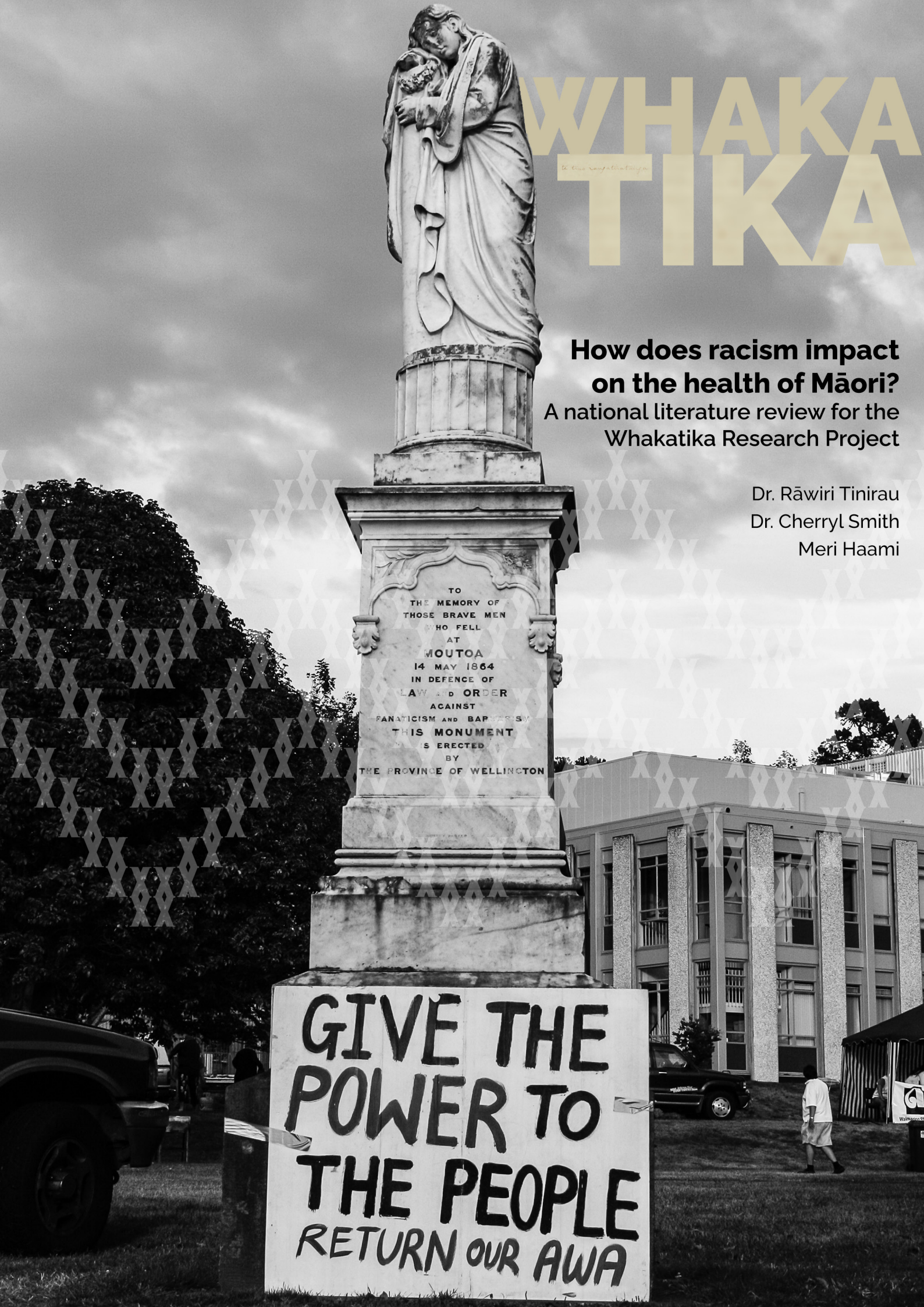

How does racism impact on the health of Māori?

A national literature review for the Whakatika Research Project

Dr. Rāwiri Tinirau
Dr. Cherryl Smith
Meri Haami

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HE MIHI

Whakarongo mai e te iwi nei! Whakarongo mai e te motu nei! Whakarongo mai ki ngā kōrero e hāngai pū ana ki ngā mahi kaiā a te Karauna, ki ngā mahi kaikiri a tauiwi, e pēhi tonu nei i a tātau te iwi Māori. Inā te kōrero a Tohu Kākahi ki ngā iwi e rua, ā ka hakaina e te motu katoa: "E kore e piri te uku ki te rino, ka whitingia e te rā, ka ngahoro". Ahakoa ka whakapiri atu tātou ki a tauiwi, he Māori tonu tātou, kāore he āhua kē atu. Kāti, mā ngā hīhī e whiti mai ana i te aranga ake o te rā Māori e ngahoro i ngā pēhitanga. Ā ka puta tātou ki te whai ao, ki te ao mārama. Tīhei mouri ora.

We wish to acknowledge: all those who have felt the effects of racism over generations, and those who have fought fearlessly in the hope of eradicating it; the Health Research Council, for funding He Kokonga Ngākau Research Programme (14/1005), including the Whakatika Research Project; and the project advisory group, consisting of Sr Makareta Tawaroa, Professor Helen Moewaka Barnes, Associate Professor Donna Cormack, Eljon Fitgerald and Kerri Kruse.

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1. Introduction

This literature review examines the health impacts of racism on Māori within the context of Aotearoa. This literature review has four sections that are pertinent to the ways in which health impacts of racism affect Māori. These four sections are:

1. Defining racism
2. Racism as a part of colonisation
3. Tools of racism
4. Racism health impacts

These four sections also investigate how racism is becoming more recognised as a determinant of health, is a key driver of Māori health disparities and how it creates poorer health outcomes for Māori. Racism did not originate in Aotearoa but is tied to centuries of wars, trade and invasion of other countries. For that reason, some time is spent in this literature review examining the global context of racism and the theories that consolidated racism.

2. Defining racism

> Waiho ngā tāngata kaikiri, kūware, ki a au, ā, māku e whakatika, e ārahi hoki. Kīkī tonu ngā kete o te iwi taketake nei!
> (Emery-Whittington & Te Maro, 2018, p. 1).

The above statement is written in the foreword or mihimihi of a keynote presentation during a conference on the decolonisation of Indigenous occupational therapy. The excerpt illuminates the theme of the conference, which sought to discuss the solutions to decolonise and heal from racism as well as the different experiences of racism faced by Māori occupational therapists within their field. More broadly, this conference focused on racism within the public health sector of Aotearoa. The extract uses a newer te reo Māori term, such as 'kaikiri' to denote racism, as it means hostility and antagonism. In conjunction with an older term, 'whakatika', which refers to the correction of behaviours, in this case the behaviours are racist transgressions. Both kaikiri and whakatika are terms that allude to the historical origin of racism rooted in colonisation (Emery-Whittington & Te Maro, 2018; Gillon et al., 2018; Jackson, 1993; Reid & Robson, 2007). Emery-Whittington and Te Maro (2018) touch on many levels of racism that are defined in other public health literature, both nationally and internationally, using qualitative and quantitative methods on Māori, Indigenous, Black and people of colour, as well as LGBTQIA+ (Awofeso, 2011; Ben et al., 2017; Brown et al., 1999; Carter, 2007; Gillon et al., 2018; Jones, 2000; Jones et al., 2008; Kelaher et al., 2014; Nairn et al., 2006; Paradies, 2006a; Paradies et al., 2008; Paradies & Cunningham, 2012; Paradies et al., 2015; Paradies, 2016; Williams & Mohammed, 2013).

Therefore, racism can be viewed as a practice, sometimes covert, constantly evolving and omnipresent (Gillon et al., 2018; Jackson, 1993; Reid & Robson, 2007; Smith, 1999).

2.1. CONCEPTS OF RACISM

Studies on the concept of racism within sociology have provided the frameworks for how racism is analysed and contextualised within public health literature. Two key terms discussed through sociology that are used interchangeably within racism studies are 'race' and 'ethnicity', which are social constructs. The literature defines 'race' as a group that share physically defined characteristics that are socially and externally assigned, such as having a certain skin colour, facial features or hair texture. 'Ethnicity' can refer to a group with shared ancestry, culture or nationality and does not infer physical characteristics. 'Race' and 'ethnicity' have different bases for group association and are dependent on locale, social and historical context but often overlap within racism discourse (Bonilla-Silva, 1997; Fitzgerald, 2014; Kivisto & Croll, 2012). Sociologist Bonilla-Silva (1997, p. 469) states that ethnicity is malleable in terms of who belongs, while "racial ascriptions (initially) are imposed externally to justify the collective exploitation of a people and are maintained to preserve status differences." The literature debates these definitions but acknowledges that both terms produce different ways of social organisation and that race informs concepts of racism (Bonilla-Silva, 1997; Fitzgerald, 2014; Kivisto & Croll, 2012).

Bonilla-Silva (1997) critiques ideological notions of racism as being inadequately simplistic and stemming from a lack of structural theory of racism. He proposes that defining racism must move away from being purely ideological, static, solely overt and only seen as a remnant of the past. Therefore, racism can be viewed as a practice, sometimes covert, constantly evolving and omnipresent (Gillon et al., 2018; Jackson, 1993; Reid & Robson, 2007; Smith, 1999). Paradies (2006b) affirms these arguments, highlighting how racism uses 'power' as a measurement of accessibility to a better quality of life through resources that dialectically connects the dominant racial group and Black, Indigenous and/or people of colour. Furthermore, this dialectical connection between groups are influenced by either group having an increase or decrease in power.

These meanings of power underpinning racism are often expressed in harmful stereotypes, prejudice and discrimination, which illustrates the importance of racism within health research in two critical ways. Firstly, racism within health research provides a predictive ability to explain its contributions towards patterns of population health, and secondly, a paradigm to examine racism as a determinant of health (Paradies, 2006b). Cormack et al (2020) reinforces these conceptualisations of power and racism through examining multiple forms of discrimination experienced by Māori. Discrimination can be viewed as the actions or practices that express racism in covert and overt ways that produce negative impacts for Black, Indigenous and/or people of colour and maintain power for others (Dovidio et al., 2010; Krieger, 2001; 2014).

defining racism as an organised, hierarchal and stigmatisation grouping system, based on racial inferiority to others that "differentially allocates desirable societal resources to the superior ethnic/racial groups" (Paradies & Cunningham, 2012, p. 1).

2.2. LEVELS OF RACISM

Literature from public health (Bonilla-Silva, 1997; Jones, 2002; Robson & Reid, 2001; Paradies, 2006b; Paradies et al., 2008; Paradies & Cunningham, 2012) reinforces these critiques by defining racism as an organised, hierarchal and stigmatisation grouping system, based on racial inferiority to others that "differentially allocates desirable societal resources to the superior ethnic/racial groups" (Paradies & Cunningham, 2012, p. 1). Paradies et al (2008) state that racism can be characterised as avoidable and unfair actions that further disadvantage Black, Indigenous and/or people of colour, while maintaining privilege and advantage by the dominant racial group. The literature argues that racism is one aspect amongst the broader phenomenon of oppression that can encompass sexism, classism, heterosexism, ableism, ageism, fatism as well as others, which are considered dialectical opposites to the concept of privilege (Paradies, 2006b; Paradies et al, 2008; Puhl & Heuer, 2009). Paradies (2006b) advocates for studies examining health and racism to define racism prior to measuring and operating their research.

The literature has varying and interchangeable names for the levels of racism. However, the definitions are relatively similar, which are dependent on cultural and locale specific variables (Barnes et al., 2013; Jones, 2000; Paradies, 2006b; Paradies et al., 2008). The literature sets out three to four agreed upon concepts on the levels of racism (see Figure 1). These four concepts on the levels of racism include; internalised; interpersonal or personally mediated; institutional or systemic; and lastly, societal. Most of the literature concurs with the first three levels of racism and gives comprehensive overviews on its definition, real life examples as well as its health impacts on the emotional, mental, spiritual and physical aspects of well-being for Māori, Indigenous as well as Black and/or people of colour communities. The literature encompasses both national and international data on the health impacts of racism at the four levels (Barnes et al., 2013; Carter, 2007; Thompson & Neville, 1999; Cormack et al., 2020; Harris et al., 2012; Harris et al., 2018; Jones, 2000; Paradies et al., 2008; Paradies & Cunningham, 2012; Waitangi Tribunal, 2019).

Barnes et al (2013) added the level of 'societal racism', which is a concept similarly described by Paradies et al (2008) as 'elite racism' and involves the ways in which racism is perpetrated by influential figures in the public domain. The literature also acknowledges that while racism is discussed as being contextually and operationally different depending on locale (Paradies et al., 2008), the health impacts due to racist treatment are similar between Māori, Black, Indigenous and/or people of colour (Barnes et al., 2013; Carter, 2007; Harris et al., 2012; Jones, 2000; Paradies et al., 2008; Paradies & Cunningham, 2012; Thompson & Neville, 1999; Waitangi Tribunal, 2019) (see Table 1).

...systemic racism is the level of racism that fundamentally underpins racial/ethnic inequalities in health. Systemic racism is the most pervasive form of racism across a range of life domains such as education, employment and housing. These life domains have, in turn, been found to strongly influence health and wellbeing ... systemic racism can persist in institutional structures and policies in the absence of prejudice at the individual level and that it is a fundamental cause of both internalised and interpersonal racism.

2.2.1. Levels of racism in health

The literature argues that the first three levels of racism are pervasive in different ways. Internalised racism, and its acceptance, is harmful towards mental health due to shame, cultivating a "self-perpetuating cycle of oppression" resulting in psychological distress and depression (Jones, 2000; Molina & James, 2016; Paradies, 2006). Similarly, the literature states that interpersonal or personally mediated racism is detrimental to mental health and access to resources (Jones, 2000; Molin & James, 2016; Speight, 2007). Institutional or systemic racism is described as a highly prevalent level of racism overall, as it impacts Indigenous people's access to resources and quality sectors of life, such as housing, meaningful employment, education and health facilities (Barnes et al., 2013; Harris et al., 2012; Jones, 2002; Paradies et al., 2008; Waitangi Tribunal, 2019).

The literature argues that institutional or systemic racism is the "most insidious and destructive form of racism" (Department of Social Welfare, 1988, p. 19; Barnes et al, 2013; Harris et al., 2012; Jones, 2002; Paradies et al., 2008; Waitangi Tribunal, 2019). Barnes et al. (2013, p. 72) reaffirms this notion by stating:

> The institutional structuring of racism of course reflects and supports the wider racialised society within which it is embedded.

These ideas are further reinforced by Paradies et al (2008, p. 4) commenting on the health sector within Australia and Aotearoa:

…systemic racism is the level of racism that fundamentally underpins racial/ethnic inequalities in health. Systemic racism is the most pervasive form of racism across a range of life domains such as education, employment and housing. These life domains have, in turn, been found to strongly influence health and wellbeing … systemic racism can persist in institutional structures and policies in the absence of prejudice at the individual level and that it is a fundamental cause of both internalised and interpersonal racism.

2.2.2. Intra-racism or internalised racism

Intra-racism or internalised racism is racist action against Indigenous peoples being perpetrated by another Indigenous person (Brondolo et al., 2005). Paradies et al (2008) cites lived experiences of symposium members who discuss the conflicts with this definition of intra-racism due to power imbalances faced by Indigenous in relation to the dominant racial group.

Although Indigenous people can express racism towards others, they largely do not have the power to restrict resources to other Indigenous peoples, which is a crucial element underpinning institutional or systemic racism (Clark et al., 1999; Jones, 1997). Others view intra-racism as a 'victim-blaming' narrative that characterises racism as an Indigenous issue. This, they argue, serves as a distraction to the racism propagated against Indigenous peoples, through living within a non-Indigenous society.

Paradies et al. (2008) and Paradies (2006b) propose that intra-racism could be a manifestation of internalised racism, resulting from the lived experiences of Indigenous peoples whose opportunities were diminished. This could be due to discrimination encountered by other Indigenous peoples based on racial identity or skin colour. This can lead to internalisation of a Māori or Indigenous hierarchy based off what they have internalised as stereotypical or 'authentic' Māori traits. The internalising of negative stereotypes is widely discussed within the literature relating to the health impacts on Black people, Latinx communities, as well as socially assigned race identities, by probing white health statuses within the United States (Brondolo et al., 2005; Clark et al., 1999; Clark, 2004; Jones et al., 2008; MacIntosh et al., 2013; Vargas et al., 2015).

2.2.3. Colonial and historical trauma

Explanations for lateral violence, such as racist abuse, can often be fuelled by negative colonial narratives that are intergenerational and complex historical trauma responses, sometimes resulting in violence. These aspects connect with internalised and interpersonal racism impacting on Māori surrounding their access and treatment from welfare, justice and health institutions (Family Violence Death Review Committee, 2020; Reid et al., 2019). Public health literature on trauma-informed responses to violence and its health impacts are beginning to incorporate colonial violence. The literature examines how colonial violence actioned through racism can occur, not only through traumatic events, but can also be enabled through institutional agencies. The literature argues that institutional or systemic racism is the most pervasive form and that its health impacts, specifically its clinical outcomes require further research (Barnes et al, 2013; Department of Social Welfare, 1988; Jones, 2002; Family Violence Death Committee, 2020; Paradies et al., 2008; Waitangi Tribunal, 2019). The relationship between colonial violence and racism has been studied through the Family Violence Death Review Committee (Family Violence Death Review Committee, 2020). This report provides a statistical and qualitative overview of intimate partner violence, discussing how institutional, systemic or structural pathways within welfare and justice sectors for intimate partner abuse are ineffective for women, particularly Māori women. Māori women face an overlap in oppressive identities embedded within racism and sexism, called intersectionality[1]. As a consequence of institutional or systemic racism, as well as interpersonal or personally mediated racism, Māori women are less likely to use welfare and justice institutions or agencies to report experiences of violence due to feelings of fear, mistrust and irremediable help.

1. Intersectionality is a term coined by Crenshaw (1989), which describes how aspects of a person's social and political identities might integrate to form unique modes of discrimination. This includes the combinations of gender, race, class, sexuality and ability (Family Violence Death Review Committee, 2020).

2.2.4. Table 1. Levels of racism

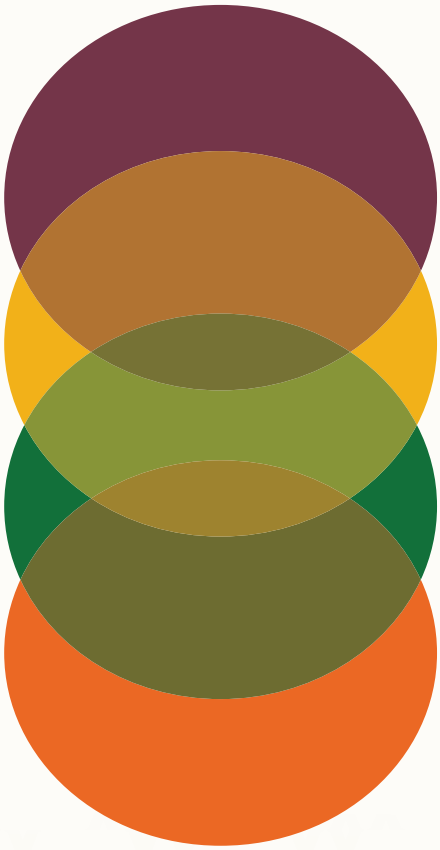
Levels of racism	Definition	Examples
Societal	The maintenance of negative stereotypes, attitudes, values, beliefs or ideologies that perpetuate the inferiority of a particular disadvantaged racial group, which are upheld by the privileged racial group. This is done through forming obstacles to the historical, socio-political and colonial education.	Māori being viewed as 'privileged' for receiving scholarships but Pākehā ignoring its purpose to remediate historical and colonial inequities through education.
Institutional or systemic	Legislation, policies, practices, material conditions, processes or requirements that maintain and provide avoidable and unfair inequalities and access to power across racial groups. This includes differential treatment and access to quality sectors such as education, health (medical facilities), housing, employment and income as well as living in a clean environment.	Māori experiencing inequitable outcomes within the criminal justice system.
Interpersonal or personally mediated	Interactions with people that continue and perpetuate unfair and avoidable inequalities within racial groups. Interpersonal racism involves prejudice based on differential assumptions on the abilities and intentions of others based on their race.	A Māori person receiving verbal abuse due to their race (as an overt example) OR A Māori person receiving surprise due to their competency (as a covert example).
Internalised	Belief and acceptance of negative stereotypes, attitudes, values or ideologies by members of a disadvantaged or stigmatised racial group regarding the inferiority of one's own racial group.	A Māori person believing that Māori are naturally less intelligent than Pākehā

Table 1: Levels of racism

Health impacts of racism

Emotional, mental and spiritual health impacts

Feelings of shame due to a low value associated with their culture
Reduced self-esteem
Low self-efficacy
Reduced self-control
Pessimism
Aggression
Hyper-vigilance
Rumination
Psychological distress
Lack of control
Precipitate negative social connections or reduce capacity of tolerating social connections
Clinical depression
Anxiety disorders
Post-traumatic stress disorder (PTSD)
Personality disorders



Physical and clinical health impacts

Hypertension
Cortisol dysregulation
Sleep disturbance
Obesity
Smoking
Negative alcohol and illicit drug use
Poor mental health
Poor physical health
Cardiovascular disease
Stroke
Heart failure
Rheumatic heart disease
Mortality
Breast cancer (women)
Lung cancer
Liver cancer (men)
Stomach cancer (men)
Higher cancer mortality rates
Asthma
Chronic obstructive pulmonary disease (COPD)
Diabetes, renal failure
Lower limb amputation

Table 1 shows the 'levels of racism' through its terms, definitions and Māori specific examples of this type of racism. The four levels include internalised racism (Barnes et al., 2013; Jones, 2000; Paradies et al., 2008; Paradies & Cunningham, 2012), interpersonal or personally mediated racism (Barnes et al., 2013; Jones, 2000; Paradies et al., 2008), institutional or systemic racism (Barnes et al., 2013; Jones, 2000; Paradies et al., 2008) and lastly, societal racism (Barnes et al., 2013; Paradies et al., 2008). The health impacts are divided into two separate columns, which include emotional, mental and spiritual health impacts, as well as physical health impacts. This is due to the literature indicating that the first health impact column seems to transfer and develop into the second health impact column of the physical (Carter, 2007; Paradies and Cunningham, 2012; Molina & James, 2016; Speight, 2007; Waitangi Tribunal, 2019). The two health impact columns are a combination of both national and international literature relating to the health impacts of racism (Barnes et al., 2013; Carter, 2007; Harris et al., 2018; Jones, 2000; Paradies et al., 2008; Paradies & Cunningham, 2012; Waitangi Tribunal, 2019). A portion of the health impacts are cited from Ministry of Health (2015) and given by Bloomfield (2018, as cited in Waitangi Tribunal, 2019, pp. 23-24). The Waitangi Tribunal (2019) and Bloomfield (2018, as cited in Waitangi Tribunal, 2019) acknowledge that racism is a health determinant for Māori and illustrate how racism could be a driver of Māori health disparities. Bloomfield (2018, as cited in Waitangi Tribunal, 2019) as evidence for a submission to the Hauora Report for the Health Services and Outcomes Kaupapa Inquiry (WAI 2575) (Waitangi Tribunal, 2019). This statistical information regarding Māori health disparities is also integrated within the table above, despite only having implicit connections with racism as a contributing factor. The literature delineates between the health impacts of emotional, mental and spiritual as well as physical (Barnes et al., 2013; Carter, 2007; Jones, 2000; Paradies et al., 2008; Paradies & Cunningham, 2012; Waitangi Tribunal, 2019). However, within a Māori worldview of health, these two health impact columns would be intertwined as they are not seen as separate (Penehira, 2015; Smith, 2019). For the purposes of this table and in order to accurately highlight the measurements undertaken by the literature, this table separates the two health impacts but acknowledges that Māori worldviews within health would not differentiate these two columns.

"it is well established that racism, a foundation stone of colonialism, is a potent and measurable social determinant of health" (Emery-Whittington and Te Maro, 2018, p. 15)

The literature illustrates that key to colonisation are the racist ideologies and beliefs of white superiority, which creates and maintains a 'new history' that proclaim European colonisers as the arbiters of defining Indigenous identity and 'true' knowledge forms (Churchill, 1996; Reid & Robson, 2007; Reid et al., 2019; Smith, 1999; Waitangi Tribunal, 2019).

3. Racism as a part of colonisation

The literature, including Emery-Whittington and Te Maro (2018, p. 15) argue that "it is well established that racism, a foundation stone of colonialism, is a potent and measurable social determinant of health" (Balsam et al., 2011; Family Violence Death Review Committee, 2020; Fiske, 2010; Gillon et al., 2018; Harris et al., 2006; Jackson, 1993; Page-Gould, 2010; Priest et al., 2012; Reid & Robson, 2007; Reid et al., 2019; Williams & Mohammed, 2013), thus, outlining the inextricable connections between colonisation, racism and health (Bécares et al., 2013; Grosfoguel et al., 2015; Paradies & Cunningham, 2012; Paradies, 2016; Robson, 2007; Reid et al., 2019; Walters et al., 2011). Gillon et al. (2018, p. 128) state that contemporary experiences and definitions of racism within Aotearoa "stem from the ongoing, deliberate colonisation of Māori and Aotearoa" as well as the obligations of honouring Te Tiriti o Waitangi being unsuccessfully met and upheld (Jackson, 1993; Reid & Robson, 2007; Waitangi Tribunal, 2019).

3.1. IMPERIALISM

Colonisation is one expression of imperialism that "still hurts, still destroys and is reforming itself constantly" (Smith, 1999, p. 19). Smith (1999) explains that the Indigenous experience is framed through interruptions of radically transformed landscapes, languages, cultures and imaginative worlds due to the introduction of European imperialism. The literature reiterates these notions, stating it is impossible to improve or understand the status of Māori health without acknowledging colonial history within Aotearoa (Family Violence Death Review Committee, 2020; Reid & Robson, 2007; Reid et al., 2019; Smith, 1999). The literature illustrates that key to colonisation are the racist ideologies and beliefs of white superiority, which creates and maintains a 'new history' that proclaim European colonisers as the arbiters of defining Indigenous identity and 'true' knowledge forms (Churchill, 1996; Reid & Robson, 2007; Reid et al., 2019; Smith, 1999; Waitangi Tribunal, 2019).

Māori customary forms of knowledge, including traditional healing practices and understandings of well-being were also regarded as primitive, 'myth' or superstition (Cowan, 1955; Reid & Robson, 2007; Smith, 1999; Smith, 2019). This was permitted through "the confiscation and misappropriation of Māori resources through colonial processes impacted both by historical trauma … and by impoverishment" as well as continual restrictive legislation and policies (Reid 2018, as cited in Waitangi Tribunal, 2019, p. 20; Reid & Robson, 2007; Harris et al., 2012). Through European imperialism and colonisation, Pākehā became the dominant colonising group that oversaw the systematic dispossession of resources from Māori, while instilling ideas surrounding the racial inferiority of Māori (Hamilton, 2019; Mikaere, 2011; Reid & Robson, 2007; Reid et al., 2019; Smith, 1999; Smith, 2004).

Imperialism provided the means through which concepts of what counts as human could be applied systematically as forms of classification, for example through hierarchies of race and typologies of different societies. In conjunction with imperial power and with 'science', these classification systems came to shape relations between imperial powers and Indigenous societies.

3.2. DEHUMANISATION

Colonisation and racism is underpinned by dehumanisation through the process of subjugation, where Indigenous peoples become 'Othered' and are fed negative narratives as being incapable of intellect or innovation, and being without imagination, unable to produce valuable things, and incompetent at land management, through the continual centralising of 'whiteness' as the pinnacle of the race hierarchy (Churchill, 1996; Reid & Robson, 2007; Reid et al., 2019; Smith, 1999; Walker, 2015). Smith (1999, p. 25) argues that:

> Imperialism provided the means through which concepts of what counts as human could be applied systematically as forms of classification, for example through hierarchies of race and typologies of different societies. In conjunction with imperial power and with 'science', these classification systems came to shape relations between imperial powers and Indigenous societies.

This is reaffirmed through Reid & Robson (2007, p. 4) who outline the concept of race as simplistic, based on the presumption of a hierarchy of peoples founded on a spectrum of "black to white, where white is proposed to be more advanced genetically, biologically, intellectually, socially, culturally and spiritually." Moreover, colonisation outcasted Māori with negative stereotypes encompassing laziness, primitivism, savagery as well as Māori language and knowledge systems, like te reo Māori as irrelevant. Thus, Māori became the 'other', were not 'normal', which empowered ideas of white supremacy ("Don Brash – Ragging on te reo," 2017; Cowan, 1955; "Māoris and gentlement", 1865; Matthews, 2018; Mikaere, 2011; Reeves, 1898; Reid et al., 2019; Taylor, 1868; Walker, 2015; Witherow, 2017).

Furthermore, colonisation introduced these new processes and created a new system that misappropriated sovereign rights and transferred power of resources from Indigenous peoples to colonisers. Colonisers were able to introduce new systems with new values, as well as construct and manage ways that resources could be obtained and redistributed, which was based on principles of race hierarchies favouring 'whiteness' (Gillon et al., 2018; Matthews, 2018; Reid & Robson, 2007; Reid et al., 2019). The literature thematically conveys that central to inequitable Māori health disparities underlying Aotearoa, are introduced beliefs, values and principles from colonisation that dehumanise Māori as inferior and are therefore, either not worthy to, restricted or are unable to receive quality health care (Gillon et al., 2018; Matthews, 2018; Reid & Robson, 2007; Waitangi Tribunal, 2019).

The Waitangi Tribunal (2019) states that Māori-led primary health care providers were concerned with their resourcing, role and their inability to exercise tino rangatiratanga. This encompasses designing and delivering Māori-led health care frameworks that best suit Māori communities. Governmental support through resources has been inconsistent or insufficient, which inhibits Māori-led primary health care delivery (Durie, 1998a; Waitangi Tribunal, 2019).

3.3. COLONISATION AND RACISM ON PRIMARY HEALTH CARE FRAMEWORKS

The Waitangi Tribunal (2019) investigates the ongoing connections between colonisation, racism and health through documenting witness testimonials that were given towards 'the Health Services and Outcomes Kaupapa Inquiry' (WAI 2575). This inquiry sought to provide a stage one report addressing two claims concerning the legislative and policy framework of the primary health care system within Aotearoa. The primary health care system's main objective is preventive treatment in order to decrease more serious concerns, which necessitate a higher level of care. The primary health care system refers to the services provided to the community, including general practitioners, nurses, pharmacists, dentists, counsellors as well as others. The report outlines the central allegation that the primary health care system has been unsuccessful in achieving Māori health equity and that this failure exemplifies the current framework being inadequate and insufficient (Waitangi Tribunal, 2019).

The Waitangi Tribunal (2019) states that Māori-led primary health care providers were concerned with their resourcing, role and their inability to exercise tino rangatiratanga. This encompasses designing and delivering Māori-led health care frameworks that best suit Māori communities. Governmental support through resources has been inconsistent or insufficient, which inhibits Māori-led primary health care delivery (Durie, 1998a; Waitangi Tribunal, 2019). Further testimonials attribute these issues to the cumulative effects of colonisation. The Waitangi Tribunal (2019) acknowledge that they were not required to establish a causative link between colonisation and the present-day disparities. However, they provide historical and socio-political examples surrounding the legacy of colonisation within the primary health care context, which is largely discrimination through institutional or systemic racism. The literature reaffirms these concerns and highlights past unsuccessful attempts of governments to rectify Māori health disparities and inequities (Mikaere, 2011; Smith, 1999; Waitangi Tribunal, 2019; Walker, 1990).

Throughout the COVID-19 pandemic within Aotearoa, Māori are openly cognisant of the institutional or systemic racism interplaying within the healthcare system and that this crisis could negatively exacerbate the quality of their primary health care delivery (Jones, 2020, as cited in Johnsen, 2020; Strongman, 2020; McLeod et al., 2020).

3.3.1. Racism, health and Māori COVID-19 responses

The literature (Durie, 1998a; Mikaere, 2011; Smith, 1999; Waitangi Tribunal, 2019; Walker, 1990) argues that governmental policies including, 'closing the gap' initiatives and working towards He Korowai Oranga do not remediate Māori health inequities, rather they amount to "mere rhetoric" (Waitangi Tribunal, 2019, p. 71). During the global pandemic of Coronavirus (COVID-19) within Aotearoa, the media discussed the potentially devastating impacts the virus could have on Māori communities, stating:

Personal and institutional racism is significant on both the determinants of health and on access to and outcome from health care itself and is associated with poorer health, including poorer mental health … Jones, like Ngata, worries that if Covid-19 does get into Māori and Pasifika communities, it could spread rapidly. Higher rates of cancer, diabetes, heart and kidney disease, and respiratory problems occur in those populations at a younger age. Overcrowded and multigenerational living situations could expose those higher risk people to transmission within their own bubble (Strongman, 2020, p. 1).

Additionally, the Māori National Pandemic response group, Te Rōpū Whakakaupapa Urutā, reported that the government had promised to release plans to enable support for Māori-led primary healthcare providers through financial assistance, as well as providing more healthcare workers. However, four weeks into the nation-wide lockdown process, the group had yet to receive this plan stating:

It provides high-level and aspirational statements and uses language and words that will resonate with Māori but offers no clear and tangible actions to bring to life the aspirations of the plan … Instead, it devolves almost all responsibility for the provision of Māori healthcare to whānau, hapū and iwi Māori—something that has been taking place already—while not expressing any expectation for mainstream healthcare to do their job in ensuring equitable healthcare for Māori (Jones, 2020, as cited in Johnsen, 2020, p. 1).

Throughout the COVID-19 pandemic within Aotearoa, Māori are openly cognisant of the institutional or systemic racism interplaying within the healthcare system and that this crisis could negatively exacerbate the quality of their primary health care delivery (Jones, 2020, as cited in Johnsen, 2020; Strongman, 2020; McLeod et al., 2020).

This can be attributed to the explicitly racist historical treatment institutionally and interpersonally of Māori during the introduction and spread of measles, whooping cough and small pox from Europeans (Hamilton, 2020) as well as the Spanish Influenza outbreak of 1918, where "Māori were seven times more likely than Europeans in New Zealand to die of Spanish flu" (Rice 2005, as cited by Breitnauer, 2020, p. 1). During these pandemics, Māori had limited or no access to quality health care and this was further worsened due to the aftermath of the New Zealand Land Wars. This had halved the pre-European Māori population as well as forced Māori to live in poverty due to land dispossession (Breitnauer, 2020; Hamilton, 2020).

Their practical actions revolved around the care for kaumātua, which included staying in contact through ringing them, giving weekly food parcels as well as providing them with updates on the latest COVID-19 information during the lockdown.

3.3.2. Asserting tino rangtiratanga through COVID-19

Before the New Zealand Government initiated the nationwide lockdown at the beginning of the COVID-19 pandemic, Māori moved quickly and began placing road checkpoints to protect their rohe and moved to establish an independent pandemic response group (Te Rōpū Whakakaupapa Urutā), with iwi organisations, Māori-led primary healthcare providers and community groups providing local responses to whānau needs.

Their practical actions revolved around the care for kaumātua, which included staying in contact through ringing them, giving weekly food parcels as well as providing them with updates on the latest COVID-19 information during the lockdown. These measures were implemented without governmental guidance and were established to safeguard their own Māori communities who were most vulnerable to COVID-19 (Castles, 2020; "How Māori across Aotearoa are working to stop the spread of Covid-19," 2020; Hurihanganui, 2020; Johnsen, 2020; Strongman, 2020; McLeod et al., 2020).

Whilst police worked with iwi on the road checkpoints, some members of the public did not refrain from racist behaviour, including accusing Māori of intimidation at road checkpoints. Complaints were made to local authorities, police and politicians, and the National Party sought legal clarity of the rights of Māori to hold checkpoints during the lockdown. Frontline Māori on these road checkpoints stated that they worked alongside police to conduct these checkpoints, gave brochures about COVID-19 and turned away non-essential travellers (Castles, 2020; "National wants clarity on checkpoint legality," 2020).

The particular highlighting of these road checkpoints exemplifies how one out of many Māori-led pandemic responses is used by politicians and the media to perpetuate racist notions. Such racist notions deflect issues surrounding the preventive healthcare of COVID-19 on Māori communities to politicising legalities, while the other discussions of healthcare, such as calling or giving food parcels to kaumātua, are neglected ("National wants clarity on checkpoint legality," 2020). Furthermore, these forms of preventative healthcare measures used by Māori communities demonstrates the assertion of tino rangatiratanga, as the media credit the reduced spread and low Māori numbers affected by COVID-19 as a direct result of road checkpoints, which closed tribal borders prior to the lockdown, as well as other independent Māori-led actions (Smith, 2020).

Mainstream media as well as the literature highlight the importance of recognising the effects of colonisation and racial discrimination on Māori health, which has been emphasised as paramount in iwi decision-making and protection strategies against COVID-19. However, the literature further points out the critical need for these phenomena to be monitored through research. Research within this area not only illustrates the impact of racism on the health of Māori, but also provides evidence of racism as a significant health determinant at a national policy level (Harris et al., 2006a; Harris et al., 2006b; Harris et al., 2012). Furthermore, the literature further highlights how colonisation is manifested by either institutional or systemic racism, as well as interpersonal or personally mediated racism through discrimination, which impacts on Māori access to quality primary healthcare (Barnes et al., 2013; Gillon et al., 2018; Jones 2020, as cited in Johnsen, 2020; Harris et al., 2012; Mikaere, 2011; Strongman, 2020; Waitangi Tribunal, 2019; McLeod et al., 2020).

4. Tools of racism

The literature conveys how four levels of racism utilise several tools that sustain inequity and inequality, which contribute towards Māori health disparities (Barnes et al., 2013; Gillon et al., 2018; Harris et al., 2012; Jones, 2000; Mikaere, 2011; Reid & Robson, 2007; Reid et al., 2019; Robson & Reid, 2001; Waitangi Tribunal, 2019). These tools encompass ideas of essentialism and biological determinism, which descend from concepts associated with the dehumanisation of Black, Indigenous and/or people of colour, (Gillon et al., 2018; Harris et al., 2012; Reid & Robson, 2007; Ryan, 1976; Valencia, 1997; Walker, 2015). These ideas of placing Māori into a race hierarchy as 'unfit' and inferior to Europeans interweaves with eugenics, which used scientific theory to legitimise racism and classify indigeneity (Carson, 2001; Gobineau, 1853; McConnochie et al., 1988; Smith, 2004; Walker, 2015). These race theories became the underlying current that perpetuated racism within Aotearoa by being enacted through legislation and policy. This has led to Māori being predisposed to substandard socio-economic conditions such as poorer housing, employment, access to quality healthcare and being discriminated against interpersonally (Harris et al., 2006a; Harris et al., 2006b; Harris et al., 2012; Reid & Robson, 2007; Waitangi Tribunal, 2019).

4.1. ESSENTIALISM AND BIOLOGICAL DETERMINISM

Essentialism and biological determinism stem from colonisation and use scientific knowledge to propel narrow notions of identity. These identities correspond to authenticity in relation to colonisers' interpretations of indigeneity as well as biologically determined differences between races (Gillon et al., 2018; Jones, 2000; Reid & Robson, 2007; Robson & Reid, 2001; Smith, 1999; Smith, 2004). The literature agrees that 'race' is a social construct and not a biological construct. However, racism sustains these lingering notions that 'race' is biologically determined for the maintenance of privilege surrounding the colonising dominant group. Race classification would eventually evolve its definitions to promote unequal outcomes for Māori (Jones, 2000; Gillon, et al., 2018; Harris et al., 2012; Liu et al, 2005; Paradies, 2006; Reid & Robson, 2007; Robson & Reid, 2001; Reid et al., 2019; Smith, 1999; Smith, 2004; Smith, 2012; Waitangi Tribunal, 2019).

One of the ways in which race classification evolved is through Māori being viewed within 'deficit theory' or 'victim blame' analysis (Reid & Robson, 2007; Ryan, 1976; Valencia, 1997; Walker, 2015). These theories created the illusion that Māori are to blame for the unequal health outcomes, due to "any mix of inferior genes, intellect, education, aptitude, ability, effort or luck" (Reid & Robson, 2007, p. 5). Reid & Robson (2007) argue that this narrative allows for the dominant racial group (Pākehā) to ignore institutional, structural and systemic bias through locating the 'problem' within Māori. Therefore, the narrative places the emphasis on Māori, rather than the outcomes of Pākehā who are never examined, thus never exposing the privilege of Pākehā (Reid & Robson, 2007; Reid et al., 2019; Fine et al., 2004).

4.1.1. Pākehā privilege and coping mechanisms

Mikaere (2011) examines Pākehā privilege through the complexities of colonial guilt, which can be exhibited using denial, appropriation of indigeneity or ignorance of race altogether. Mikaere (2011) and Jesson (1999) argue that these attitudes are a result of being dislocated from their cultural identities as settlers and due to the internalisation of racial supremacy, specifically white supremacy. These coping mechanisms allude to the idea of colonial amnesia (Jesson, 1999), in that colonising dominant groups, such as Pākehā:

> …desire to be cut off from their history as the descendants and inheritors of the privileges of the colonisers of Aotearoa. That many Pākehā would like such unpleasant matters to be forgotten or overlooked is undeniable (Mikaere, 2011, p. 102).

Mikaere (2011) also places the problem of racism back onto Pākehā through exploring a speech given by Dame Tariana Turia during her time as Associate Minister of Māori. This speech discussed the history and effects of violent trauma perpetrated on Māori due to colonial contact and behaviour (Turia, 2000).

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The literature conveys the uncomfortable truths surrounding racism within Aotearoa in that it is and has historically been used as a system of violence against Māori (Hamilton, 2019; Jesson, 1999; Mikaere, 2011; Reid & Robson, 2007; Reid et al., 2019; Turia, 2000; Smith, 2004). Reid et al (2019, p. 2) expand on the violent system of racism underpinned by the belief of racial hierarchies within the context of white[2] privilege visibility stating:

> Racism is so abhorrent and life-threatening that it is possible to lose sight of its real purpose, which is to deliver and maintain unearned privilege for groups constructed as superior within racism hierarchies. This privilege is so normalised that it is invisible to those who benefit from it, so much that even raising the possibility of unearned white privilege in discussions about racism can result in beneficiaries of white privilege exhibiting 'white fragility.' This fragility, often expressed as hostility, defensiveness or other emotions, derails constructive conversations to identify and name racism and privilege.

While Reid et al (2019) explores the relationship between health impacts, racism and colonisation through an international and Indigenous lens, this process of privilege can be contextualised within Aotearoa through Pākehā coping mechanisms surrounding the ongoing effects of racism and colonisation (Mikaere, 2011; Reid & Robson, 2007).

4.2. EUGENICS

> Gobineau uses the metaphor of the human body for a race; he describes some of the Polynesian and African races as "embryo societies" permanently arrested at that stage … the lowest race in Gobineau's scale belongs to Oceania, which "has the privilege of providing the most ugly, degraded, and repulsive specimens of the [black] race, which seems to have been created with the express purpose of forming a link between man and brute pure and simple" (Gobineau, 1853, p. 29; p. 107, as cited in Carson, 2001, p. 287).

The above excerpt shows harmful race theories that were covertly embedded within eugenics (Richardson, 2004; Smith, 2004). Eugenics was formulated by Francis Galton during the early twentieth century, proposing state-controlled reproduction, in "which steps would be taken to prevent the unfit from passing on their characteristics to future generations" (Bowler, 1990, p. 276). Eugenics was influenced by writings coinciding with the Enlightenment period, Imperialism and European colonisation (Bowler, 1990; Lange, 1999; Richardson, 2004; Smith, 2004).

2. Reid et al (2019) discuss the health impacts between colonisation and racism internationally and through an Indigenous scope using 'white' to denote the pinnacle of racial hierarchies. Within the context of Aotearoa, the term 'white' has been used interchangeably to reference Pākehā as they emulate the preferred racial hierarchy and are the dominant privileged group within Aotearoa benefitting from the ongoing effects of racism and colonisation (Mikaere, 2011; Reid & Robson, 2007).

Within the context of Māori and Aotearoa, Jackson (2003 as cited in Smith, 2004) and Smith (2004, p. 2) believe that eugenics simultaneously shaped and was shaped by colonisation and that Māori did experience racism institutionally through eugenics, arguing that "colonisation was in itself an assertion of eugenics, in that power was asserted over 'unfit' populations."

These writings include Gobineau's (1853) essay, entitled *The Inequality of the Human Races*, as well as *Origin of the Species* written by Darwin (1859). The literature states that eugenics is a classification system placing people into 'fit' or 'unfit' categories (Bowler, 1990; Richardson, 2004; Smith, 2004). These categories then extend into two further aspects: the elimination or exclusion of the 'unfit'; as well as the enhancement of the 'fit' (Smith, 2004).

Eugenics does not encapsulate just those that are seen as genetically undesirable, but it also targets those that are socially 'unfit'. This includes the poor, immigrants, physically and mentally disabled, Indigenous peoples, women, children, ethnic groupings, members identifying with the LGBTQA+ community and others (Carson, 2001; Reynolds,2003 as cited in Smith, 2004; Smith, 2004). Within the context of Māori and Aotearoa, Jackson (2003 as cited in Smith, 2004) and Smith (2004, p. 2) believe that eugenics simultaneously shaped and was shaped by colonisation and that Māori did experience racism institutionally through eugenics, arguing that "colonisation was in itself an assertion of eugenics, in that power was asserted over 'unfit' populations." Quiggin (2003 as cited in Smith, 2004, p. 7) reinforces this within the context of legislation and cultural influences, stating:

> The methods used to discourage reproduction include sterilization, contraception, institutionalisation, forced relocation and migration policies and laws. It was believed that by encouraging desirable traits and discouraging undesirable traits, a more fully functioning society could be created. The kinds of traits that were considered desirable were heavily influenced by cultural assumptions.

Quiggin (2003 as cited in Smith, 2004) illustrates that eugenics can be a violent manifestation of institutional or systemic racism as well as interpersonal racism through legislation and health.

The violence of eugenics can be articulated throughout the history of Aotearoa, being propagated by politicians, doctors, academics and organisations such as Plunket. During the 1920s, national sterilisation was considered for those who were mentally or physically ill and viewed as 'unfit' (Fleming, 1981; Harvie, 2018; McClure, 2017; Smith, 2004; Stace,1998; Writes, 2019). Some of the mainstream media and literature do not mention Māori, or state that Māori were not systematically targeted through eugenics, and try to claim that eugenics aligned with Māori political thinking and worldviews (Brookes, 2018; Harvie, 2018; McClure, 2017; Writes, 2019). However, other literature disputes this (Durie, 1998b; Lange, 1999; Richardson, 2004; Smith, 2004). The literature points to the overlapping ideologies of eugenics and colonisation, including the systematic dehumanisation of Indigenous peoples, classified as inferior and 'unfit' (Durie, 1998b; Richardson, 2004; Smith, 2004). Moreover, eugenics can be argued as being masked behind imperialistic actions of Māori depopulation (Durie, 1998b; Lange, 1999; Richardson, 2004; Smith, 2004).

4.2.1. Eugenics, the 'depopulation of Māori' and assimilation

The depopulation of Māori is expressed through accounts such as Darwin (1835, as cited in Lange, 1999) during his visit to Aotearoa in 1835. Darwin uses biological evolution, specifically 'the survival of the fittest' theory attributed as social Darwinsim to legitimise and justify Māori depopulation. Darwin (1835, as cited by Lange, 1999, p. 57) stated:

Wherever the European has trod, death seems to pursue the aboriginal ... The varieties of man seem to act upon each other; in the same way as different species of animals — the stronger always extirpating the weaker.

Māori depopulation encompassed assimilation in that Māori would be integrated within the Pākehā population or would die. Richardson (2004) and Durie (1998b) further reiterate how eugenics was exhibited through the depopulation of Māori, and ultimately, interconnects with colonial thinking through citing other accounts. This includes views from the politician Dr. Isaac Featherston in 1846, who stated:

Barbarous and coloured race must inevitably die out by mere contact with the civilised white; our business therefore, and all we can do is smooth the pillow of the dying Maori race (1846, as cited in Durie, 1998b, p. 30)

The depopulation of Māori was observed through both the political and medical establishment of hospitals within Aotearoa and through its European physicians with Salesa (2001, p. 20) arguing that "whether they were in hospitals or outside of them, the doctors who treated or otherwise dealt with Maori were a part of colonial expansion." The literature discusses that prior to colonisation, Māori were described as being muscular, well-built and a healthy people, rendering the introduction of British physicians and health care as "almost useless" (Nicholas, 1817, as cited in Kingi, 2011, p. 92). This is contradictory to the aforementioned colonial eugenic literature categorising Māori as 'unfit' (Darwin, 1835, as cited in Lange, 1999; Featherston, 1846 as cited in Durie 1998b; Richardson, 2004; Smith, 2004). Some of the literature acknowledge that European settlers were partially concerned with the consequences of colonisation resulting in Māori population decline. However, imperial expansion and colonisation still continued despite other harmful Indigenous examples internationally (Salesa, 2001; Waitangi Tribunal, 2001). Masters-Awatere et al. (2019) states that the assimilation of Māori was evident through the establishment of hospitals within Aotearoa imposing British health system models, which sought to gain "an influence over the Native mind, for the alleviation of suffering" (Fitzgerald to Earl Grey, 1855, as cited in Salesa, 2001, p. 17).

The literature argues that colonisation through assimilative policies, legislation and institutions forced Māori to be social dependent on Pākehā. This social dependency arguably links to eugenic notions cultivating Māori inferiority. These notions were then further affirmed through racist tools such as biological determinism, essentialism and colonial paternalism (Department of Social Welfare, 1986; Family Violence Death Review Committee, 2020; Kingi, 2011; Masters-Awatere et al., 2019; Smith, 2004; Waitangi Tribunal, 2001). The use of colonial paternalism automatically positioned European superiority within health, justice and welfare systems. This process interconnects with current issues of institutional or systemic racism, which simultaneously created the idea that there was a need for European institutions, while obstacles were initiated that restricted Māori to its access (Barton, 2008; Masters-Awatere et al., 2019; Family Violence Death Review Committee, 2020; Smith, 1999).

Masters-Awatere et al (2019) exemplifies this through the exploration of hospitals within Aotearoa being both assimilative as well as restrictive in access for Māori. These restrictions encompassed the location of hospitals being situated in heavily concentrated Pākehā settlements, as Māori mainly lived in rural localities, as well as including user-pay hospital service fees. These issues made it difficult for Māori to access hospital health care (Barton, 2008; Masters-Awatere et al., 2019; Waitangi Tribunal, 2001). This process furthered the disproportion of Māori being met with ineffective health, justice and welfare systems (Department of Social Welfare, 1986; Family Violence Death Review Committee, 2020; Kingi, 2011; Masters-Awatere et al., 2019; Waitangi Tribunal, 2001). Through the political and medical establishment of the hospital system, Māori depopulation was seen as inevitable and unavoidable as a result of assimilation (Masters-Awatere et al., 2019; Salesa, 2001). Furthermore, the popular eugenic thinking of the time was applied to the depopulation of Māori (Lange, 1999; Salesa, 2001).

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4.2.2. Eugenics and colonisation

Smith (2004) and Richardson (2004) examine the connections between eugenics and colonisation. Smith (2004, p. 12) discusses how Māori were impacted by eugenics through colonisation, stating:

> Māori, like Indigenous Peoples in colonised lands who suffered colonisation, were cast as the 'unfit'. The specific ways in which Māori were seen as unfit can be traced through many ways, including the labelling and classifying as primitive, as a lower social order, as physically and mentally less able, as socially deficient and uncivilised. One example was the way in which Māori (and Indigenous) were seen as weaker species when introduced diseases such as measles, chickenpox, T.B took a huge toll on the population.

Smith (2004, p. 8) further points out that "numbers of Māori were being made wards of the state and being placed into mental homes and borstals" alluding to Māori being also cast as 'socially unfit' and thereby, covert targets of eugenics. Richardson (2004) argues that eugenics became unpopular due to the rise of fascist politics and Smith (2004) refers to the Holocaust and the racism of Nazism. The literature theorises that eugenic thinking was historically disassociated within Aotearoa by Pākehā, due to its alignment with the violence of white supremacy and racism exemplified during World War II (Richardson, 2004; Smith, 2004).

4.2.3. Eugenics, racism and violence

The distancing between eugenics and racism within Aotearoa colonial history relates to past and current Pākehā coping mechanisms of settler guilt exhibited through denial, appropriation or ignorance (Mikaere, 2011). These coping mechanisms are conveyed in current literature discussing Aotearoa eugenic history as not targeting Māori; attempts to appropriate Māori worldviews as similar to eugenics; or by not exploring the overlap between eugenics and the racism underpinning colonisation (Brookes, 2018; Harvie, 2018; McClure, 2017; Writes, 2019). In other cases, eugenics, racism and white supremacy within Aotearoa are overt through The National Front, a white supremacist organisation (MacDonald, 2018; MacDonald, 2019). Smith (2004) discusses how eugenics has been used by this extremist group to characterise Māori as inferior, as well as advocate for anti-immigration and pro-white policies. The Dominion Movement are a youth-oriented white supremacist organisation within Aotearoa, gaining traction during 2017 and 2018 amongst an international rise and mobilisation in far-right groups[3]. Although the Dominion Movement does not directly link to eugenics, their ideologies interconnect, revealing "ideas of white supremacy, white nationalism and male superiority" (Enoka, 2018, p.1).

3. The rise in international far-right groups advocating for white supremacy refers to the Charlottesville 2017 rally, as well as the association with supporters of the Trump government (MacDonald, 2018; MacDonald, 2019).

The literature discusses how the theoretical foundations of eugenics surrounding race theory align with principles of imperialism and colonisation, thereby making eugenics an introduced and violent concept (Durie, 1996b: Lange, 1999; Richardson, 2004; Smith, 2004).

The violence of eugenics and racism can be exemplified by these extremist groups, as these ideologies have fuelled violence towards Māori, leading to past leaders of The National Front admitting to the bombing of marae in South Auckland and other violent racist attacks (Beckford, 2019; Hamilton, 2019; MacDonald, 2018; Smith, 2004). The literature discussing the mobilisation of these extremist groups are dated a year prior to the Al Noor Mosque Terror Attacks in Christchurch (Enoka, 2018; MacDonald, 2018), which illustrate the ignorance of Pākehā to the potential violence fuelled by racism. The Islamic Women's Council and its national co-ordinator, Anjum Rahman, have reported long standing Islamophobic threats to the police, as well as made governmental submissions to advocate for state protection against the rise of emboldened white supremacist groups. These public submissions and reports were ignored and continually dismissed by the state until after the attacks, with mainstream media ("Islamic women tell Royal Commission warnings were dismissed," 2020; MacDonald, 2019; McRae, 2019; Tolley, 2019) reaffirming this by reporting that the Security Intelligence Service (GCSB) had released "10 years of annual reports and ministerial briefings and the threat of right nationalists is never specifically mentioned" (Patterson, 2019, p. 1).

The National Front and the Dominion Movement have released public statements that distance themselves from the Al Noor Mosque Terror Attacks of Christchurch, with both of their online presence and recruiting campaigns becoming dormant (Beckford, 2019; Hamilton, 2019; MacDonald, 2019). The literature discusses how the theoretical foundations of eugenics surrounding race theory align with principles of imperialism and colonisation, thereby making eugenics an introduced and violent concept (Durie, 1996b: Lange, 1999; Richardson, 2004; Smith, 2004). Health impacts as a result of racist violent events, and eugenics within the context of Māori as well as colonial violence on Māori, are further research areas that need to be examined (Family Violence Death Review Committee, 2020; Smith, 2004).

The census measured race using fractions of blood adopted from the idea that Māori were either 'less than half caste', 'half castes' and 'full bloods' (Cormack, 2010; Gillon et al., 2018; Robson & Reid, 2001).

4.3. BLOOD QUANTUM

Essentialism, biological determinism and eugenics have influenced how Māori identity has been categorised by Pākehā within Aotearoa through blood quantum (Borrell, 2005; Cormack, 2010; Leoni et al., 2018). Blood quantum is defined as "where one's ethnic identity is determined by arbitrary measures of biology, usually fractions of blood" (Gillon et al., 2018, p. 128). The literature provides an historic and socio-political overview of blood quantum as a method of assimilationist interests that aligned with Victorian societal ideals. These ideals in conjunction with quantifying indigeneity through blood quantum, sought to reduce data on the Indigenous population over time to negate the obligations of the state to Indigenous peoples (Bond et al, 2014 Collins, 2012; Cormack, 2010; Gillon et al, 2018; Reid, 1997; Reid & Robson, 2007; Trask, 1999).

Blood quantum was integrated within Aotearoa legislation from the 1920s to the 1950s, focusing on colonial definitions of Māori identity through population census data. The census measured race using fractions of blood adopted from the idea that Māori were either 'less than half caste', 'half castes' and 'full bloods' (Cormack, 2010; Gillon et al., 2018; Robson & Reid, 2001). As a result of assimilationist politics, Māori who were considered 'less than half' were encouraged to enrol into the general electoral roll (Gillon et al., 2018; Metge, 2013; Pihama, 1993; Robson & Reid, 2001). The literature highlights that over time, the reclamation of Māori identity through active resistance has proven that the use of blood quantum as a measurement of Māori identity is problematic and outdated. However, the literature also examines how blood quantum was and still is a tool of racism and colonisation (Borrell, 2005; Cormack, 2010; Gillon et al., 2018; Leoni et al., 2018; Reid, 1997; Reid & Robson, 2007; Robson & Reid, 2001).

The literature acknowledges that Māori identity has officially shifted from race measurements, specifically blood quantum, to self-assigned identification within Aotearoa. However, blood quantum as well as other essentialist ideals are pervasive amongst Māori identity today, feeding into dangerous concepts of not being 'Māori enough' (Bevan, 2000; Collins, 2004; Cormack, 2010; Gillon et al., 2018; Leoni et al., 2018). Gillon et al. (2018, p. 128) reinforces how dangerous blood quantum is for Māori identity, explaining:

> Blood quantum perpetuates ideas of authenticity and fragments Māori ethnicity into fractions. This restricts Māori identity to essentialised ideas of how much is required to be authentic. Māori who are socially assigned as Pākehā are often questioned about "how much" Māori they are so others can evaluate whether they are "Māori enough."

These queries of authenticity regarding Māori identity through blood quantum is a tool of racism that can impact on Māori health and well-being (Barnes et al., 2018; Durie, 1998a; Gillon et al., 2018).

They explore how Māori are forced to perform authenticity through Pākehā interpretations of Māori identity, but conclude that Māori realities are diverse and that there is "no single Māori reality" (Leoni et al., 2018, p. 519).

4.4. SOCIALLY ASSIGNED IDENTITY

The literature reaffirms the links between blood quantum and authenticity of Māori identity to various negative health impacts of internalised racism (Barnes et al., 2018; Cormack et al., 2013; Gillon et al., 2018; Harris et al., 2013). These negative health impacts include cultural shame, denigration as well as a personal rejection of Māori identity (Barnes et al., 2018). While the transition of measuring Māori identity from blood quantum to self-assigned identity has occurred officially through population census data, these ideals are still ingrained within Aotearoa society. The repercussions are expressed through interpersonal or personally mediated racism probing Māori of 'how much Māori' they are (Bevan, 2000; Collins, 2004; Cormack, 2010; Gillon et al., 2018). These experiences are documented within the concept of socially assigned ethnicity and its connection to health within Aotearoa (Cormack et al., 2013; Gillion et al., 2018; Harris et al., 2012; Reid et al., 2016). Socially assigned ethnicity refers to the ways in which people make assumptions about a person's ethnicity or race without discussion with them, sometimes implicitly and prior to knowing this person's actual ethnicity or race (Gillon et al., 2018; Jones et., 2008; MacIntosh et al., 2013; Roth, 2016; Vargas et al., 2015).

These studies explore how 'whiteness' is proven advantageous and protective for individuals who both self-identify and are socially assigned as Pākehā by Pākehā, rather than Māori (Gillon et al., 2018; Reid et al., 2016). These individuals experienced better socio-economic status and less exposure to interpersonal or personally mediated racism (Cormack et al., 2013; Gillon et al., 2018; Harris et al., 2013; Reid et al., 2016). Gillon et al. (2018) explores the experiences and well-being of Māori who are socially assigned Pākehā using three models outlined by Roth (2016). These three models involve having an observed race, a reflected race and phenotype[4]. Gillon et al. (2018) argues that the mechanisms of socially assigned ethnicity and 'whiteness' is complex and nuanced. They further contextualise this within colonisation, racism and health through briefly exploring how racialised societies are introduced, constructed and maintained by the dominant group.

Leoni et al. (2018) discusses the stereotypical pressures placed on Māori to exhibit an 'imagined' Māori identity, which interconnects with socially assigned identity discourse. They explore how Māori are forced to perform authenticity through Pākehā interpretations of Māori identity, but conclude that Māori realities are diverse and that there is "no single Māori reality" (Leoni et al., 2018, p. 519). Both Gillon et al. (2018) and Leoni et al. (2018) touch on contemporary insecurities of Māori identity expressions due to racism. Leoni et al. (2018) examines these insecurities through five areas that continually challenge Māori to perform 'authenticity'. These five areas include: having to visit ancestral homelands (tūrangawaewae); liking certain foods associated with Māori including seafood (lifestyle); being adept at performing Māori arts (kapa haka); fluency in te reo Māori; as well as having 'brown skin' (physical appearance).

4. These three models dissect how socially assigned ethnicity works from others. An observed race is the race that "others believe you to be" (Roth, 2016, p. 1315). Reflected race refers to how individuals believe they are classified by others. Phenotype denotes physical appearance such as eye colour, hair colour or texture, skin colour as well as others (Gillon et al., 2018).

4.4.1. Colourism, light skinned privilege and Māori

Gillon et al. (2018) and Leoni et al. (2018) examine the intricacies of phenotype or physical appearance, specifically through skin colour in that racism has cultivated the narrative that 'brown skin' equates to authentic 'Māori' identity. The literature further contextualises this within the frame of colourism or light skinned privilege, which is the differential treatment based on skin colour and is studied within the United States (Gillon et al., 2018; Keith & Monroe, 2016). The literature acknowledges the existence of colourism as well as light skinned privilege interplaying with Māori (Gillon et al., 2018; Jones et al., 2008; Reid et al., 2016). However, Gillion et al. (2018, p. 136) argues that these concepts are based on the "phenotypical closeness to whiteness providing access to aspects of societal advantage," illustrating that there are clear distinctions between Pākehā privilege, light skinned privilege and light skinned advantage.

The literature further explores how Māori who are aware of light skinned Māori privilege have used this to disrupt racism from occurring (Bevan, 2000; Kannen, 2008). Gillon et al. (2018) and the literature further reiterate that light skinned advantage can be accumulated, but that overall, despite light skinned privilege, racism, colonisation and trauma still permeate all Māori lives and well-being (Jones et al., 2008; Reid et., 2016). The nuances of Māori light skinned privilege and advantage, identity as well as its impacts of Māori health are growing research areas that require further examination.

5. The questioning of measurements and racism health impacts

The quote invoked by Emery-Whittington and Te Maro (2018) at the beginning of this literature review reveal possible solutions for rectifying racism impacts on health within Aotearoa. Emery-Whittington and Te Maro (2018) use personal and professional insights of racism on health within their field, but also look towards its connection with colonisation in order to decolonise and learn from historical trauma. Moreover, the excerpt at the beginning of this literature review proposes returning to customary Māori knowledge as a way to decolonise and heal from racism. The literature outlines that the complexities of solving racism surround using Kaupapa Māori health models, but are primarily embedded within its use and inequitable distributions of power (Family Violence Death Review Committee, 2020; Harris et al., 2012; Pack et al., 2016; Paradies, 2006b; Smith, 1999).

5.1. RACISM AND POWER

Smith (1999, p. 24) discusses power in relation to history and Indigenous being 'Othered', stating:

> History is also about power. In fact history is mostly about power. It is the story of the powerful and how they became powerful, and then how they use their power to keep them in positions in which they can continue to dominate others. It is because of this relationship with power that we have been excluded, marginalized and 'Othered'. In this sense history is not important for [I]ndigenous peoples because a thousand accounts of the 'truth' will not alter the 'fact' that [I] ndigenous peoples are still marginal and do not possess the power to transform history into justice.

Smith (1999) and Paradies (2006b) maintain that power is at the crux of racism and oppression to exist and continue. Furthermore, they argue that in order to decolonise and dismantle racism that the tools within the current constructions of power created by the dominant group, cannot do this. The literature argues that racism is an application of power and resources, which creates inequitable and unequal Māori health outcomes. This idea suggests that power redistribution can work towards remediating racism (Harris et al., 2006a; Paradies, 2006b; Robson & Reid, 2007; Reid et al., 2019; Smith, 1999). Jackson (2002) suggests framing this as arising Māori health needs, due to Māori rights being breached. This re-framing acknowledges the power imbalances, consequently from colonisation, that give rise to Māori health inequalities as well as steer away from victim blaming Māori for ongoing negative health outcomes (Robson & Reid, 2007).

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5.2. CRITIQUE OF RACISM MEASUREMENTS, APPROACHES AND FRAMEWORKS

The literature examining the health impacts of racism on Māori question the measurements designed within their own studies as well as critique the existing power structures that enable racism to occur (Harris et al., 2006a; Harris et al., 2006b; Harris et al., 2012; Robson & Reid, 2007; Paradies, 2006b). Paradies (2006b) implies that previous studies through the disciplines of psychology, sociology and other social sciences focused solely on the causes of racism, examining its theoretical concepts, which was separate from health research at the time. Paradies (2006b) combines the interdisciplinary theoretical conceptualisations of racism by characterising this as a determinant of health. This characterisation is used as a framework through two approaches. The first approach is subjective, looking at the experience of racism, known as perceived racism. The second approach is objective, which explores the indirect inference of racism through an experiment or through observation.

Paradies (2006b) conveys how both of these approaches have different limitations and explains that due to the complexities of racism operating through its four levels (see Table 1) that often, subjective approaches (perceived racism) are utilised. The objective approach can lead to incomplete coverage and may not adequately explore the interactions between racism and other societal variables (Bonilla-Silva, 1997). However, the objective approach can be appropriate for measuring racism that is neither perceivable or expressive through institutional or systemic racism as well as internalised racism (Paradies, 2006b). The literature using these two approaches on the health impacts of racism on Māori acknowledge the limitations of their frameworks. For example, self-reported interpersonal, discrimination and perceived racism are primarily researched (Harris et al., 2006a; Harris et al., 2006b; Harris et al., 2012; Paradies et al., 2008; Reid et al., 2016). However, other literature examines the other four levels of racism as well as the structural influences of racism that contribute to being health determinants (Mikaere, 2011; Reid, 1997; Reid & Robson, 2007; Waitangi Tribunal, 2019). Within Aotearoa, most of the literature uses qualitative approaches (Barnes et al., 2013; Mayeda et al., 2014; Huria et al., 2014; Pack et al., 2015; Waitangi Tribunal, 2019) as well as quantitative methods to study racism as a health determinant on Māori (Ben et al., 2017; Harris et al., 2006a; Harris et al., 2006b; Harris et al., 2018; Paradies et al., 2015; Paradies, 2006a).

Māori experience negative feelings such as sadness, belittlement and anger, which harmfully contribute towards having poorer emotional, spiritual, mental and physical health (Barnes et al., 2018; Gillon et al., 2018; Harris et al., 2006a; Harris et al., 2006b; Harris et al., 2012; Harris et al., 2018; Paradies et al., 2008; Reid et al., 2016; Reid & Robson, 2007; Waitangi Tribunal, 2019).

5.3. RACISM HEALTH IMPACTS ON MĀORI

The literature shows an overwhelmingly similar message that all four levels of racism are health determinants for Māori and that consequently, Māori experience negative feelings such as sadness, belittlement and anger, which harmfully contribute towards having poorer emotional, spiritual, mental and physical health (Barnes et al., 2018; Gillon et al., 2018; Harris et al., 2006a; Harris et al., 2006b; Harris et al., 2012; Harris et al., 2018; Paradies et al., 2008; Reid et al., 2016; Reid & Robson, 2007; Waitangi Tribunal, 2019). Table 1[5] shows the intricacies of how the four levels of racism impact on health both internationally and nationally. Within the context of Aotearoa, the literature provides the specific clinical health impacts on Māori (Barnes et al., 2018; Gillon et al., 2018; Harris et al., 2006a; Harris et al., 2006b; Harris et al., 2012; Paradies et al., 2008; Reid et al., 2016; Reid & Robson, 2007; Waitangi Tribunal, 2019).

Clinical health impacts and medical conditions as a result of racism on Māori, and the related literature, include the following:

- Psychological distress (Barnes et al., 2018; Gillon et al., 2018; Harris et al., 2018);
- Feelings of low value associated with Māori culture (Barnes et al., 2018; Gillon et al., 2018);
- Aggression and pessimism (Barnes et al., 2018);
- Clinical depression (Harris et al., 2006a);
- Hypertension (Harris et al., 2006a; Harris et al., 2006b);
- Lower self-rated health linking to cardiovascular disease and blood pressure (Harris et al., 2006a; Harris et al., 2006b; Harris et al., 2018);
- Poor physical health (Harris et al., 2018);
- Poor self-rated general health and self-rated physical functioning (Harris et al., 2018);
- Mental disorders (Harris et al., 2018); and
- Racial discrimination experiences within primary patient care, particularly for lower breast and cervical cancer screening coverage of Māori women (Harris et al., 2018).
- Harris et al (2018, p. 2) attribute "both the experience of interpersonal racism and socioeconomic position (as a marker of [institutional or] systemic racism) have been shown to contribute to health inequities between Māori and European ethnic groups."

5. See Table 1: Levels of racism, on page 16

The Waitangi Tribunal (2019) interviewed the Director-General of Health, Dr. Ashley Bloomfield, who acknowledged that racism is a health determinant for Māori. Bloomfield (2018 as cited in Waitangi Tribunal, 2019) also highlighted statistical Māori health inequities cited from the Ministry of Health's Tatau Kahukura: Māori Health Chart Book (Ministry of Health, 2015) during his testimonial. While the Waitangi Tribunal (2019) and Bloomfield (2018 as cited in Waitangi Tribunal, 2019) do not make clear connections between racism and the Māori health disparities he cites, it can be implied that racism, along with colonisation, is a critical contributing factor to the negative clinical health outcomes for Māori. Bloomfield (2018 as cited in Watiangi Tribunal, 2019, pp. 23-24) presents the following Māori health disparities (see Table 2).

5.3.1. Table 2. Māori health disparities and outcomes

Year	Health impact
2013	5 percent of Māori lived in decile 10[6] (most deprived) areas compared with 6.8 percent of non-Māori.
2013-2014	Māori adults were almost twice as likely as non-Māori adults to have experienced racial discrimination in their lifetime.
Unknown	Gap in life expectancy at birth between Māori and non-Māori is 7.3 years for males and 6.8 years for females.
2010-2012	Ischaemic heart disease is the leading cause of death for Māori, except for Māori females, which is lung cancer and this is the most common cause of death.
2010-2012	Māori experience disproportionate cancer rates, having a higher risk of dying from their cancer than non-Māori (17 times as likely). Māori adults aged 25 years and over had significantly higher cancer registration rates than non-Māori adults for total cancers. The total-cancer mortality rate among Māori adults is more than one-and-a-half times as high as that among non-Māori adults.
2010-2015	There are screening programmes for both breast and cervical cancer. For both of these programmes, coverage rates to 31 March 2015 were lower for Māori than for non-Māori.
2010-2012	The total cardiovascular disease mortality rate among Māori was more than twice as high as that among non-Māori.
2010-2012	Rheumatic heart disease mortality is over five times that of non-Māori. However, rheumatic heart disease hospitalisation is almost six times higher than non-Māori
2010-2014	Māori aged 5–34 years were more than twice as likely as non-Māori in the same age group to have been hospitalised for asthma.

6. The Ministry of Health neighbourhood depraviation index is measured from 1, the least deprived, to 10, most deprived.

Year	Health impact
2010-2012-2014	The chronic obstructive pulmonary disease (COPD) mortality rate among Māori aged 45 years and over is almost three times that of non-Māori in the same age group. Māori aged 45 years and over had a COPD hospitalisation rate over four times that of non-Māori in the same age group.
2014	88.9 percent of Māori children at the age of eight months had completed age-appropriate immunisations, compared with 91.9 percent of total New Zealand children. At the age of two years, the coverage rates were 91.9 percent for Māori children and 92.8 percent for total New Zealand children.
2010-2012	The SUDI or the sudden unexplained death of infant rates among Māori infants is nearly five times as high as that among non-Māori infants.
2013-2014	Māori babies were significantly less likely than non-Māori babies to have been solely breastfed when they were three months (13 weeks) old and six months (26 weeks).
2010-2012-2014	Māori children and adults had significantly higher unintentional injury hospitalisation rates (2012-2014), higher mortality rates than non-Māori (2010-2012).
2010-2012	Amenable mortality rates among Māori aged 0–74 years were almost two-and-a-half times as high as those among non-Māori at the same age group.
2012-2014	Ambulatory-sensitive hospitalisation (ASH) rates among Māori aged 0–74 years were almost twice as high as those of non-Māori at the same age group.
Unknown	Māori are more likely than non-Māori to access services later and to experience serious disorders and/or co-existing conditions.
2013-2014	Māori adults are less likely than non-Māori adults to report having seen a general practitioner (GP) in the last 12 months.
2013-2014	In comparison to non-Māori, Māori children and adults are more likely to report cost as a barrier to seeking health care from a general practitioner (GP). It is assumed that a lack of transport is likely to be a barrier to accessing general practitioner (GP) or after-hours services for Māori than non-Māori.
2013-2014	Due to cost, Māori children and adults were more likely than non-Māori children and adults to have reported not collecting prescriptions.

Table 2: Māori health disparities and outcomes

Table 2 illustrates the cited statistical information (Ministry of Health, 2015) read by Bloomfield (2018 as cited in Waitangi Tribunal, 2019, pp. 23-24) during his testimonial. This information has also been integrated within Table 1. However, Table 2 shows specifically Māori health disparities and acknowledges that while racism is not stated as an explicit health determinant of these disparities, that the wider context of colonisation and its use of racism is perhaps the cause of these (Waitangi Tribunal, 2019).

6. Summary

This literature review examines the health impacts of racism on Māori within the context of Aotearoa. This literature review first examined international literature that explores racism as a health determinant, then localised the overview of this research within Aotearoa on Māori. Racism is underpinned by imperialism and colonisation, which negatively affects Māori health and well-being. The literature provides a historical, socio-political and intergenerational summary of both the causes of racism as well as its influences on Māori health through clinical. The literature highlights that colonisation and racism is on-going, and illustrates the need for further research in examining racism as a health determinant for Māori. Additionally, other research areas include comprehensively examining specific health conditions due to racism, as well as the nuances of socially assigned identity for Māori.

7. Glossary

Aotearoa	New Zealand
hapū	cluster of extended families, descended from an eponymous ancestor
He Korowai Oranga	Ministry of Health's Māori health strategy
iwi	tribe, nation
kaikiri	racism
kapa haka	Māori performing arts group
kaumātua	elders
Kaupapa Māori	a philosophical doctrine, incorporating the knowledge, skills, attitudes and values of Māori society
mihimihi	greetings
rohe	tribal areas
Tatau Kahukura	Ministry of Health's Māori health chart book
te reo Māori	the Māori language
Te Rōpū Whakakaupapa Urutā	Māori National Pandemic response group
Te Tiriti o Waitangi	The Treaty of Waitangi
tino rangatiratanga	self-determination, sovereignty
tūrangawaewae	place of belonging
whakatika	to correct
whānau	extended family

8. Definitions

ableism	prejudice, power and discrimination against people with disabilities or people who are perceived to have disabilities.
ageism	prejudice, power and discrimination over a person against people who are old.
Al Noor Mosque	based in Christchurch (Ōtautahi) and the site of the terror attacks in March, 2019.
anti-Blackness	a specific type of racism that only affects Black people. Indigenous and people of colour can perpetuate as well as profit from anti-Blackness.
anti-immigration	views, processes and actions that are against immigration through its policies and legislation. Having prejudice, power and discrimination against immigrants. These views coincide with white supremacy.
assimilation	when a minority racial or ethnic group becomes integrated into the dominant racial or ethnic group through strategic legislation and policy to decrease the minority racial or ethnic group.
biological determinism	a colonial tool used in eugenics where hereditary physical and mental traits measure the humanity and differences between white people and BIPOC.
BIPOC	acronym for Black, Indigenous and/or people of colour.
Black	used to describe a racial group of people having dark skin and/or of African descent.
blood quantum	colonial measurement of assessing Indigenous identity through units of blood.
classism	prejudice, power and discrimination over people based on their social class.
colonial paternalism	view, processes and actions from colonisation where the dominant racial group through governments, local bodies and non-government agencies decide on issues that have an impact on Indigenous communities.
colonisation	an expression of imperialism exploiting and subjugating BIPOC through military force as well as oppressive policies and legislation.
coloniser/s	the dominant European group subjugating and exploiting BIPOC for resources and labour.

colourism	differential treatment of a racial group based on physically presenting characteristics such as, skin colour, facial features and hair texture. These physically presenting characteristics are measured against race hierarchies.
deficit theory/ victim blame analysis	places the blame on BIPOC for poor health outcomes (and other outcomes) due to their perceived inferiority.
dehumanisation	the process of subjugation, where BIPOC are deprived of positive human rights and are not viewed as human by the dominant racial or ethnic group.
discrimination	the actions or practices that express racism in covert and overt ways that produce negative impacts for BIPOC and maintain power for others.
Dominion Movement	white supremacist organisation based in Aotearoa that is youth-oriented and mobilises far-right groups.
Enlightenment period	philosophical and intellectual movement propagated by imperialism focusing on the advancement of science.
essentialism	BIPOC identities are to correspond authentically to colonisers' interpretations of BIPOC.
ethnicity	a group with shared ancestry, culture and/or nationality.
eugenics	classification system placing people into 'fit' or 'unfit' categories through biological and scientific reasoning of the Enlightenment period.
fatism	prejudice, power and discrimination against people who are fat and who do not present thinness.
heterosexism	prejudice, power and discrimination that favour same sex relationships.
historical trauma (also intergenerational trauma)	sites of struggle and harm passed down through the generations, which are due to cultural, social and political events.
imperialism	on-going global European expansion through enforcing European ideals, power and influence through exploitative means of acquiring wealth and capital.
Indigenous	a racial and ethnic group of people being the original inhabitants of a region and/or country.

institutional racism (systemic racism)	legislation, policies, practices, material conditions, processes or requirements that maintain and provide avoidable and unfair inequalities and access to power across racial groups. This level of racism operates without identifiable perpetrators but through practices as well as legal and policy frameworks that govern societal institutions
internalised racism	belief and acceptance of negative stereotypes, attitudes, values or ideologies by members of a disadvantaged or stigmatised racial group, regarding the inferiority of one's own racial group.
interpersonal racism (personally mediated racism)	interactions with people that continue to perpetuate unfair and avoidable inequalities within racial groups through overt and covert discrimination.
LGBTQIA+	acronym for the lesbian, gay, bisexual, trans, queer, intersex, asexual and more communities.
light skin advantage	BIPOC with light skin using this physical characteristic to access resources, such as quality healthcare.
light skinned privilege	access to resources and institutions, such as quality healthcare being afforded to BIPOC with light skin rather than BIPOC with dark skin.
oppression	a layered system of prolonged disadvantage.
othered	ascription applied to a group of people who do not fit into societal norms and a process of negating an individuals or groups humanity.
Pākehā privilege (also white privilege)	the dominant and colonising group within Aotearoa being unable to recognise that through subjugating Māori, have unfair power, access and allocation of resources as well as capital.
People of Colour (POC)	used to describe a racial and/or ethnic group of people having brown and black skin as well as facial features and hair texture associated with characteristics outside of whiteness.
power	underpins racism and is the expression and practices of harmful stereotypes, prejudice and discrimination. Having the majority allocation of resources and capital.
prejudice	conscious and unconscious bias as well as preconceived opinions without reason or experience.
privilege	special rights, advantages and/or immunities given to a group of people. The on-going maintenance of the dominant group having access to all of the resources and capital.

pro-white	view, processes and actions that support white people. This coincides with white supremacy and white fragility, but can be considered a reaction to the perceived societal and inter-personal threat to white people.
race	a group that share physically defined characteristics that are socially and externally assigned, such as having a certain skin colour, facial features or hair texture used to categorise people for harm, subjugation and exploitation.
race hierarchies (or race classification)	an organisation of races that are measured across a spectrum with 'whiteness' viewed as the superior and 'blackness' viewed as the inferior. The humanity of BIPOC are measured along this spectrum using their physically presenting characteristics.
racism	an organised, hierarchal and stigmatisation grouping system, based on racial inferiority to whiteness. Prejudice, power and discrimination over a person based on their race.
right nationalists/ Far right groups	groups that support pro-white and anti-immigration policies as well as white supremacy.
sexism	prejudice, power and discrimination over people based on their gender.
socially assigned identity	ways in which people make assumptions about a person's ethnicity or race without discussion with them, sometimes implicitly and prior to knowing this person's actual ethnicity or race.
societal racism	The maintenance of negative stereotypes, attitudes, values, beliefs or ideologies that perpetuate the inferiority of a particular disadvantaged racial group, which are upheld by the dominant racial group.
The National Front	white supremacist organisation based in Aotearoa.
white fragility	when constructive discussions of race from BIPOC to white people are derailed through hostility, defensiveness, appropriation and/or ignorance.
whiteness/white people	a group sharing physical racial characteristics of light skin, facial features and hair texture that are allocated the most resources in society and are the dominant group through imperialism. This term has been used interchangeably with Pākehā in Aotearoa.
white supremacy	the belief that whiteness and white people are the superior race.

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Conceptual design

We use the term rangatiratanga to describe well-being for an individual, whānau, hapū, iwi. We also use this term to describe leadership and self-determination, and along with the prefix of 'tino', rangatiratanga was also used in the second article of Te Tiriti o Waitangi. Defining racism as anything that is an attack on our rangatiratanga makes this definition uniquely Māori. The mamae we feel when exposed to racism resonates intergenerationally, and each time we experience racism, the mamae ripples outwards. With this in mind, the conceptual design for this Report is based on addressing the past, present and future mamae; and reclaiming rangatiratanga.

The arapaki (or tukutuku, woven panels) design used throughout the Report has various meanings, but exemplifies the kaokao pattern. The pattern is presented within the Whanganui mūmū arapaki that are displayed at the Whanganui Regional Museum. These arapaki were woven by kuia at Pūtiki Wharanui Pā in time for the opening of the museum extension in 1968, which included the Māori Court, Te Āti Haunui-a-Pāpārangi (Horwood & Wilson, 2008).

As mentioned earlier, there are various meanings for the kaokao pattern. The downwards slanting chevron is representative of a warrior, in the haka stance, readying themselves for protection and, if needed, attack. In the context of this Report, the kaokao signifies strength and integrity, and protecting our rangatiratanga. The descendants of Hinengākau from the upper reaches of the Whanganui River view kaokao as the armpit, which is symbolic of physical strength, and the repeating pattern represents a group of people swinging their arms as they march forth in unison (Jones, 1975). Within Whanganui, and according to Te Otinga Waretini (1990), the kaokao pattern was used on takapou wharanui (matrimonial woven 'mats'), used for those of high rank, and woven using human hair. The tapu associated with takapou wharanui is therefore apparent, and was used to help with conception and ensure a long line of succession.

Meanings associated with the kaokao pattern are complementary to our definition of racism and at the same time, the design suggests that there are several ways to address attacks on our rangatiratanga. But as rangatiratanga asserts, we will decide how that will be best achieved to address the mamae of our tūpuna, for us, and for our uri. Kaokao, therefore, is a symbol of change, and encourages us to move forward with the original intentions of our tūpuna who signed Te Tiriti o Waitangi, in our hearts and minds.

The cover image of Te Tiriti o Waitangi on *Whakatika: A Survey of Māori Experiences of Racism*, is used because accordingly, our rangatiratanga is protected by law. However, we are very clear as to our history, and we know that we have not been afforded the protection that was guaranteed under Te Tiriti o Waitangi. The colouring of Te Tiriti o Waitangi, as it has faded, is used throughout the publication, as a reminder that, while the original colour may have faded, the intents, desires and beliefs that our tūpuna had in signing it are stronger than ever and will not wane.

The purple colour is borrowed from the skin of the Ōwairaka kūmara, the most recognisable kūmara variety. The growing, harvesting, eating and ensuring there is enough left to grow again the following season was done with much ceremony, exactness and tapu ("Kumaras and kumara magic", 1962). Rongomātāne, atua of the kūmara, was acknowledged throughout the various stages of growing, harvesting and partaking in kūmara. Kūmara was the most important cultivating crop for our tūpuna and at harvest time, was used in festivities amongst whānau, hapū and iwi ("Kumaras and kumara magic", 1962).

The journey towards whakatika, or making things right, will require commitment and hard work from all, including Māori, Pākehā, government agencies, retailers, educators, health professionals and others, if racism is to be eliminated. A lofty goal, but a worthy one.

SMITH (1999) AND PARADIES (2006B) MAINTAIN THAT POWER IS AT THE CRUX OF RACISM AND OPPRESSION TO EXIST AND CONTINUE. FURTHERMORE, THEY ARGUE THAT IN ORDER TO DECOLONISE AND DISMANTLE RACISM THAT THE TOOLS WITHIN THE CURRENT CONSTRUCTIONS OF POWER CREATED BY THE DOMINANT GROUP, CANNOT DO THIS.

Te Atawhai o Te Ao
Independent Māori Institute for Environment & Health