

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The Māori hauora ā-iwi/public health competencies project was built on the understanding that medical education institutions have an important role to play in addressing Indigenous health inequities[11] and that public health as a discipline is also uniquely placed to do this due to its focus on upstream determinants.[12] How Indigenous health content is integrated into public health curricula can influence the effectiveness of programmes in developing culturally safe practitioners. In particular, a combined integration model has been promoted, where there is both vertical integration (a specialist stream), as well as horizontal integration with linked content across core subjects.[13]

The Māori hauora ā-iwi competencies project was initiated in 2019 by staff in the Department of Preventive and Social Medicine at the University of Otago, who recognised through review that, aside from three focussed courses, there was little Māori health content in the public health courses.[14] Broadly speaking, the aims of the project were to embed core Māori hauora ā-iwi/public health competencies within the discipline of public health and make them everyone's business and responsibility, so normalising kaupapa Māori (Māori approach, principles, practices) and culturally safe values and practices. Initial work culminated in a set of core Māori hauora ā-iwi/ public health competencies across eight competency domains.[15,16]

This paper focusses on the second phase of the Māori hauora ā-iwi/ public health competency project, which sought to expand on the competency framework developed in the first phase by defining progressive steps of achievement, or competency 'levels'. Furthermore, it examined how the competencies could be applied in multiple contexts, including workplaces. This is in recognition that education is lifelong and that many public health practitioners would have trained in Western institutions with a limited Indigenous health curriculum. Workplaces in Aotearoa New Zealand therefore carry certain responsibilities to build a workforce better equipped to improve Māori health but may lack the tools to do so. A set of Māori hauora ā-iwi competencies could assist with many workplace functions including assessing capacity, identifying training needs, planning and securing funding for workforce development, and recruitment functions. They could also help individuals with their own career planning and professional development goals.

Methods

The second phase of the Māori hauora ā-iwi competency project was completed in four stages: development of draft levels of competence for the core competencies identified during phase one, consultation hui to acquire feedback, analysis of the feedback and redrafting of the competencies including their associated levels, and respondent validation.

The research used a kaupapa Māori methodology, which centres Māori ways of knowing and understanding, along with Māori protocols for engagement.[17] The research team included both Māori and non-Māori researchers, with leadership provided by Māori team members, especially during consultation hui, where non-Māori team members' primary role was to listen to and document participant's views. The 'Give way rule' was applied in other stages, particularly when analysing and responding to feedback. This rule was developed in the Success for All project[18,19] as a way to manage different interpretations or meanings amongst research team members. For this research, it meant that where there were differences in interpretation of participants' views and suggestions, Māori researchers' interpretations took precedence over those of non-Māori team members.

Development of the expanded competency document

The second phase of the Māori hauora ā-iwi competencies project was preceded by a thorough review of the literature to identify any new publications relevant to this work. Databases included Scopus, ERIC, PubMed, CINAHL, Medline, Google Scholar, and PsycInfo, with search terms of Māori, Indigenous, public health, competencies, and their synonyms. This was followed by a much broader review of public health competency documents from around the world and the educational models on which these are based to inform the structuring of competency levels.

Drafting of the expanded competencies was done over a series of 14 research meetings/workshops between members of the research team. The existing competencies from phase one were reviewed to confirm the key overarching statements for each competency and to identify and map subcompetencies to appropriate levels in the framework. The first draft of the expanded competency document included competency statements for each competency at each level, describing what is expected of a public health practitioner, and a more detailed description underneath of the skills, knowledge, and attitudes that could be assessed. This is in keeping with the definition of competency referenced for this work, which considers a person to be competent when they have 'the attributes necessary for job performance to the appropriate standard'.[20] According to this definition, attributes that combine to constitute a competency will likely include knowledge, skills, and attitudes.

National consultation (hui) with Māori colleagues

All participants involved in the first phase of drafting of the Māori hauora ā-iwi[14] were invited to participate in this second phase, along with additional individuals identified through snowball sampling. The initial sample comprised 21 Māori hauora ā-iwi/public health academics, practitioners, and leaders from 15 organisations. A further three individuals joined the second phase after having been identified by colleagues. Participants included teachers and researchers at universities, people with senior roles in government and non-government organisations, and community-based practitioners.

Feedback was broken up into four three-hour Zoom hui, with additional options for individual Zoom times or a written response for those unable to attend all or part of the hui. Participants were sent the initial draft of the expanded competency document two weeks prior to the hui. At the hui, they were asked to comment on and discuss the preamble and the framework structure, as well as share more specific feedback on each of the competencies and subcompetencies. Informed consent was obtained from participants for their participation and for recording of feedback sessions.

Thematic analysis and redrafting

All hui, totalling around 12 hours of discussion, were recorded and transcribed anonymously. Each transcript was read closely, and the findings were thematically analysed[21] and synthesised in combination with notes captured during the hui. Themes and interpretations were triangulated among researchers to ensure credibility. Detailed results of the thematic analysis are not presented in this paper due to space

constraints; however, general insights have been grounded through short, illustrative quotes where possible.

Once themes were identified, the research team worked through responding to each over a series of workshops. Where necessary, subject area experts were consulted. In some instances, there was consensus already during the hui process as to changes that needed to be made to the competency framework or suggestions given for the specific wording of competencies.

Respondent validation

A report detailing themes identified during consultation, along with changes made to the competency document, was circulated to all participants with the revised competencies for further comment and validation before they were finalised.

Results

The expanded Māori hauora ā-iwi competency 'levels', or progressive steps of achievement, were framed with reference to the Dreyfus Model of Skill Acquisition[22] (Table 1) because it has been adapted specifically for public health[23] and used in other public health competency frameworks, such as that for the European region.[24] Only the three levels in which the greater public health workforce operates (competent, proficient, and expert) were included. The novice level was considered more relevant to students, who would then be expected meet level one (entry level) at the time of graduation. The advanced expert and luminary levels included in the expanded model[23] could potentially describe the skill level of advanced Māori hauora ā-iwi practitioners, but would not apply to the non-Māori workforce.

Many key themes emerged from the consultation process that informed the Māori hauora ā-iwi competencies. They fell into two broad categories, namely those related to the content of the competencies and associated skills, knowledge and attitudes, and those related to the understanding, application, and presentation of the competency framework as a whole.

Key themes related to competency content

Increasing expectations of communities, with particular reference to te reo Māori (Māori language) and tikanga (correct practice and protocol)

During feedback discussions, it became apparent that participants held different views on the expectations of public health practitioners in relation to the use of te reo Māori (Māori language) and tikanga (correct practice and protocol). This was partly due to the multiple dimensions of these competencies—on the one hand there are actual language skills or knowledge of tikanga, and on the other there is an advocacy component, demonstrated through efforts to create an enabling environment. However, dilemmas around how high the bar should be set were also explained by reflections on a changing context and increasing community expectations.

Commonalities and diversities in the colonising experience and the importance of context

Participants sought to underscore that Māori are just one population group worldwide for whom colonisation has ongoing impacts, while also highlighting the need to appreciate the diversity of experience within Aotearoa New Zealand. At many times during the feedback sessions, and in relation to many competencies, participants revisited the importance of public health practitioners truly knowing the context in which they work and not simply having a 'pan Māori, pan nation understanding' (Participant 21) of colonisation and coloniality. Experiences of colonisation are nuanced and differ not only between countries but also between different regions of Aotearoa.

An appreciation for the context in which research or programmes are located was also considered fundamental to being able to communicate and engage effectively. It was necessary not only to know the different iwi and any issues between them, but also to appreciate the voice of urban Māori. Participants suggested that it was about having 'good people around you to navigate that complexity' (Participant 18).

Reflective practice as cross cutting

Participants repeatedly underscored how reflective practice was interconnected with every other competency and fundamental to culturally safe public health practice. They considered, when using te reo Māori, for example, it would be important for practitioners to 'read the room' (Participant 21) by considering the language skills of those they were interacting with to avoid undermining their mana (prestige, status). A reflective public health practitioner would inherently understand their role in various situations. Ultimately, participants felt that being reflective allows people to engage meaningfully with the history of colonisation in Aotearoa New Zealand and to decolonise their practice.

Individual responsibility for organisational issues

Participants highlighted two levels of responsibility in relation to many Māori hauora ā-iwi/public health competencies, particularly those focussed on practising in accordance with te Tiriti o Waitangi and addressing racism. At a lower level, it is about understanding one's role as an individual within an institution and the impact that one can have simply by taking responsibility for one's own attitude and behaviour. At a higher level of competence, individuals could be expected to influence organisational culture and work collaboratively to effect change.

Table 1: Outline of competency levels used in the Māori hauora ā-iwi/public health competency framework.

Level one	Aligned with the 'competent' level of the Dreyfus[22] model, meaning that someone at this level would recognise complexity and have moved beyond being entirely rule-based in their approach to tasks. For example, they would understand context and be able to adapt their approach or tools appropriately. It is expected that most public health practitioners entering the workforce would operate at this level, acknowledging that people enter from many professions, and many would have tertiary training.
Level two	Aligned with the 'proficient' level of the Dreyfus[22] model, meaning that someone at this level would have more experience, act using intuition and analytic thinking, likely lead projects and mentor a limited number of others.
Level three	Aligned with the 'expert' level of the Dreyfus[22] model, meaning that someone at this level would likely be in a leadership role with significant authority and responsibility, be involved with strategy, and would perform almost entirely intuitively.

Prioritising contemporary needs and action

Overall, participants felt that the focus of the competencies should be on contemporary Aotearoa New Zealand and determinants of health impacting equity. Historical content is helpful for context but should not mislead public health practitioners into thinking that some issues are no longer relevant today. Emphasising current manifestations of colonisation, for example, reinforces that it is still ongoing and places the focus firmly on decolonising practice. Furthermore, in moving through the levels of competence, a more academic understanding should also be expected to translate into the kind of action that is necessary for change.

An emphasis on self-determination and strength-based approaches

An appreciation for strength-based approaches and respect for the right to self-determination were key themes in many competencies. Issues such as racism, for example, were felt to operate implicitly through the lack of recognition of Māori strengths. How Māori are viewed as people and the rights they are understood to have impact all public health policies, programmes, and research.

Additional determinants of Māori hauora/health: te taiao/planetary health, political ideologies

Feedback highlighted that a greater emphasis was needed on two less-often recognised determinants of hauora Māori, namely planetary health and political ideologies. Not only was deteriorating planetary health disproportionately impacting hauora Māori, but participants also commented on the many ways that a closer relationship with te Taiao (the natural world) could be nurtured to improve health outcomes. Indigenous worldviews and knowledge systems could lead in lessons to mitigate and adapt to climate change. Participants also felt that public health practitioners need to understand how political ideology plays out in the nuances of hauora ā-iwi/public health policy, especially for Māori.

Key themes related to the understanding, application, and presentation of the competency framework as a whole

Navigating the intersection between worldviews

During consultation, participants indicated a need to challenge the status quo by drawing more on Māori philosophies and worldviews in all aspects of the competency document. This was, however, balanced by concerns that Māori concepts could be simplified or misappropriated. The intersection of worldviews was evident in discussions around the presentation of the competencies, where an appreciation for interconnectedness (an Indigenous way of understanding) was pitched against a need to deconstruct competencies into their component parts (a more Western understanding) so they could be used for teaching and assessment in Western institutions.

Target audience, differing roles, and ensuring all public health practitioners are 'seen'

Researchers and participants alike grappled with the need for core competencies that could be applied universally in workplaces, given the diversity and varying backgrounds of the public health workforce. Public health practitioners in Aotearoa New Zealand come from a range of different disciplines, may have undergraduate or post-graduate training, may be Māori or non-Māori, and working for Western institutions or Māori health providers. A key concern centred around where Māori see themselves in these competencies and how their unique knowledge and skills could be recognised.

Ultimately, participants felt it was not appropriate for the competency framework to smooth over differing roles for Māori and non-Māori, particularly in areas such as tikanga (correct practice and protocol) and mātauranga Māori (Māori knowledge), allyship, kaupapa Māori research (research with a Māori approach), and Indigenising practice. In these competencies, the role of non-Māori was understood to be about privileging Māori conceptions of identity, supporting ways of knowing and being, and 'staying in one's lane.

Cultural safety: As a basic requirement and in the application of the competencies

During feedback on the Māori hauora ā-iwi competencies and their application, many comments could be distilled down to issues related to cultural safety, and a need emerged to be explicit about it as a basic, level -one requirement in all competency domains. This did not mean naming cultural safety specifically, but rather ensuring it was inherent in skills, knowledge, and attitudes concerned with critical awareness, power differentials, and equitable relationships, in line with recognised key components.[25]

The notion of cultural safety was also raised in relation to the application of Māori hauora ā-iwi/public health competencies. There were concerns around who would assess competence, how it would be done, and what support would be available to those going through the process of being assessed. There was solicitude around the potential lack of recognition of 'other' learning and an acknowledgement of skills not traditionally valued under core public health functions.

The competency document

Addressing the issues identified in the thematic analysis of feedback on the Māori hauora ā-iwi/public health competencies resulted in some new content and re-arranging of the overall structure and order of the competencies, as outlined in Table 2. Respondent validation supported the full final version of the competency document which includes 'I' statements for each competency at each level outlining more specific skills, knowledge, and attitudes. It is available under a Creative Commons licence.[26]

Discussion

To our knowledge, this is the first set of Māori hauora ā-iwi/public health competencies in Aotearoa New Zealand, although other public health departments at universities are also addressing their responsibilities with regard to te Tiriti o Waitangi.[27] Pre-existing Generic Competencies for Public Health in Aotearoa-New Zealand[28] were based on a definition of public health that incorporated Māori perspectives and did place importance on equity issues and cultural safety. They also required public health practitioners to appreciate the colonial history of Aotearoa New Zealand and to understand Crown obligations under te Tiriti o Waitangi. However, their scope was very limited in many areas identified as important through this research, and some competency domains, such as te reo Māori, were completely absent. That basic language skills are now considered a foundational competency, serves to underscore the increasing expectations in relation to language and tikanga. Due to their

Table 2: Outline of Māori hauora ā-iwi/public health competency groups, competencies, and subcompetencies.

1. Foundational competencies			
	At level 1, a public health practitioner should be able to	**At level 2, a public health practitioner should be able to**	**At level 3, a public health practitioner should be able to**
1.1 Tiriti o Waitangi: Be able to practise in accordance with Tiriti o Waitangi			
	Identify/comprehend Tiriti o Waitangi articles and/or principles in their practice.	Undertake Tiriti o Waitangi analysis (in/of organisations) and make associated recommendations for improvement.	Implement te Tiriti o Waitangi articles and/or principles in policy, service and programme design, implementation, and evaluation.
1.2 Te reo Māori me ōna tikanga: Be able to utilise te reo Māori and tikanga in hauoa ā-iwi/public health practice.			
1. Te reo Māori	Demonstrate a commitment to the use of te reo Māori in the work environment.	Demonstrate a commitment to expanding the use of te reo Māori into the work environment.	Provide leadership for the use of te reo Māori in the work environment.
2. Core Māori values, concepts, tikanga Māori and mātauranga Māori	Understand core Māori values, concepts, tikanga Māori and mātauranga Māori.	Demonstrate core Māori values, concepts, tikanga Māori and mātauranga Māori.	Actively advocate and champion the inclusion of mātauranga Māori into practice.
1.3 Socio-political determinants of health: Be aware of and practice to address the socio-political determinants of health and their impacts on health and health inequities.			
1. Colonisation and coloniality	Understand the processes of contemporary and historical colonisation.	Critique coloniality.	Mentor others to understand and identify the process of colonisation and coloniality.
2. Historical trauma	Understand historical trauma.	Heal historical trauma.	Advance understanding about historical trauma and healing.
3. White privilege, racism, and the effects of these on the social determinants of health, health status and outcomes, inequities, experiences of illness, and access to and through health and disability services.	Understand white privilege, racism, and discrimination.	Critically analyse and intervene with anti-racist activities.	Lead anti-racist and anti-discriminative activities.
4. Te Taiao/planetary health	Demonstrate an understanding of te Taiao and Māori approaches to planetary health.	Demonstrate a commitment to te Taiao and Māori approaches to planetary health.	Actively advocate and champion te Taiao and Māori approaches to planetary health.
2. Overarching competencies			
	At level 1, a public health practitioner should be able to	**At level 2, a public health practitioner should be able to**	**At level 3, a public health practitioner should be able to**
2.1 Effective communication and engagement: Be able to engage and communicate with a range of Māori groups (whanau, hapū, iwi, NGOs, urban Māori)			
1. Relationships	Form relationships that engender trust and are mutually beneficial.	Demonstrate open, receptive, and reflective engagement practices.	Actively advocate and champion respectful and reciprocal relationships.
2. Health literacy	Identify and manage effective communication for health literacy.	Communicate in ways that enhance community health literacy.	Work in collaboration with Māori to support the development of critical health literacy.
2.2 Māori hauora ā-iwi/public health allyship for tangata Tiriti: Be able to develop and maintain strong collaborative relationships and partnerships with Māori to achieve hauora ā-iwi/public health goals.			
	Understand allyship to support and strengthen Māori hauora ā-iwi/public health.	Act as a good ally of Māori to support and strengthen Māori hauora ā-iwi/public health.	Advocate for Māori health and hauora ā-iwi/public health outside of the health sector.
2.3 Reflective hauora ā-iwi/public health practice: Be able to reflect on personal, organisational, and societal beliefs and values, and how they impact on personal practice, organisational systems, and societal constructs.			
	Understand personal, organisation, and societal beliefs and values.	Incorporate the outcomes of their reflections in their personal practice and professional development plans.	Demonstrate leadership in reflective practice.
3. Practice competencies (The practice competencies are designed to be applied with reference to a person's specific role within hauora ā-iwi/public health)			
	At level 1, a public health practitioner should be able to	**At level 2, a public health practitioner should be able to**	**At level 3, a public health practitioner should be able to**
3.1 Rangahau—Research: Be able to undertake culturally safe research and evaluation that contributes to Māori advancement and/or reducing inequities.			
1. Cultural safety and health equity	Assess research/evaluation for its benefit to Māori, its contribution to Māori health equity, and for cultural safety.	Design research/evaluation that benefits Māori, contributes to Māori health equity, and is culturally safe.	Demonstrate leadership in research/evaluation that benefits Māori, contributes to Māori health equity, and is culturally safe.
2. a) Kaupapa Māori research/evaluation (Māori practitioners)	Understand the different approaches to Kaupapa Māori research/evaluation.	Undertake Kaupapa Māori research/evaluation.	Demonstrate leadership in the use of Kaupapa Māori research/evaluation.
2. b) Kaupapa Māori research/evaluation (non-Māori practitioners)	Understand the different approaches to Kaupapa Māori research/evaluation.	Collaborate in Kaupapa Māori research/evaluation.	Demonstrate a commitment to supporting Kaupapa Māori research/evaluation.
3.2 Programme planning, implementation, evaluation, and policy			
1. Cultural safety and health equity	Assess hauora ā-iwi/public health policies and programmes to ensure they are mana-enhancing, equity-focussed, and culturally safe.	Plan and implement hauora ā-iwi/public health policies and programmes that are mana-enhancing, equity-focussed, and culturally safe.	Demonstrate leadership in planning and implementing hauora ā-iwi/public health policies and programmes that are mana-enhancing, equity-focussed, and culturally safe.
2. ReMāorification and Indigenisation, decolonising and antiracist practice	Assess hauora ā-iwi/public health policies and programmes to ensure they demonstrate decolonising and antiracist practice.	Plan and implement hauora ā-iwi/public health policy and programmes that are decolonising and antiracist.	Demonstrate leadership in planning and implementing hauora ā-iwi/public health policy and programmes that are decolonising and antiracist.

datedness, the generic competencies didn't capture more contemporary understandings of what it means to be te Tiriti o Waitangi compliant, evolving out of proceedings of the Waitangi Tribunal,[29] , nor did they take account of the many tools and frameworks that have become available to aid public health practitioners in their work today, such as critical indigeneity-grounded analysis[30] or the CONSIDER statement.[31]

The Māori hauora ā-iwi/public health competencies, while reflecting the views of Māori public health practitioners in promoting cultural safety and equity within the profession, also align with competency frameworks for the public sector in Aotearoa New Zealand and share key cultural competencies common to all health professions globally. Public servants in Aotearoa New Zealand are expected to be familiar with the history of the Māori Crown relationship (including te Tiriti o Waitangi) and be committed to it, understand institutional racism, have some level of te ao Māori (worldview) knowledge and awareness, and incorporate tikanga (correct practice and protocol) and te reo Māori (language) appropriately in their workplaces.[32] These were also identified as 'foundational' competencies for public health practitioners in Aotearoa New Zealand. In the health professions, the ability to be self-reflective through a commitment to lifelong learning is valued as a crucial competency for cultural safety,[33–35] in line with its inclusion as an 'overarching' public health competency.

The Māori hauora ā-iwi/public health competencies include as foundational, in addition to more core general public sector or health professions competencies, a focus on equity in relation to specific determinants of health. The feedback and redrafting process highlighted an increasing recognition of planetary health alongside long-standing and ongoing determinants like colonisation, historical trauma, and racism. This reflects the growing importance of planetary health in the general public health discourse, where climate change has been described as 'the biggest global health threat of the 21st century'.[36] For Māori, as for many Indigenous people, climate change has the potential to worsen inequities in the social determinants of health by exacerbating colonising processes such as land dispossession, economic marginalisation, and the disruption of important relationships with the environment.[37–40] However, Indigenous epistemologies, worldviews, and practices also hold many lessons for restoring our relationship with te Taiao (the natural world).[41–43] The resulting competency allows both these facets of planetary health to be addressed.

In terms of content, the Māori hauora ā-iwi/public health competencies have emerged as consistent with three pou (pillars) identified for a decolonised public health curriculum.[12] These pou were reconfigured from four elements which, when integrated, constitute an approach for humanising and decolonising health sciences pedagogy originally applied in South Africa.[44] Pou one centres around epistemological decolonisation and challenging knowledge hierarchies, which is addressed in the competency on research. Pou two concerns itself with understanding the social context, how this has evolved as a result of colonialism, and how social injustices continue to reproduce inequalities. The Māori hauora ā-iwi/public health competencies incorporate this more nuanced understanding of determinants of health through a series of subcompetencies on colonisation and coloniality, historical trauma, and white privilege and racism. Lastly, pou three is captured in overarching competencies focussed on reflective practice, communication and engagement, and allyship and is about 'challenging the image of the health professional'.[12] It sees health practitioners as reflective people who care, heal, advocate, and engage respectfully.

This research aligns with other calls to recognise that competencies and curricula are only a part of what needs to happen in educational institutions and workplaces to realise improvements in Māori health. The international consensus statement on 'Educating for Indigenous health equity'[11] informed the development of the first phase of research into the Māori hauora ā-iwi/public health competencies and covers much of the same ground as the first two pou described earlier in terms of how we define rigour, and the importance of understanding and addressing colonisation, racism and privilege. However, the consensus statement is also explicit about the need for a comprehensive institutional approach, with adequate resourcing for investment in Indigenous leadership, and institutional policies and processes that are congruent with Indigenous health concepts and principles outlined in curricula or competencies. Such an approach speaks to concerns elicited in this research around cultural safety—that it should not only underpin all the competencies but also dictate the way the Māori hauora ā-iwi/public health competencies are applied.

Conclusions

Research focussed on developing a set of Māori hauora ā-iwi/public health competencies in Aotearoa New Zealand has resulted, through extensive consultation with Māori public health leaders, in a set of competencies in three levels for use in tertiary institutions and workplaces. It has raised some interesting questions around how best to navigate the intersection of worldviews and to ensure that everyone in the public health workforce is 'seen'. In terms of content, the competencies include skills, knowledge, and attitudes that are relevant to all public servants, ones common to all health professionals, and a more public-health-specific focus on the social determinants of health driving health inequities. Further efforts to develop this set of Māori hauora ā-iwi competencies will aid their application. These will include more detailed work on what the best practice looks like within each environment or setting where public health students learn or the workforce is located; a set of national standards, which capture the action-in-practice with more specific measures for each competency statement; and a trial of mapping course curricula to the competencies for future teaching. Academics and practitioners alike are invited to use the competencies[26] under the Creative Commons licence and share their experiences and feedback with the research team for future improvements.

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Ethical statement

Ethical approval for this research was granted by the University of Otago Human Ethics Committee (D20/200).

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Conflicts of interest

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