Ao Mai te Rā
The Anti-Racism Kaupapa

Evolution of Racism and Anti-Racism

Lessons for the Aotearoa New Zealand Health System

Stage One Literature Review

August 2022

Released 2022 **health.govt.nz**

Citation: Ahuriri-Driscoll A, Williams M, Vakalalabure-Wragg U. 2022. *Evolution of Racism and Anti-Racism - Lessons for the Aotearoa New Zealand Health System (Stage One Literature Review)*. Wellington: Ministry of Health.

Published in August 2022 by the Ministry of Health
PO Box 5013, Wellington 6140, New Zealand

HP 8705

Context for this work

Ao Mai te Rā: the Anti-Racism Kaupapa (Ao Mai te Rā) is a Manatū Hauora (Ministry of Health) initiative to support the way the health system understands, reacts and responds to racism in the Aotearoa New Zealand health system.

Phase one of Ao Mai te Rā comprises three literature reviews that can be read individually or as an integrated portfolio of work. This is the first literature review in the portfolio.

Collectively the three literature reviews have been used to inform the major outputs for phase one. This review was completed by researchers from the University of Canterbury and Tokona Te Raki – Māori Futures Collective.

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Glossary

CULTURE:
can be defined as all the ways of life of a society, including the customs, language, arts, norms of behaviour, beliefs and institutions of a population that are passed down from generation to generation (Boston University School of Public Health, 2016).

ETHNICITY:
the ethnic group or groups a person identifies with or has a sense of belonging to. It is a measure of cultural affiliation (in contrast to race, ancestry, nationality, or citizenship) (Statistics NZ, n.d).

SCIENTIFIC RACISM:
also referred to as biological racism, this involves the belief in a biological basis of racial inferiority or racial superiority. Despite the use of the term 'scientific', this is not considered scientifically robust and has been discredited.

CULTURAL RACISM:
involves the belief in a cultural basis for racial/ethnic inferiority or superiority. In other words, a person or group's culture is an explanation for their success or disadvantage, rather than structural/ systemic explanations.

COLOUR BLINDNESS:
or colour evasiveness is the idea that to not notice colour or race, racism can be avoided. However, the belief that "we are all one people and all equal" not only disregards racial differences and the lived experiences of racial 'others', but also racial discrimination (Fitchburg State University, 2021).

INSTITUTIONAL RACISM:
the patterns, procedures, policies and practices within institutions and organisations that, intentionally or not, produce outcomes that persistently favour or disadvantage individuals based on their membership of particular ethnic or racialised groups (Griffith et al., 2007).

SYSTEMIC RACISM:
is used interchangeably with the term institutional racism to refer to the systematised discrimination embedded in the laws and regulations of a society or organisation.

STRUCTURAL RACISM:
exists across a society, within and between institutions and organisations. Public policies, institutional practices, cultural representations and social norms across social, economic and political systems culminate to foster and perpetuate inequities based on ethnicity and/or race. Building upon the concept of systemic racism, structural racism attends to historical, cultural and social psychological aspects (Aspen Institute Round table on Community Change, n.d).

INTER-PERSONAL RACISM:
occurs when personal beliefs about the inferiority of members of racial/ethnic groups (i.e. differential assumptions about abilities, motives and intentions) impact on interactions between individuals through differential actions and behaviours towards others, stereotyping, commission and omission (disrespect, suspicion, devaluation and dehumanisation). Also called individual racism or personally mediated racism. Individual racism can occur unconsciously and consciously, and can be both active and passive (Jones, 1997).

SYMBOLIC RACISM (ALSO KNOWN AS MODERN OR EVERYDAY RACISM):
is so named for its foundation in abstract, moral values (for example equality) rather than personal experiences. Symbolic or modern racists may reject overt interpersonal racism but nonetheless hold attitudes that maintain racial inequities. For example, an individual may support equality among ethnic groups in principle, while being opposed to affirmative action policies (Reading, 2013).

INTERNALISED RACISM:
this form of racism relates to an individual's private beliefs and biases about race. It can manifest as an internalised sense of oppression and negative ideas of one's own culture and community for people of colour (e.g. self-devaluation, resignation, helplessness, hopelessness), and beliefs of superiority and/or entitlement held by white people or dominant culture members (Byrd & Clayton, 2003).

UNCONSCIOUS BIAS:
refers to a bias that lies beneath an individual's conscious awareness. Also referred to as implicit, it occurs when an individual makes initial judgements and assessments of people often based on stereotype.

COLONISATION:
the term for the practices and processes whereby a foreign power establishes control over another territory and its residents, through the use of power and prejudice, in order to extract resources and wealth. This involves implementing policies, laws, practices and rules to privilege the coloniser's language, culture, values and interests.

RACIALISATION:
the process by which people are categorised and distinguished based on how they look (skin colour, facial and other physical features), their 'race' and the inferred differences used to position them in a hierarchy of superior and inferior beings.

RACE COGNISANCE/CONSCIOUSNESS:
when individuals acknowledge racial differences (on the basis of cultural autonomy rather than hierarchies of value) as well as racialised outcomes or experiences, and are committed to challenging racial inequities and systemic racism (Frankenberg, 1992).

CULTURAL PLURALISM:
exists when a minority group is able to participate fully in society while maintaining their cultural distinctiveness, identities, values and practices.

ANTI-RACISM:
recognition of and efforts to counter prejudice and discrimination based on race/ethnicity at individual, interpersonal and institutional levels.

TĀNGATAWHENUA:
the indigenous peoples of Aotearoa.

TĀNGATATIRITI:
all others who have come here.

Kupu Whakataki | Introduction

The purpose of this literature review is to trace the evolution of the philosophical and ethical underpinnings of racism and anti-racism for New Zealand (Aotearoa). The overarching question it seeks to answer is: What would definitions of racism and anti-racism, designed to support a shared understanding of racism and anti-racism solutions in the health and disability system, look like for an Aotearoa context? To reach this point, this review will first trace how understandings of racism have shifted over time and the various definitions that have been utilised.

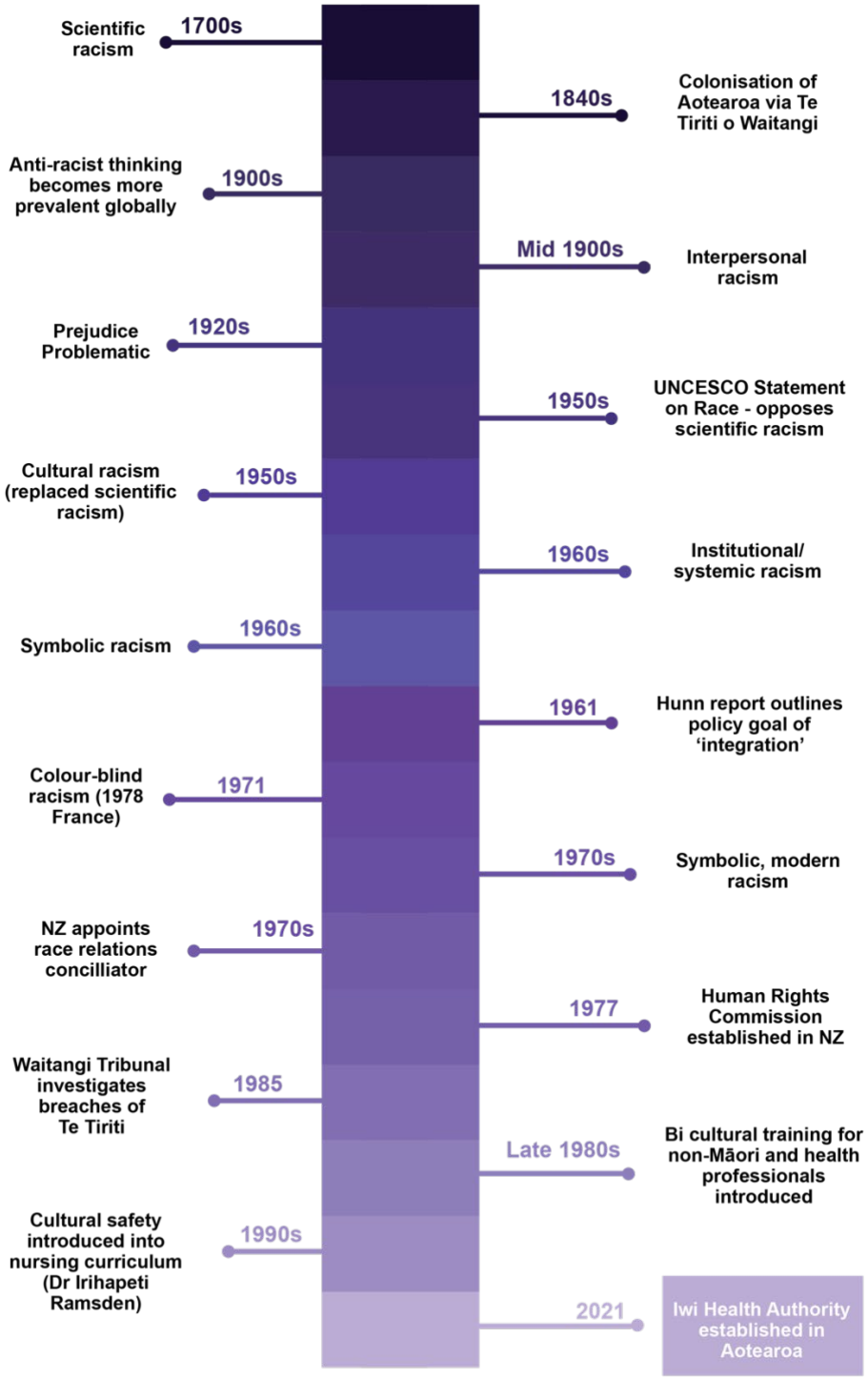
This review is focused on Māori and Pasifika peoples' experiences and perspectives of racism and anti-racism. Racism is not unique to Māori and Pasifika but these are the two groups most historically affected by systemic racism in Aotearoa. Getting it right for Māori and Pasifika will ultimately ensure other ethnic groups also benefit. There are also important differences however, which will be noted both for their reflection of the nuances of the racialised experience, and the responses required.

This review is framed around several critical shifts which have occurred in the conceptualisation of racism, and consequently, anti-racism:

- the foundation of 'scientific' racism in biological concepts of race: 17th – 19th centuries
- the reinvigoration of cultural racism and emergence of 'colour-blind' ideology: early to mid-20th century
- the turn to interpersonal prejudice:
- early to mid-20th century
- the acknowledgement of institutional and systemic racism and emergence of race cognisance: late 1960s onwards
- the reconfiguration of racism: symbolic, modern and the everyday: 1970s onwards.

Although each of these shifts is associated with particular chronological time periods, they are "not paradigm shifts in any total sense" (Frankenberg, 1993, p. 15). Elements of each can be found in modern day racism. This is indicative of the endurance and resilience of the dominant racist ideologies in reconfiguring and maintaining them (Song, 2014; Paradies, 2016a).

A timeline of racism and anti-racism



"He taniwha kei te haere mai, ōna niho he hiriwa he kōura, ko tāna kai he whenua. Kaua e mataku i te hiriwa me te kōura, engari kaua e tuku i te hiriwa me te kōura hei atuatanga mōu."

Āperahama Taonui

THERE IS A TANIWHA ON ITS WAY WITH TEETH OF SILVER AND GOLD AND AN INSATIABLE DIET FOR LAND. DO NOT FEAR THE TEETH OF SILVER AND GOLD, JUST DO NOT ALLOW THE SILVER AND GOLD TO BECOME YOUR GOD.

Prior to the signing of Te Tiriti o Waitangi, Āperahama Taonui gave foresight into the nature of the relationship between Māori and the British and foretold of the imminent impacts this would have on Māori culture, land and language. A cautionary warning that the future would bring dark times and change, but importantly that we should be aware and awake to it.

Racism

From Fact to Fiction – Biological race and the real problem of [scientific] racism

The colonisation of Aotearoa by the British began in the late eighteenth century. As a practice of political, economic and cultural domination (Kohn, 2006), Western colonialism was founded on an ideology of racial superiority and hierarchy.

This has been referred to by some as a form of "*pre-racism*" (Santas, 2000), which set the scene for the development of racial hierarchies as the European world exploded outward.

The Enlightenment and later the Industrial Revolution were important historical forces that influenced the development of racism. Intertwined within these shifts were also notions of capitalism and nationalism. The Enlightenment of the seventeenth and eighteenth centuries was a philosophical and intellectual shift that centered humanity and reason. It placed man at the centre of the universe and man was seen as emerging from Europe and the Western world. A hierarchy of man was subsequently created, ranging from human to subhuman based on the concept of race. More than social categorisation, race marked a new way of perceiving human differences and of structuring society. First, it was posited that distinct subdivisions of humans exist that differ genetically, based on ancestral geographic origins (Smedley & Smedley, 2005), and second, that this explains a 'natural' inequality between races (Littlefield et al., 1982). In a time and context where equality, civil rights, democracy, justice and freedom for all human beings constituted the dominant political philosophy, the concept of race and the subsequent dehumanisation of African peoples provided justification for slavery (Smedley & Smedley, 2005; Popkin, 1974; Grosfoguel, 2016).

Racial hierarchy was a "*device of colonial domination*" (Fanon, cited in Bonnett, 2000, p. 42). However, the non-White or indigenous "*subhuman*" was able to become human by emulating the "*prototype [of] Western humanity*" exemplified by the Western middle and upper classes (Fanon, 1963/1991, p.162). This was what occurred in Aotearoa where Māori were seen as 'noble savages' with the capacity for civilisation by becoming more like Europeans.

The emergence of modern biology circa 1800 saw a shift away from the eighteenth-century optimism in man's ability to adapt and evolve, "*towards a nineteenth century biological pessimism, and a belief in the unchangeability of racial 'natures*". Therefore, although racial science was "more 'scientific' by the 1850s, it was also more racist – in its insistence on the permanency of racial types, and the existence of a scale of racial worth" (Stepan, 1982, pp. 4-5). These views were widespread within colonial

Aotearoa, for instance the following text was published in the Southern Cross newspaper in 1844:

The native race is physically, organically, intellectually and morally, far inferior to the European. No cultivation, no education will create in the mind of the present native race that refinement of feeling, that delicate sensibility and sympathy, which characterise the educated European … the Maori is an inferior branch of the human family. (Came, 2012, p. 49).

Charles Darwin's concepts of evolution and natural selection were applied to humans based on race as part of Social Darwinism. This theory suggested that in an inevitable future of "*a struggle for survival among different human 'races'*", those lower on the evolutionary scale and with lesser intelligence or capacity for 'civilisation' would disappear (Miles & Brown, 2003, p. 43). However, there were also attempts to help this 'natural' process along, such as through eugenics. Proponents of eugenics advocated for the 'improvement' of the human species through the selective mating of those with specific desirable hereditary traits, and the 'breeding out' of undesirable traits (Ansell, 2013; Brown, 2017).

There were two key strands of eugenic thinking that dominated Aotearoa in the late nineteenth and early twentieth centuries: Māori as a dying race (Sutherland, 1940)[1] and the desire to avoid future generations inheriting 'negative' characteristics or traits (Ansell, 2013; Bashford, 2017; Stenhouse, 2017). The categorisation of race was not the only means by which White men were situated at the pinnacle of the social hierarchy; as companion colonial ideologies, Christianity and capitalism worked in the same way (Pihama, 2019).

Through colonisation, racism, classism and capitalism are all inextricably linked. Capitalism is reliant on the exploitation of labour and the division of society into classes. Everything is commodified and seen as a resource, including people. However, when value is attributed solely to capital, those without, or in the case of Māori, dispossessed of it, are doomed to "take their place in the inferior ranks" (Pihama, 2019, p. 31).

In many societies including Aotearoa, class runs predominantly, but not exclusively, along racial lines. Through the exploitation of certain classes for labour, capitalism also gives rise to racism and oppression making Māori destined to serve as a working underclass (Hokowhitu, 2004).[2] Pasifika peoples were brought to Aotearoa expressly for this purpose as early as the 1860s, in the form of indentured labourers from Vanuatu (Walrond, 2005). Economic imperatives again drove the accelerated migration from the Pacific Islands in the 1940s, to meet the demand for cheap labour post-World War II (Southwick, 2001).

Although the concept of race endured, early in the 20th century the notion of inequality was challenged, and scientific consensus grew around the notion that races

[1] Scientist, Dr. Alfred Newman, expressed a belief in the inevitable extinction of Māori in 1881, stating that "the disappearance of the race is scarcely subject for much regret. They are dying out in a quick, easy way, and are being supplanted by a superior race." (Sutherland, 1940, p. 28)

[2] Perceptions of the intellectual inferiority of Māori informed education policy for over a hundred years after the establishment of the first Native Schools, which confined Māori boys and girls to manual training, setting them up for manual labour or 'blue-collar' employment (Hokowhitu, 2004, pp. 267-8).

were "*essentially equal in behavioural potential*" (Littlefield et al., 1982, p. 641; Barkan, 1992). A further shift occurred mid-century, with developments in genetic understandings which contested the biological 'reality' of race. This position argued the relative unimportance of the small amount of real genetic differences (0.01%), compared to the similarities (humans are 99.9% alike).

A legacy of this shift is observed in uncertainties regarding how to discuss race; if it is not a biological fact, then ought it be given any attention at all? If we do, are we reinforcing the racist thinking of the nineteenth century? The colour-blind thinking that emerged in the mid-20th century responded to this concern, proposing that racism could be avoided by not explicitly recognising race (Quiroz, 2007; Doane, 2003).

But, within a colour-blind frame, white is not counted as race or colour, rather the absence of both (Medina, 2013). White then becomes the 'default'; in Aotearoa, this can be seen in the claims that we are all 'one people', New Zealanders (assimilative nationalism: Bell, 1996).

This denies the existence of difference (Gibson, 2006) and the taken for granted image of the New Zealander as a Pākehā New Zealander. However, people do perceive race differences in others. For example, differences such as non-Whiteness, Blackness or 'Māoriness', are largely perceived negatively, as "*departures from normalcy*" (Medina, 2013, p. 50; Pihama, 2019). A naive belief in a 'post-racial' society contradicts the racialised realities that many non-White people experience. Recent research has demonstrated that colour-blindness may implicitly condone racial discrimination (Banks, 2000) and perpetuate racial inequities, through the non-recognition of the racism (Knowles, Lowery, Hogan & Chow, 2009, cited in Apfelbaum, Norton & Samuel, 2012; Doane, 2003). Colour-blindness has therefore been described as a form of active ignorance (Medina, 2013).

From Race to Culture – The ascendance of cultural racism

By the early to mid-twentieth century ideas of racial superiority saw a shift from a purely biological explanation to a broader cultural justification. Cultural differences between Whites and non-Whites have always been framed in terms of superiority and inferiority, and this form of 'cultural racism' has always co-existed with scientific/ biological racism in colonial regimes (Pehrson & Leach, 2012).

However, World War II and the horrors of Nazism raised considerable concern about biological concepts of race based on eugenics. Cultural differences were increasingly employed as an alternative explanation for enduring racial inequalities (Essed, 1991). Researchers shifted their focus to topics such as the role of cultural or linguistic factors in the educational achievement of minority groups, or the role of family structure in reproducing poverty across generations. In a colour-blind climate in which race was no longer permitted to be 'seen' or spoken of (Doane, 2003), culture became a substitute and/or code. Social inequities could be explained away as a result of lack of effort, loose family organisation and inappropriate values, 'blaming the victim' (Bonilla-Silva,

2010). As such, the larger national, global, economic, and political forces that contribute to social inequality endured unhindered (Mukhopadhyay & Chua, 2008; Bonilla-Silva, 2010).

This perspective has flourished in Aotearoa, epitomised in the 1961 Hunn Report in which the policy goal of 'integration' was outlined. Māori were broadly classified into three groups "*a completely detribalised minority whose Māoritanga is only vestigial (Group A); the main body of Māoris [sic], pretty much at home in either society, who like to partake of both (an ambivalence, however, that causes psychological stress to some of them) (Group B); and another minority complacently living a backward life in primitive conditions (Group C).*" *The object of the integration policy was to "eliminate Group C by raising it to Group B, and to leave it to the personal choice of Group B members whether they stay there or join Group A*" (Hunn, 1961, p. 16). Health inequities, in the form of 'cultural/behavioural' and 'lifestyle' explanations continue to exist (see Table 1, p. 15, e.g. Hodgetts, Masters-Awatere & Robertson, 2004).

From Racialised to Racialising Subjects – The 'prejudice problem'

The next major shift moved the focus from the victim of racism to the perpetrator portraying racism as an individualised phenomenon that was unconscious and accidental, thereby removing accountability and intent. In the eighteenth, nineteenth and early twentieth centuries, scientific thinking about racial relations was preoccupied with beliefs about racial difference and hierarchy (Dixon & Levine, 2012, p. 14).

Psychologists were among those who studied racial differences, "*treating racial conflict as an inevitable outcome when a biologically superior group encounters the deficiencies of less developed groups*" (Dixon & Levine, 2012, p. 14). This focus recognised both racialised group identities, and the interpersonal dimensions of race. However, between the 1920s and 1940s, an "*abrupt reversal*" saw a shift in focus away from the nature of group differences, to that of intergroup prejudice, where negative opinions against an out group are formed without sufficient evidence (Allport, 1954). World War II prompted the reframing of 'the race question', now perceived as a problem for the oppressed caused by the oppressor (Reicher, 2012, p. 35). The racial prejudices of majority group members became the target of social psychological research, resolving the 'prejudice problematic' was psychology's contribution towards the creation of a more tolerant society (Dixon & Levine, 2012, p. 15). These developments reframe the problem of racism not as one of 'racialised others', but the perpetrators instead. However, there are several problematic implications, which have arguably stood in the way of progress towards anti-racism. First, focusing solely on the individual as the source of prejudice (Dixon & Levine, 2012), meaning there is less attention on the contexts or environments for it to exist. Second, this frames prejudice as irrationality and error, rather than deliberate and purposeful, with racist systems and structures working exactly as they are intended to – favouring in-groups over out-groups (Al Ramiah, Hewstone, Dovidio & Penner, 2010). The predominant perspective is now that prejudice thinking is "*a regrettable by- product of otherwise adaptive mechanisms for processing information*", and that prejudice happens unconsciously (Dixon & Levine, 2012, p. 19). The notion of unconscious bias limits individual responsibility (Beckles-

Raymond, 2020). The implication is that people cannot be held accountable for those attitudes and behaviours or the resulting harms (Beckles-Raymond, 2020).[3] This is part of the concept's appeal.

Here, change focuses on modifying the thinking and behaviours of the advantaged to address their aggression and discrimination towards others (Dixon & Levine, 2012, pp. 20, 20). Prejudice is treated as a personal rather than a social pathology (Wetherell, 2012). Although race superiority is not necessarily supported in this approach, the status of racial categories as 'real' is not examined or challenged nor racism as an ideological phenomenon (Pehrson & Leach, 2012).

Towards Institutional and Systemic Racism

The emergence of institutional racism marks a shift from racism being framed as an individualised phenomenon to being institutionalised and embedded in systems and structures to maintain racial inequity.

The concept of institutional racism grew out of the civil rights movement of the 1960s, which had an explicit objective to address the racial inequalities evident in housing, employment, criminal justice and democratic representation. Writing about the Black Power movement, Carmichael and Hamilton (1967) had introduced the term 'institutional racism' to account for the more subtle and covert, but pervasive and systemic attitudes and practices that led to racist outcomes (Murji, 2007). Countering the personalisation of racism supported by the 'prejudice-causes-discrimination' model, Carmichael and Hamilton asserted that this form of racism could not be reduced to the acts of individuals. This important work was reinforced later with the concept of institutional discrimination explored by Feagin and Feagin (1978), who understood this as part and parcel of internal colonialism; the institutionalisation of privilege via norms, roles and social, economic and political organisations (cited in Huygens, 2007).

Analysis of colonialism and institutionalised racism generated a "useful rang" of concepts spanning personal racism (negative stereotypes and attitudes held by individuals resulting in discrimination); institutionalised or structural racism (the reduction of oppressed groups' access to resources and power via organisational policies and practices); and cultural racism (the embedded values, beliefs and ideas in social representations that endorse the superiority of one group over another) (Jones, 1997, cited in Huygens, 2007, p. 64).

[3] Philosopher Lewis Gordon argues that the framing of racism as implicit or beyond one's control is a "manifestation of bad faith", that is, the choice to evade freedom and responsibility for holding racist views. Instead, because bad faith is a matter of choice, anti-Black racists bear responsibility for their dehumanising attitudes.

Hiding in Plain Sight: Symbolic, modern, and everyday racism

Greater attention to institutional and structural forms of racism and the growth of anti-racism shifted individualised and inter-personal racism to become more covert and underground. The concept of institutional racism was unsettling for the dominant culture. The suggestion of unearned privilege conflicts with the liberal values of egalitarianism and fairness espoused in many Western societies (Bonilla-Silva, 2010). This resulted in new dominant narratives evoking individualism and meritocracy – 'anyone can succeed if he or she works hard' may be invoked (DiAngelo, 2018; Jones, 2018; Borell, Moewaka Barnes & McCreanor, 2018). Combined with cultural racism or deficit thinking, dominant cultures can "*attribute their advantages to their own hard work while attributing disadvantages of racialised others to personal irresponsibility*" (Salter, Adams & Perez, 2017, p. 152).

Efforts to correct or address racial inequity (i.e. through affirmative action) may then be challenged as unfair, race-based differential treatment (Doane, 2003; Bonilla-Silva, 2010). The dominant group can avoid responsibility for the racism that exists (Mahoney, 1997) and the racist status quo is thereby maintained.

The concept of "*symbolic racism*" was developed by theorists Kinder and Sears (1981) to describe some of the responses above, increasingly observed in the late 1960s and early 1970s in the United States. Despite visible egalitarian public policies and popular support for racial equality, there was also widespread covert opposition to further implementation (Wood, 1994). Whether this is a form of racism per se has been debated vigorously because some argued that it was not necessarily based in anti-Black affect. In today's terms, it is more likely that the opposition to equity would satisfy the charge of racism. The 'symbolic' component refers to the holding of progressive racial attitudes as a matter of principle simultaneously with disapproval of the policy implications involved in advancing racial equality (Essed, 1991).

In a similar vein, McConohay (1986) coined the term "*modern racism*" to describe neoconservative questioning of both the existence of discrimination and the legitimacy of ongoing Black anti- racism activism in the post-civil rights era. In both symbolic and modern racism, the norm of democratic equality was/is utilised by dominant group members to oppose institutional change via anti-racist policies and practices (Essed, 1991), essentially a defence of the racist status quo. These forms might also be described as covert, in the sense that the holders of such beliefs and attitudes may not think of themselves as racist, and their commitment to the principle of equality may indeed be genuine (Wood, 1994).

The concepts of symbolic and modern racism highlight an increased focus on contradictory and covert attitudes in racism scholarship. McKenzie (1999, cited in Came, 2012) proposed that the rise of these forms of racism was likely a result of anti-racist action/intervention – forms of racism changing over time in response to the increased unacceptability of racism, transforming from overt to more covert or subtle.

These "*new racisms*" were "*more in-direct, more subtle, more procedural, more ostensibly non-racial*", with a "*new strength*" precisely because they did not appear to be racism (Pettigrew, 1979, p. 118, cited in Sniderman, Piazza, Tetlock & Kendrick, 1991, p. 423).

Although symbolic and modern racisms exist largely in the individual– interpersonal domains, they are responses to institutional and structural changes. Similar to notions of systemic racism, everyday racism is pervasive and normalised, its routine and familiar practices rendering it barely noticeable despite being in full, unrestricted view. The reproduction of racism through ordinary and unremarkable moments is distinguished from the "*incidental and uncommon ex-pressions*" of blatant racism (Essed, 1991, p. 53).

Section Conclusion

The purpose of racism is entangled with its origins and it is primarily intended to exclude some and privilege others (Came, 2012). Racism is a purposeful system that was established in Aotearoa via colonisation, and the intersecting concepts of capitalism and nationalism that came with it. Power and resources were systematically shifted from the indigenous occupants to the colonising and increasingly dominant group, creating an unjust and inequitable society. The effects are observed in ethnic health and social inequities today, intergenerational inequities of opportunity as well as outcome (Berman & Paradies, 2010). Racism should be understood as a "*complex system of processes and ideas that reinforce each other*" (Spector, 2014, p. 122). That system consists of structures, policies, practices and norms that structure opportunity and assign value based on the observable characteristics of an individual (Jones, 2002).

The effect of racism as a system is that it excludes and unfairly disadvantages some individuals and communities while unfairly advantaging others (Jones, 2002). Racialisation is the process by which people are categorised and distinguished based on how they look (skin colour, facial and other physical features), their 'race' and the inferred differences used to position them in a hierarchy of superior and inferior beings (Clarke, 2003; Grosfoguel, 2016). Non-White beings are dehumanised and relegated into a "*zone of non-being*" of the sub-human or non-human (Fanon, 1967, p. 2). The process of racialisation ensures that power remains with the dominant group/s (Fanon, 1967).

The notion of unconscious bias sustains racism because it enables the perpetrator to maintain an innocence or ignorance. This leaves racism untouched, and individuals unaccountable for their role in its perpetuation (Bargallie & Lentin, 2020). Therefore, racism "*includes inaction as well as action, ignorance as well as beliefs, of a dominant group when it has the effect of widening the unequal positions between a dominant and subordinate group*" (Miles & Brown, 2007, p. 7).

Racism is constructed and sustained by historical context and inheritance, competitive dynamics, psychological processes, and norms and values. There are different levels of racism which include: systemic/institutional, interpersonal, and internalised.

Each of these levels is intertwined and mutually reinforcing. The following section will outline how racism has been conceptualised and is evident in the context of health.

"Hāpaitia te ara tika pūmau ai te rangatiratanga
mō ngā uri whakatipu".

FOSTER THE PATHWAY OF KNOWLEDGE TO STRENGTH, INDEPENDENCE AND GROWTH FOR FUTURE GENERATIONS.

Exposing, confronting and dismantling racism is limited without a shared understanding of the impacts of racism on health and health outcomes. Understanding our part in the problem of racism, unlocks the power to be part of the solution.

Understandings of Racism in the Context of Health

Discussions of race and racism in public health have drawn on and been informed by conceptual and empirical understandings in the fields of anthropology, psychology, sociology and philosophy, as well as events in wider society. What this means is that the shifts noted above are also evident in the field of public health, albeit with some delay (Cooper & David, 1986). Key focuses in public/population health have included accounting epidemiologically for persistent racial/ ethnic inequities in health as well as "*vigorous[ly] exploring*" the root causes (Jones, 2000, p. 1212). The hypothesis that race-associated differences in health outcomes are due to the effects of racism has emerged from this research, which has prompted further investigation of the health impacts of racism as well as efforts to address racism within the health system (also in Aotearoa).

Jones' (2000) levels of racism framework, outlined below, identifies how racism in three key forms is conceptualised as leading to health impacts, and how these can be 'reverse engineered' to eliminate health disparities. The framework is comprehensive, distinguishing between and incorporating structural/societal level racism and interpersonal racism ('the prejudice problematic'), with the added dimension of intra-personal racism.

Level of racism framework

- **Institutionalised racism** – differential access to the goods, services, and opportunities of society by race/ethnicity or social group. This form of racism is embedded within social norms, customs and practices and is sometimes legalised, which means there may not be an identifiable perpetrator (Jones, 2000, p. 1212). It is evident both in impoverished material conditions and reduced access to power, which is often intergenerational.
- **Personally mediated racism** – assumptions about the differential abilities, motives and intentions of others according to their race or social group (prejudice), and

differential actions towards others on that basis (discrimination). This manifests as lack of respect, suspicion, devaluation, scapegoating and dehumanisation (Jones, 2000, p. 1212).

- **Internalised racism** – stigmatised ethnic group members' internalisation of the oppressive attitudes and beliefs of dominant social groups about them (Berman & Paradies, 2010; Robson & Harris, 2007; Moewaka Barnes, Taiapa, Borell & McCreanor, 2013). This includes acceptance of negative messages about their inferiority, low levels of worth and abilities. This may manifest as embracing of 'Whiteness', self-devaluation, and resignation, helplessness and hopelessness (Jones, 2000, pp. 1212-3).

Health inequities and race

Racism is fundamentally unequal, but in its more recent forms (colour-blind racism), espoused equality is the source of its political strength (Bonilla-Silva, 2010). This makes the differences between equality and equity all the more important to identify and tease out. Although both equality and equity promote fairness, equality achieves this by treating all individuals the same, or allocating resources or opportunities equally regardless of need. Conversely, equity achieves this by treating people differently depending on need, which may entail the differential distribution of resources, opportunities or inputs (Reid & Robson, 2007). A key concern in social epidemiology has been to distinguish inequalities from inequities. Both involve differences, but while inequalities are differences that may be unnecessary and avoidable, inequities are differences that are unfair and unjust (Whitehead, 1992, cited in Reid & Robson, 2007, p. 4). Woodward and Kawachi (2000, p. 923) assert that "*inequalities become 'unfair' when poor health is itself the consequence of an unjust distribution of the underlying social determinants of health*." Given the colonial history of Aotearoa, it is inarguable that the disparities in health status experienced by Māori and Pasifika peoples are inequitable.

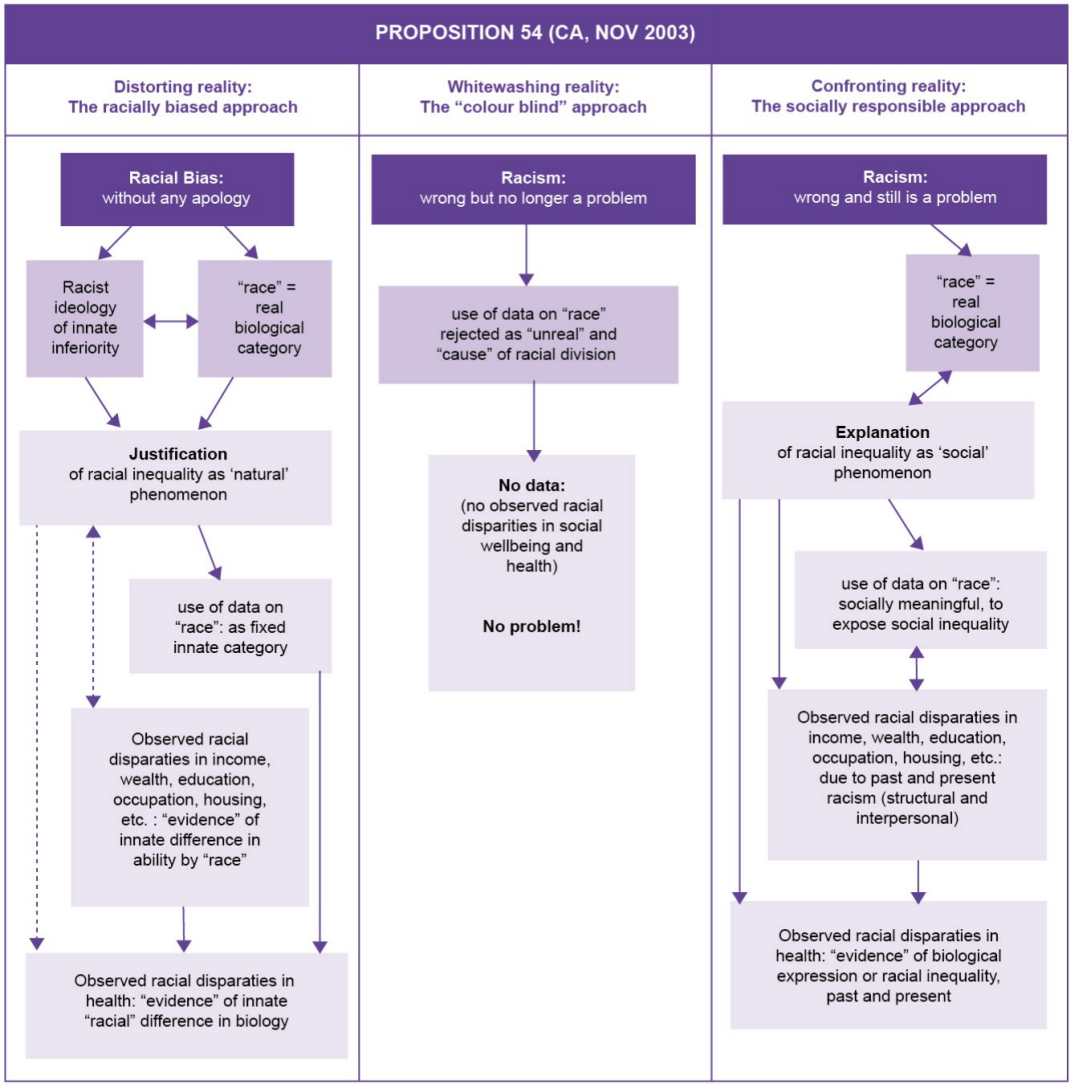
In epidemiology, the question has been posed whether "*unscientific racial categories*" should continue to be used, or categories of deprivation resulting from racism instead (Krieger, 2000, p. 212). Where seeing racial/ethnic health inequities as "*racialised expressions of biology*" is problematic, understanding them as "*biological expressions of racism*"(Krieger, 2001, p. 696) is a meaningful way to document, monitor and analyse the impact of racial injustice on people's lives and health ('distorting reality' compared with 'confronting reality' in Figure 1 on the following page). Furthermore, it enables us to move from a discriminatory use of racial data to providing evidence of discrimination that must be countered (Krieger, 2010). The difference lies in the data interpretation. Rather than locating the cause of disparities, deprivation, disadvantage, dysfunction and difference (Walter, 2016) within the pathological or deficient indigenous/racial person (their biology, genetics or culture), an alternative view considers the impact of discriminatory structures and race relations (Reid & Robson, 2006).

Health disparities literature reflects the changes in conceptualisation of race and ethnicity derived from anthropological debates (Dressler, Oths & Gravlee, 2005). Where references to race were predominant in articles published in the American Journal of Epidemiology between 1921 and 1990 (Jones, LaVeist & Lillie-Blanton, 1991), between 1996 and 1999 three-quarters of articles published in the American Journal of Epidemiology and the American Journal of Public Health referred to either race or ethnicity. However, race and ethnicity were rarely defined explicitly, suggesting a possible blending of these concepts. Dressler et al (2005) argue that in order for health disparities to be most effectively researched and understood, how race and/or ethnicity are being used with respect to the following factors, must be specified: (a) genetic variants contributing to disease risk; (b) culturally constructed ethnoracial categories

that denote essential differences conceived in terms of biological ancestry; or (c) ethnic group membership.

Dressler et al (2005) also found that explanations for racial/ethnic health disparities in the literature had shifted over time from a racial-genetic model, through to more complex psychosocial stress and structural-constructivist models. The shift in favoured models also reflects changes in the conceptualisation of racism (see Table 1, page 15).

Figure 1: Three approaches to conceptualising and collecting data on race/ethnicity and racial inequality, as revealed by the Proposition 54 campaign in California, 2003 (Figure 11.1, Krieger, 2010, p. 229)



Thus, the racial-genetic explanation that persists in some research quarters resembles the supposedly 'old' way of thinking about race, whereas some of the culturally-oriented racisms are observed in the health-behaviour and socio-economic status explanations. Dressler et al demonstrate the limited explanatory power of these simplistic accounts of racial/ethnic health disparities. While socio-economic status and health behaviours contribute towards health outcomes, in these models little or no consideration is given as to why or how they are correlated with race/ethnicity (Dressler et al., 2005). The psycho-social stress explanation is the first in which racism is

properly considered as a determinant of health disparities. The work of social epidemiologists Krieger (1999; 2003) and Williams (Williams & Collins, 1995) is prominent here. The structural- constructivist explanation builds on the notions of institutional, and perceived interpersonal racism, but is more nuanced in terms of allowing for malleability and the moderation of race due to other factors (e.g. Socioeconomic status, conformity to social values).

Table 1: Explanations for racial/ethnic health disparities as they correspond to definitions of racism

Model	Explanation for disparities	Form of racism
Racial-genetic model	Emphasises population differences in the distribution of genetic variants (Dressler et al., 2005, p. 234).	*Scientific racism:* race as biological fact, immutable biological hierarchy explaining 'natural' inequalities (Pehrson & Leach, 2012, p. 120)
Health-behaviour model	Emphasises differences between racial and ethnic groups in the distribution of individual behaviours related to health, such as diet, exercise, and tobacco use (p. 234).	*Cultural racism* – essentialist culturalism attributes cultural characteristics to traditionally defined racial groups (Blum, 2020, p. 3). Cultural characteristics deemed inherent and deficient.
Socio-economic status model	Posits the over-representation of some racial and ethnic groups within lower socio-economic status (p. 234).	**'***New racism' – symbolic and modern racism*: minorities are not biologically incapable of succeeding, but their unwillingness to adopt appropriate modern virtues of individualism, self-reliance is to blame. Minority inferiority understood in terms of inferior work ethic and values, behaviour and culture rather than inferior DNA (Pehrson & Leach, 2012, p. 120)
Psychosocial stress model	Emphasises the stresses associated with minority group status, and especially the experience of racism and discrimination (p. 234)	*Institutional racism* – structured inequalities place minority group members lower on all indicators of wellbeing, limit access to resources Perceived racism – conscious perception of interpersonal racism, discriminatory acts and practices and the distress associated with that perception (p. 239).

Model	Explanation for disparities	Form of racism
Structural-constructivist model	Emphasises the intersection of racially stratified social structures with the cultural construction of routine goals and aspirations as the cause of differences in morbidity and mortality (p. 235).	*Intersectionality* – race is a socially or culturally constructed concept and may be malleable and subject to interpretation in a given social field. The effects of racialisation or racial stratification may be either amplified or moderated (pp. 241, 243).

Kaupapa Māori Epidemiology

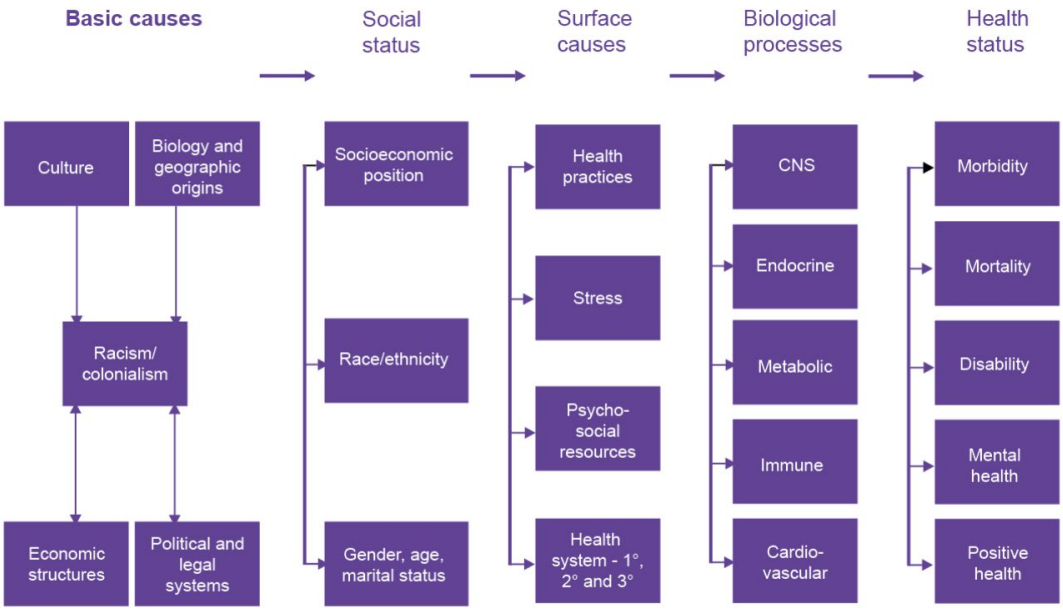
The discipline of Kaupapa Māori epidemiology has been critical in establishing the evidence base pertaining to Māori health disparities, in order to "*prompt system change and increased responsiveness*" (Robson & Harris, 2007, p. 2). In the 1980s and 1990s, Te Rōpū Rangahau Hauora a Eru Pōmare (University of Otago, Wellington School of Medicine) produced several reports profiling patterns of mortality and morbidity for Māori and non-Māori between 1955 and 1991. Using official datasets, Hauora, Hauora II and Hauora III verified the inequitable health outcomes experienced by Māori, highlighting the relative contribution of socioeconomic factors, health risk behaviours and health services. However, a deficit lens remained, with these inequities commonly explained in terms of Māori behaviour, genes, culture, socioeconomic status and engagement with health services. Such a lens would maintain a focus on problematic and deficient Māori, rather than discriminatory social institutions and practices (Reid, Robson & Jones, 2000, p. 44). In Hauora IV and the Decades of Disparity work that followed, Kaupapa Māori epidemiology was fully realised, centring the Māori population through the critique and refinement of standard statistical tools (Simmonds, Robson, Cram & Purdie, 2008). Māori being identified and counted correctly, consistent with their self-identification, was a central principle (Robson, 2005). The use of a standardised, consistent ethnicity question, in conjunction with an ancestry question across official datasets was proposed (Kukutai, 2003), challenging previous measures of race via blood quantum. Socially-assigned racial identification had been shown to significantly undercount Māori and therefore Māori health inequities. For example, approximately one third more decedents self-identified as only Māori on Census data than were identified as Māori on mortality data in the late 1980s and 1990s (Ajwani, Blakely, Robson, Atkinson & Kiro, 2003).

In order to reduce the underestimate of Māori mortality, cancer and hospitalisation rates, the 'ever Māori' method of classification was instituted – anyone ever recorded as Māori in any ethnicity field of the deaths, hospital admissions, cancer registrations or National Health Index is counted as Māori (Robson, 2005). Together with age standardisation using a '*Māori standard*', and the disaggregation of data so that Māori-specific data would be visible rather than masked, these mechanisms aimed to establish equal explanatory power (Robson, 2005).

In seeking to explain the Decades of Disparity III report finding that differential access to socioeconomic resources accounts for much but not all of the disparities in mortality

between Māori and non-Māori (Ministry of Health/University of Otago, 2006, p. 62), the work of U.S. social epidemiologist Williams was utilised. Williams' theoretical framework names racism and colonialism as basic causes of health inequities (see Figure 2 below), factors that have informed the development of economic, political and legal structures that lead to racial/ethnic impoverishment and disenfranchisement. Lifestyle behaviours, psychosocial stress and health system performance are located in the framework as surface causes, pathways to health each affected by socioeconomic as well as non-socioeconomic influences. Racism and prejudice also have direct effects, in generating psychosocial stress, as well as discriminatory treatment or referral patterns in health services (Ministry of Health/University of Otago, 2006, pp.59)[4].

Figure 2: Proximal and distal causes of health inequities, Ministry of Health/ University of Otago, 2006, p. 3.



The Prejudice Problematic and Health in Aotearoa

A number of studies have found that Māori receive differential care compared to non-Māori, including unequal access to prevention services and early detection, differential management according to best practice guidelines, and lower rates of referral to specialist care and tertiary interventions (Reid & Robson, 2006, pp. 18, 27; Houkamau, 2016, pp. 126-7; Health Quality & Safety Commission (HQSC), 2019, p. 46).

Increased attention to health system and care delivery has brought a focus upon the practices of individual health professionals, and the role that interpersonal racism might play. Two early studies in Aotearoa highlighted the prejudicial attitudes held by medical practitioners. For example, Johnstone and Read (2000) found from their survey of clinically experienced psychiatrists, that 11.3% of respondents adhered to something

[4] Other models have since been developed e.g. Williams and Mohammed's model 2013 (HSQC, 2019, p. 47).

of a deficit, racialised view, perceiving that Māori were genetically predisposed to mental illness. A similar view was reported by general practitioners interviewed by McCreanor and Nairn (2002, p. 2), who attributed health disparities primarily to the constitution and behaviour of Māori people – a combination of genetics, socioeconomic status, culture and/or non- compliance. In such perspectives, poor health status becomes "*naturalised as a function of being Māori*", minimising the significance of historical, political context or health practices (McCreanor & Nairn, 2002, pp. 2, 5). These findings have been framed as evidence of "*implicit bias*" in the health care system (Houkamau, 2016, p. 130). Notwithstanding the limitations of the prejudice problematic when considered in isolation, practitioner prejudice as part of a broader context (i.e. in the Williams framework and Jones' levels of racism) has been deemed important for both the understanding of, and action to address, racism as a determinant of health (Harris, Cormack, Tobias, Yeh, Talamaivao, Minster & Timutimu, 2012).

While practitioner prejudices may not result in overt discrimination, they may well result in a suboptimal patient- practitioner encounter, a potentially significant deterrent for Māori and Pasifika patients' utilisation of health services (Houkamau, 2016). A number of New Zealand studies have subsequently turned their attention to the perspective and experiences of patients. Data from the New Zealand Health Survey (NZHS) (2006/07) showed that experiencing racial discrimination was associated with less positive experiences with primary care providers; patients were significantly more likely to report that they were not listened to carefully, that information was not always discussed fully with them, and that they did not feel they were treated with dignity and respect. For Māori women, these experiences were associated with lower breast and cervical cancer screening coverage (Harris et al., 2012).

It is important to note that Pasifika peoples were slightly less likely than Māori to report experience of racism, although rates were higher among overseas-born Pasifika people (Harris et al., 2012). Where it seems unlikely that Pasifika peoples are less subject to racism within health services, this suggests a possible reluctance to name racism, perhaps as part of being a "*model minority*" member, or "*grateful migrant*" (Thiruselvam, 2019, p. 65), or having come from a racially homogeneous Pacific Island nation in which racism was an unfamiliar construct (see Malatest International, 2021, p. 44).

In follow-up research, data from the NZHS and the General Social Survey showed that self-reported experiences of racial discrimination in the previous 12 months were associated with negative health and wellbeing measures (self- rated health and life satisfaction) for all ethnic groups (Harris, Stanley & Cormack, 2018). Since 2014, health impacts from the experience of racism have been reported in two large longitudinal studies (the New Zealand Attitudes and Values Study: Stronge et al., 2016; Growing Up in New Zealand Study: Becares & Atatoa-Carr, 2016), as well as several others, quantitative and qualitative (Harris et al., 2018; Talamaivao, Harris, Cormack, Paine & King, 2020).

Racism in The Health System

In 2019 the Waitangi Tribunal (p. 151) noted widespread agreement that the severity and persistence of Māori health inequities is a demonstration that institutional racism in the health system remains. Hospitals, the earliest health entities established in Aotearoa, were part of the machinery of colonisation, with dual medical-political purposes (Salesa, 2001, p. 19). Their services were offered to Māori in the hope that they would be a "*medium of civilisation*" (Salesa, 2001, p. 19), but cost and European-centric delivery were barriers to Māori utilisation (Dow, 1999). The health systems that ensued were largely oriented to meet European needs, governed and managed by Europeans, for Europeans. There have been numerous positive developments since however, including the establishment of Māori health providers in the 1990s (Cunningham & Kiro, 2001), the introduction of a Tiriti o Waitangi/ Treaty of Waitangi (Te Tiriti) clause and appointed Māori members to District Health Boards via the New Zealand Public Health and Disability Act 2000, and the introduction of the first Māori health strategy, He Korowai Oranga, in 2002 (Boulton et al., 2004).

Positive developments notwithstanding, the administration of the health system continues to generate inequity through its systems, processes and policies (Starfield, 2011, cited in Came, McCreanor, Haenga- Collins & Cornes, 2019). Not only are there "*significant gaps between policy rhetoric and operational practice*" (Came, Doole, McKenna & McCreanor, 2018, p. 133), but health policy development and contracting processes continue to marginalise Māori and Pasifika peoples. Biomedical Western evidence is often privileged over indigenous knowledge, and the dominant (European) majority prevails in decision-making (Came, 2014; Came et al., 2019). Contracts for Māori providers have been found to often be shorter in duration, making it more difficult to plan, recruit and retain staff, and associated auditing and reporting requirements are more frequent and "*aggressive*". Each of these discriminatory practices contribute to the perpetuation of systemic disadvantage (Came, 2012, pp. 135, 137).

The importance of health data for the monitoring of ethnic health disparities and outcomes has long been recognised. Technological advances (for example, integrated data use) are increasingly becoming more influential in health care (Knight et al., 2021). While data can play a positive role, there is also the risk of reinforcing existing injustices and inequities through the encoding of biases and racism in algorithms and datasets (Knight et al., 2021). Furthermore, some commentators have noted the same "*extractive logics*" as those underpinning colonialism and capitalism, in current integrated data practices (Kukutai & Cormack, 2019, p. 203). In Aotearoa, the Integrated Data Infrastructure (IDI), which links de-identified individual- level data from health datasets with census and other administrative system data, was used to supplement the approximately 30% of Māori and 35% of Pasifika peoples missed by the 2018 Census enumeration (Kukutai & Cormack, 2019). While more complete data is undoubtedly beneficial for addressing health inequities, this must be weighed up against ethical and considered usage. The changes required to this aspect of the health system infrastructure are therefore both high level and fundamental; robust data governance, and a decolonised data science field in which conceptualisations of race are critically considered.

Section Conclusion

Racism in its various forms is well researched and theorised. Conceptualisations of racism and its links to health have continued to evolve since the 1990s, culminating in the understanding that racism is a fundamental determinant of health (Paradies et al., 2015), and a public health threat (Came, 2012; Walensky, 2021). Racism is pervasive, a socio-political phenomenon that operates at macro and micro levels (Hoyt Jr, 2012). Its 'baked in' quality in colonial societies such as Aotearoa sees racist ideology infused in everything from government policy, institutions and allocation of resources, through to interactions between individuals, and even the oppressive internal dialogue of individuals (Berman & Paradies, 2010). Subsequently, the range of pathways through which racism is understood to impact health is also broad: (1) reduced access to determinants of health such as employment, housing and education, and increased exposure to risk factors; (2) adverse cognitive/ emotional processes and associated psychopathology; (3) the cumulative burden of chronic stress upon different physiological systems in the form of allostatic load and associated pathology; (4) decreased health-promoting behaviours and/or increased engagement in unhealthy behaviours as a form of stress coping or reduced self-regulation; and (5) physical injury resulting from racially-motivated violence (Paradies et al., 2015, p. 2).

Although conceptually coherent, establishing the empirical evidence-base of racism and each of these impacts has proven to be challenging. Issues with racism exposure measurement and moderating/mediating factors mean that findings are mixed with regards to the relationships between racism and physical health outcomes (Paradies et al., 2015). However, evidence of the prevalence and consistency of race-based inequities alone provides sufficient rationale for action and intervention.

The first part of this literature review describes several critical shifts in the understanding and form of racism, as they apply to health. Frankenberg (1993, p. 14) describes these as shifts "*from 'difference' to 'similarity' and then 'back' to difference radically defined*." Biological/scientific and cultural racism constitute forms of "*essentialist racism*", racialising differences and attributing them to either biological or cultural inferiority.

"*Colour-blind racism*" follows, with its denial of difference and emphasis on universal humanness and formal equality. Under this paradigm, inequities are attributed to the deficiencies of minority group members. Finally, "*race cognisance*" marks a return to difference, as defined and articulated by people of colour. Inequities are not attributed to ascribed characteristics of minority group members but rather, social structure. Frankenberg takes care to note that, rather than ensuing shifts displacing the preceding paradigm, each of these paradigms continue to co-exist. The resilience of racism is such that it persists in new forms. For example, the colour-blind paradigm has taken up elements of race cognisance, observable in the "*selective engagement*" with multiculturalism (Frankenberg, 1993, p. 2015). Nonetheless, this 'moment' of race cognisance marks a move towards anti-racism, to which the literature review will now turn.

"Ko ō tatou whakapono ngā kaiwehewehe i a tātau. Ko ō tātou moemoeā me ō tātau pākatokato ngā kaiwhakakotahi i a tātau."

- Te Wharehuia Milroy

IT IS OUR TRUTH THAT ARE THE ACTORS OF SEPARATION. IT IS OUR DREAMS AND DIFFICULTIES THAT ACT TO UNIFY US.

Aotearoa New Zealand is a diverse melting pot of different peoples and groups, with different ways of thinking, being and doing. While these differences have the potential to divide us, our shared humanity and appreciation of our unique and complementary strengths can unite us.

Anti-racism

Anti-racism and racism are linked (Paradies, 2016b). As an approach or set of approaches to combat racism, anti- racism concepts, focus and practices have shifted in parallel with the changing forms of racism. However, anti-racism is significantly less theorised and developed in the literature (Paradies, 2016b; Solomos & Back, 1996).

The following sections of this literature review are focused on the critical shifts that occurred in relation to understandings of anti-racism, in order to best achieve its ultimate objectives. This will inform the development of a definition of anti-racism for the Aotearoa context.

At its very least, anti-racism could be said to comprise "forms of thought and/or practice that seek to confront, eradicate and/or ameliorate racism" (Bonnett, 2000, p. 4). Anti-racism, although defined as a concept from the mid-twentieth century, has a much longer history in the form of activism (Aptheker, 1975, p. 21).

The historical struggle against racism can be seen across the world, in the fight against slavery and apartheid, and for civil rights and decolonisation (Hage, 2016). Broadly then, anti-racism is the bridge to creating a just and fair society, "it is a discourse of change" (Bonnett, 2000,p.91).

Anti-racism has meant different things at different times, and in different contexts. In the United States, in the 18th century for example, anti-racism was part of wider challenges to elitism, feudalism, monarchy, and oppressive colonialism (Aptheker, 1975, p. 20).

Furthermore, although there is a strong temporal dimension to anti-racism activism, different socio-political and geographical contexts may generate distinctive forms that co-exist.

In France in the early mid-twentieth century for instance, two anti-racist movements born from the experiences of inter-war antisemitism and the Holocaust, and the French colonial experience, approached the fight against racism in very different ways. The former was republican in its politics and stood for individual rights acquired through assimilation within the nation. The latter espoused anticolonialism and had communist leanings (Soulsby, 2021).

Anti-racist activity exists along a spectrum, reflecting the diversity of both the contexts in which racism occurs, and the appropriate anti-racist responses (Came, 2012).

The Retreat from Scientific Racism

The term 'anti-racism' first entered the vernacular in the era of colour-blind racism and cultural assimilation. It was at this time that the 1950 UNESCO Statement on Race was heralded for its definitive opposition of scientific racism, overlooking its paternalistic overtones and disparaging descriptions of ethnic minority 'backwardness' (Gil-Riano, 2018).

The understanding of racism that prevailed in the final statement was that of "'coloured' people at the margins of civilisation" being prevented from enjoying the benefits of modernisation. Ironically, it was considered prejudicial and discriminatory to not include minority groups in projects of cultural improvement or assimilation, but not to continue to judge them as 'lesser than'. This was a rather narrow conception of anti-racism, the opposition of scientists to political racism and the use of scientific theories to justify racial discrimination (Barkan, 1992, p. 289).

Anti-racist action centred on the replacement of racial typologies with a neo-Darwinist population genetics frame. A distinctly settler-colonial, imperial outlook remained (Gil-Riano, 2018). The rejection of the term race did not mean that racial categorisations disappeared from people's thinking (Essed, 1991).

In Aotearoa, although the notion of race was replaced with that of 'descent' in the middle of the twentieth century, and 'ethnic origin' and 'ethnic group' in the 1970s and 1990s respectively, it has been noted that the main ethnic groupings are not dissimilar from racial categories (Callister, 2008; Callister & Didham, 2009).

The move towards ethnicity was part of a paradigm of cultural pluralism and diversity, which rejected biological determinism, and espoused equality and tolerance (Essed, 1991).

There were several limitations of this outwardly positive shift: an assumed hierarchical order based on a dominant majority and 'different' minority, an increased unwillingness among dominant group members to accept responsibility for problems of racism (Essed, 1991), and continuing support for existing systems rather than divestment (Brown, 2017). It is for these reasons that it has been argued that cultural pluralism is a constrained form of anti-racism (Brown, 2017).

Reducing Racial Prejudice & Discrimination (time period)

As cultural racism persisted and racism was still largely conceptualised as an individual and interpersonal phenomenon, anti-racism efforts focused on addressing prejudice, stereotypes and discrimination. This is where the majority of existing anti-racist literature has focused (Paradies, 2016b), starting with the assumption that bias, prejudice and racism are inevitable. Two differing approaches subsequently emerged:

one based in a "*politics of distance*" via the cultivation of racial tolerance or even indifference (Paradies, 2016b), and the more common informed by a politics of engagement between different racial or ethnic groups (for example, Duckitt, 2001; Campinha-Bacote, 2002).

Proponents of racial tolerance describe it as "*an important minimum*" towards reducing discriminatory acts (Balint, 2016, p. 17), while its critics are concerned that it undermines anti-racism in several ways: it does not seek to eradicate prejudice, and it perpetuates rather than challenges asymmetrical power relations through an individual "*[refraining] from discriminating against members of races he considers inferior despite having the power to do so*" (Paradies, 2016b, p. 4; Bessone, 2013, p. 209). "*Tolerance for" is profoundly different from "having respect for*" (Essed, 1991, p. 17).

Conversely, experiencing positive personal contact with members of another racial or ethnic group has been deemed to induce more positive interactions and minimise interpersonal and inter-group discrimination (Duckitt, 2001; Ben, Kelly & Paradies, 2020). For those reasons "cultural encounters" with culturally diverse others have been identified as the "*energy source and foundation*" of cultural competence (Campinha-Bacote, 2007; Campinha-Bacote, 2002, p. 182). Effectiveness in prejudice reduction is dependent on several factors, including quality and duration of contact, and whether individual out-group members are perceived to represent the wider out- group. The fact that the success of these encounters is premised on 'ideal' conditions (vis a vis Allport's 1954 contact hypothesis: including equal status, common goals, intergroup cooperation) that might not exist in reality, has attracted some criticism (McKeown & Dixon, 2017). Furthermore, there is concern that prejudice-reduction targeted at dominant group members may neutralise collective anti-racist action by minority group members.[5]

Unlearning Racism

Education has occupied a central role in anti-racism efforts, although it is rarely labeled as such. Diversity training or cultural competence are more common terms for learning which, in its earliest forms, focused primarily on raising awareness of racial, ethnic and cultural differences and developing the skills to promote diversity (Kowal, Franklin & Paradies, 2013). Where ignorance was understood as a key cause of prejudice, the provision of information was deemed the appropriate solution.

This was the model initially adopted in 'bicultural training' for non-Māori and health professionals in the late 1980s in Aotearoa, following the introduction of biculturalism as official government policy. In a blending of cultural racism and the prejudice problematic, health professional training was framed squarely in terms of the culture thesis (Cooper, 2012); Māori health issues were deemed to be 'cultural' with the key problematic of 'monoculturalism' to be addressed through meeting 'Māoritanga' (Māori culture, practices and beliefs) or the provision of cultural checklists (Ahuriri-Driscoll, 2019). However, relying solely on this type of content, about cultural or racial

[5] Research from Aotearoa has suggested that contact with Pākehā New Zealanders is associated with a reduction of Māori support for legislation designed to restore land to Māori (Sengupta & Sibley, 2013, cited in McKeown & Dixon, 2017).

'others', runs the risk of essentialising racial identities and reinforcing stereotypes (Downing & Kowal, 2011, pp. 8-9; Curtis et al., 2019). Furthermore, it may cultivate a false sense of 'mastery', counter to the cultural humility increasingly recognised as critical to effective health practice (Ahuriri- Driscoll, 2019; Fisher-Borne, Montana Cain & Martin, 2015; Kowal et al., 2013).

The New Zealand Medical Council chose to develop standards for cultural competence, to complement those set for clinical competence (Durie, 2001).

Education on its own is insufficient to reduce racism, however more recent forms of anti-racist training bring learners closer to this end-goal. This has involved a change in emphasis, linked to the evolving understandings of institutional, systemic and structural racism. The institutional and historical bases of domination and discrimination are examined in order to produce conscientisation, a deeper awareness of sociocultural reality as it shapes people's lives, as well as the capacity to transform that reality (Freire, 1975, p. 27, cited in Huygens, 2007). The risk of leaving the systems and structures that had created and perpetuated Māori health inequities unexamined led Māori nurse and educator Irihapeti Ramsden to develop cultural safety for the nursing curriculum in the 1990s. Cultural safety incorporated critical self-reflection and analyses of power, as well as nursing practice examples that related Tiriti o Waitangi breaches and the effects of colonisation to contemporary Māori health status (Ramsden, 2002). Although not without difficulty or controversy, cultural safety moved closer to achieving the critical consciousness-raising and social change aspirations of the 1960s and 1970s political protest movements (Huygens, 2007).

White and dominant culture members need to recognise how they benefit from and are complicit in a system of privilege, without becoming "mired in guilt and anxiety" (Kowal et al., 2013, p. 325). This requires reflective race awareness (O'Brien, 2000, p. 47), comprised of several important and perhaps nuanced understandings: perceiving racism as an institutional issue as well as a personal issue.

An associated construct to emerge more recently is that of structural competency, which has been fitted to the specific focuses of medical education. The five core competencies include: recognising the economic, physical and socio-political forces and structures that shape clinical interactions; developing an extra-clinical language of structure that includes social determinants of health, health disparities or epigenetics; re-articulating 'cultural' formulations in structural terms; observing and imagining structural interventions; and developing structural humility, in which the limitations of structural competency are recognised (Metzl & Hansen, 2014). Conceptualised in this way, structural competency promises to address several of the shortcomings of cultural competence.

For dominant culture members to be conscious, requires an acknowledgment 'whiteness' and its related practices in the context of race and ethnic relations (Doane, 2003). Whiteness studies emerged in the late 1980s and 1990s.[6] Challenging the naturalised dominance of whiteness has since become a core task of anti-racist activists (Doane, 2003).

[6] Or perhaps re-emerged – W.E.B Du Bois wrote about concepts related to White privilege in publications in 1956 [1935] and 1969 [1920] (Doane, 2003, p. 5)

Depending on how this is approached, anti-racism training risks reinforcing White racial identities as inherently and inevitably racist (Kowal et al., 2013). Negative effect such as guilt and anxiety may result, leading potentially to defensiveness and resistance, paternalism and, ironically, increased prejudice (Kowal et al, 2013). Systemic change requires recognition and awareness of one's own privilege and how it supports and sustains institutional racism. In order to be engaged productively in institutional and systemic change the ultimate goals of anti-racism, (moving beyond the prejudice problematic); noticing colour or race not in an essentialist manner, but for what it means in terms of racialised (and other) experiences; and seeing race as something not just present for others who are racist, but inherent in the way all individuals view themselves and others (according to processes of racialisation). A reflexive form of anti- racism involves being able to move beyond the dichotomies of racism/anti-racism, racist/anti-racist and seeing the possibilities of and for a positive White identity (Kowal et al., 2013).

White identities have been the subject of significant anti-racism oriented scholarship in Aotearoa. Central to this work has been the imperative to re- envision indigenous and non-indigenous relationships, and establish ways of being and belonging that do not perpetuate coloniality (Bell, 2004). Adopting the position of 'ally' is one possibility, which involves acknowledging and addressing power imbalances, acknowledging privilege, being accountable to the indigenous other, knowing how to support without dominating, sitting with discomfort, and being open to unlearning assumptions (Margaret, 2013, pp. 119-28). Identifying as "tangata Tiriti" is another option, forging a sense of "belong[ing] with dignity" to Aotearoa through Te Tiriti (Peet, 2008, pp. 1-2). Common to both positions is the notion of critical awareness of one's own assumptions, power-sharing and partnership, and collaboration with Māori in the social justice project. Furthermore, work must be invested both in generating change within one's own cultural group and supporting the struggles of indigenous peoples (Margaret, 2013).

Such sophisticated and nuanced forms of anti-racism do not develop through education or self-reflection alone; they must be learnt through action and sustained practice (Margaret, 2013).

Collective and Institutional Action

The predominance of individual-level anti-racism interventions (Paradies, 2016b) might reflect a belief that prejudiced individuals 'add up' to institutional and systemic racism, and that these efforts will therefore address the root of the problem (McKeown & Dixon, 2017). However, understandings of racism are multi-level and comprehensive, with individual experiences of racism conceptualised as embedded within and emanating from discriminatory systems and structures.

Despite the interconnectedness of racism across each of these levels, individual or interpersonal-focused approaches are insufficiently transformative. Distinct policy and system-focused action is required to counter racism (Came, 2012). Came (2012, p. 256) identifies several approaches to countering institutional racism, encompassing structural changes, strengthening of controls, systemic organisational change, and enhancing the racial climate. In Aotearoa, a great deal of anti-racism action has centred

on the failure of successive governments since 1840 to meet their stated Te Tiriti obligations (Huygens, 2007). Treaty- based structural changes have therefore been proposed, such as establishing honourable kāwanatanga arrangements, enabling and resourcing hapū and iwi rangatiratanga (sovereignty), and establishing arrangements for power and resource sharing. Came argues that if Treaty/Tiriti obligations "*had been upheld, institutional racism would not be detectable within Crown practice*" (2012, p. 130).

This is a critical assumption, a merging of Te Tiriti with anti-racism. The intent of the British Crown to do better in Aotearoa than it had in other colonies has been emphasised, considering the worldwide movement to abolish slavery at that time (Consedine, 2018). However, being opposed to slavery was not necessarily equivalent to being anti-racist, because "to reject racism was a profoundly deep rejection of the entire social order" (Aptheker, 1975, p. 18). Indigenous people's racial and cultural inferiority and the colonisers' superiority and therefore right to rule persisted, despite a treaty.

Establishing a truly Tiriti-based societal and institutional structure would have ensured more equal power relations, however, this hasn't been the case.

The question now is, is an anti-racism frame more transformative than a Te Tiriti frame? Given the localised nature of both racism and anti-racism (Ladhani & Sitter, 2000), while anti-racist practice in Aotearoa might extend beyond Te Tiriti-based action, it cannot proceed without it.

It could reasonably be argued that institutional racism in Aotearoa was entrenched via a lack of acknowledgment of Te Tiriti. Taking collective responsibility for institutional racism necessitates learning about the history of the Te Tiriti and subsequent colonisation (Huygens, 2007). Te Tiriti therefore remains a key component, underpinning proposed constitutional reform (Matike Mai Aotearoa, 2016), plans for the implementation of the UN Declaration on the Rights of Indigenous Peoples (He Puapua Working Group, 2019), and the elimination of discriminatory practices and policies (for example through critical Tiriti analysis: Came, O'Sullivan & McCreanor, 2020, p. 439). A significant health systems-level anti-racism development was instigated in 2016, with the commencement of the Waitangi Tribunal Health Services and Outcomes Kaupapa Inquiry (Wai 2575). The Stage One report on the primary health care system was released in 2019, concluding that the sector's legislative, strategy, and policy framework has consistently failed to commit to achieving equity of health outcomes for Māori, as well as its Tiriti obligations.

The Tribunal considered these failings to be manifestations of institutional racism (Waitangi Tribunal, 2019). The impending health and disability system reforms aimed to include the institution of several mechanisms for increased Māori partnership -Te Aka Whai Ora, an autonomous Māori Health Authority responsible for ensuring the health system is performing for Māori, and giving Iwi-Māori Partnership Boards a formal role in agreeing local priorities with Te Whatu Ora - Health New Zealand (Department of the Prime Minister and Cabinet, 2021). In 2012, when anti- racism scholar Heather Came (p. 261) reflected on the achievements of anti- racist praxis in the public health system to date, she reported that there had been "mixed results, overshadowed by the enduring assumption of unitary Pākehā sovereignty". A changed racial climate in some respects, and some movement in terms of political will were

compromised by the need for continual revisiting of anti-racist objectives and slow progress overall. There have been further important developments since, but the fear of indigenous sovereignty and a truly equal society remains. As long as anti-racism is perceived as a "zero- sum game" that dominant culture members stand to lose, resistance to it will only increase (Norton & Sommers, 2011).

Not all Created Equal – Racism & Anti-Racism

The term anti-racism implies a state or action that is opposed to or the opposite of racism. If racism is characterised by the creation and systematisation of power difference between racialised groups, we would expect anti-racism to remove those differences (Kowal et al., 2013, p. 325).

If racism is defined as "*inaction in the face of need*" (Waitangi Tribunal, 2019, p. 21), then anti-racism would be defined by action and responsiveness to inequity, and "*an active commitment to interrupting systems of racism*" (Ladhani & Sitter, 2020, p. 56; Tatum, cited in O'Brien, 2000). If racism is understood as bias and prejudice towards racialised others, we would expect anti-racism to be either an absence of bias and prejudice, or the existence of an opposite state or affect; impartiality and good will. In each of these forms, race ceases to be a basis on which people are socially categorised and judged, but the goals of equality, and social harmony, are not equally agreeable. The 'anti' of prejudice reduction has the potential to engender denial and euphemism (indifference, colour- blindness, 'diversity'), aligning with earlier forms of racism that need to be countered (Binkley, 2016). It is on this basis that Bonnett (2000) contends that anti-racism is not simply the inverse of racism. He cites the example of deployment of racism by anti-racist activists, in terms of adherence to categories of race, and therefore, racialisation.

Consequently, questions remain about the 'post-race' environment that is being sought via anti-racism. Is the goal the elimination of race entirely, or only the adverse side-effects of racial membership (Paradies, 2016b). This is a nuanced area, requiring alternatives to the dominant racist modes of co-existing and relating (Hage, 2016, p. 125). Hage (2016, pp. 128-9) suggests moving from a "*domesticating mode of existence*", in which subordinate others are to be dominated for utilitarian purposes, to a "*mutualist mode of existence*" in which people exist in each other. This is open to misinterpretation and co-option as assimilation, as was evident in public discourse following the 2019 Christchurch mosque shootings ("*They are us*": Waitoki, 2019).

These dynamics highlight some of the important distinctions between subordinate and dominant group anti- racism. Despite being a lesser focus in sociological anti-racism literature than White/dominant group anti-racism, Black/ subordinate group anti-racism offers additional and unique insights about liberation, divestment, and resistance (Brown, 2017). As is evident throughout this literature review and anti-racism progress over the past decades, Euro-centric models of anti- racism continually revert to the safety of a mid-way point (multi-culturalism, diversity, 'inclusion': Binkley, 2016, p. 183) that falls well short of the changes needed. O'Brien (2000, p. 42) prefers to name this a form of "*nonracism*" rather than anti-racism. Conversely, anti- racism

models that "centre 'Blackness'" (Brown, 2017, p. 7) come closer to the rights-based, collectivist and self- determination oriented actions proposed by Came (2012). The significant differences between these forms of anti-racism underline the importance of ensuring that the perspectives of those impacted by racism are always to the fore (Knight et al., 2021).

Anti-Racism in Health – Where are We Now?

The field of strategic communication provides insights regarding the necessary steps for progressing a racial justice agenda (Kang, 2018; Center for Social Inclusion, 2004). Health education
and research in Aotearoa has successfully implemented the following examples:

- Affirming the "shared fate" of racial and health inequities, the effects of these upon all members of society (Woodward & Kawachi, 2000, p. 923) and conversely, the potential benefit for all through their reduction.
- Countering deficit explanations of racial and health inequities, and providing alternatives that attend to the historical context of colonisation and address race explicitly by naming structural/ institutional racism (Reid & Robson, 2007, pp. 4-6).
- Reframing Māori as people in possession of indigenous and human rights (Reid & Robson, 2006, pp. 28-9) and as positive contributors to wider society.

Problematic dominant frames are identified and contested extensively (e.g. Reid & Robson, 1999, McCreanor, 2008, Hodgetts et al., 2004), including the now widely accepted differentiation between egalitarian notions of equality compared with equity. We have been less effective in engaging emotionally with the wider public, capturing 'hearts' as well as minds.

A particular challenge for Aotearoa has been our reluctance to discuss race. This may account for the persistence of a 'cultural' frame (race coded as culture: Cooper, 2012, p. 69; Goldsmith, 2003), and the late advent of racism in explanations of health disparities (circa the late 1990s). However, increasingly comprehensive and nuanced models of racism and its health impacts have informed multi-level action to combat racism in the health system and beyond. The argument of inequity is compelling, but has been explained away through narratives of meritocracy and racial/ cultural deficit. Building empathy through the demonstration of profound health impacts might instead invoke sympathy and a more 'charitable' form of racism. While the reality of racism is widely acknowledged, recognising it as a complex societal problem continues to challenge at the individual and group level, producing 'new' or perhaps "*renewed racisms*" (Bhattacharyya, Virdee & Winter, 2020, p. 18), backlash (Ben et al., 2020, p. 210), resistance, or fatigue (Flynn, 2018). The dimensions of racism (structural and institutional) used to justify and compel action, continue to benefit powerful interests and therefore stimulate resistance. The simultaneous holding of a progressive 'frame' on race equity while preserving conservative policies, is one of the enduring challenges for anti-racist practice.

Section Conclusion

In Aotearoa, anti-racism conversations and relationships between the descendants of the colonised and the colonisers will by default include tangata whenua (Māori) and tangata Tiriti. The common assumption is that Pākehā are the primary Tiriti partner, excluding "tauiwi of colour", such as Pasifika peoples, from conversations about racism. The Pasifika history, migration and relationship to Aotearoa is unique. Failing to consider the noticeably different realities is to fail to understand "the full landscape of racism in Aotearoa" (STIR, NZPHA & AUT, 2021, p. 31). For example, the use of the 'multiculturalism' frame by dominant group members to undermine that of a Tiriti-based, bicultural or anti-racism frame, might have a different, not necessarily negative meaning for tauiwi of colour. These issues highlight the pressing need for increased consultation with Pasifika peoples regarding their experiences and needs with respect to racism. This will only strengthen the collective agency required to achieve change in power relations and address the root cause of social and health inequities (Came & Griffith, 2017).

Racism has permeated society at every level and so anti-racism must seek to negate it at every level: systemic and institutional, interpersonal, and internalised. Education is an important means but is just one of several 'building blocks'. Anti-racism training that takes a reflective approach to the historical origins and impacts of racism is a stronger approach. However, to be successful this must be accompanied by organisational development and reorientation (Ben et al., 2020, p. 208-9) as well as structural changes that restore rangatiratanga and provide redress for historic racism (Smith et al., 2021). The growing evidence base pertaining to the health impacts of racism in Aotearoa has been acknowledged in the health policy environment (Talamaivao et al., 2020).

This has resulted in a recent shift towards institutional and system-level action. System-level change interventions in public institutions need planned and intentional change management based on solid theoretical foundations that are implemented and more importantly, evaluated (Came, 2012;Ben et al., 2020). An important part of anti-racism is to reveal the patterns of racism and the levers for change within those. This necessitates asking "How is racism operating here?" and identifying associated practices (Jones, 2018, p. 232).

A useful, localised definition of anti- racism is: "the art and science of naming, reducing, disrupting, preventing, dismantling and eliminating racism. It takes a multiplicity of forms but centres around solidarity with those targeted by racism, an analysis of power and a commitment to reflective, transformative practice. In the context of Aotearoa it involves engagement with Te Tiriti o Waitangi" (STIR, NZPHA & AUT, 2021, p. 9). In two recent reports from Māori scholars and anti-racist scholars and activists, the anti-racism kaupapa has been very simply put as 'whakatika' – making that which is not right or tika, tika again (Smith et al., 2021; STIR et al., 2021, p. 25). Racism exists, and anti-racism exists or doesn't, because we let it. The systematised and deeply ingrained nature of racism in our society means that anti-racism must be intentional, we cannot rely on it to happen by default. Racism has become normalised, anti- racism must too.

"E huri tō aroaro ki te rā tukuna tō ataarangi ki muri i a koe"

TURN AND FACE THE SUN AND LET YOUR SHADOW FALL BEHIND YOU.

Let us build on the work that has been done in the past and turn towards the sun excited by the prospect of a new future. A future where all people regardless of race, ethnicity or colour are valued and treated with dignity and respect.

Kupu Whakamutunga | Conclusion

This literature review traced the evolution of the philosophical and ethical underpinnings of racism and anti-racism, to help build a shared understanding of racism and anti-racism solutions for the health and disability system. Large bodies of research and scholarship exist, building on the labour generated by activism and social movements. Conceptualisations of racism and anti-racism have evolved and continue to do so, in parallel with societal changes. Anti-racism is more difficult to theorise, partly due to the 'slippery' nature of racism, and also because there is more at stake in terms of 'getting it right' to 'make things right'. Health inequities provide compelling evidence of the historic and ongoing effects of racism, as well as providing useful measures against which to gauge the effectiveness of anti-racist actions. Critical shifts in racism and anti-racism have shown us both the error of our ways, but also the pathways forward. Me haere tonu tātou.

Proposed definitions of racism and anti-racism for Aotearoa

As has been made clear from the first part of this literature review, there are many forms and levels of racism. Therefore, it is important to define racism and anti-racism in the Aotearoa specific context.

RACISM - Working Definition

Racism comprises racial prejudice and societal power and manifests in different ways. It results in the unequal distribution of power, privilege, resources and opportunity to produce outcomes that chronically favour, privilege and benefit one group over another. All forms of racism are harmful, and its effects are distinct and not felt equally.

ANTI-RACISM - Working Definition

Anti-racism actively opposes and addresses racism in all its forms.
Anti-racism accepts the need to redistribute power, privilege, resources and opportunity. It requires people and institutions to examine their power and privilege and acknowledge and address power imbalances. It is an essential enabler of wellbeing and equity, particularly for Māori, Pacific peoples and communities of colour.

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