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Published online: 27 Sep 2016.

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COMMENTARY

Health activism against barriers to indigenous health in Aotearoa New Zealand

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ABSTRACT

Racism and government policies of colonisation and assimilation contribute to the disproportionate burden of disease carried by indigenous people globally. In colonial contexts such as Aotearoa New Zealand, these inequities are routinely monitored but governments believe economic growth and better lifestyles will resolve the issues. Stop Institutional Racism (STIR), a group of health activists, is challenging this dominant discourse and building a boutique social movement to transform racism within the New Zealand public health sector. Central to the work of STIR is partnership between indigenous and non-indigenous practitioners underpinned by Te Tiriti o Waitangi – the founding document of the colonial state of New Zealand. This paper reflects on STIR organisational processes and political achievements to date. We have worked towards mobilising the public health sector, re-energising the conversation around racism and strengthening the capacity and evidence base of the sector around key sites of racism and anti-racism praxis. This paper will be of interest to others within the global public health community who are looking for new collective ways to organise and challenge entrenched inequities.

Introduction

Inequities of all kinds are a defining issue in the contemporary era (OECD, 2014; Pickett & Wilkinson, 2011), manifest in multiple political, economic and humanitarian crises. Health disparities have been a focus for major institutions (Centers for Disease Control and Prevention, 2013; Commission on Social Determinants of Health, 2008) and the status of indigenous people is a particular concern in colonial states (Paradies, 2016; Reading & Wien, 2009). The United States, Canada, Australia and New Zealand show long-standing differences in life expectancies of 4–15 years between indigenous and settler peoples and entrenched inequalities across all causes of mortality and morbidity when controlled for age and class (Ajwani, Blakely, Robson, Tobias, & Bonne, 2003; Bramley, Hebert, Tuzzio, & Chassin, 2005; Greenwood, De Leeuw, & Reading, 2015).

The persistence of disparities suggests the failure of conventional public health approaches with indigenous communities. There are significant modifiable systemic barriers to indigenous health (O'Sullivan, 2015) arising particularly from institutional racism, a legacy of colonisation (Mowbray, 2007). In these colonial, neoliberal market economies, structural change is always pushing against the tide, but evidence and ethics call us to prioritise indigenous health.

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In health economics a systematic review by Angell, Muhunthan, Irving, Eades, and Jan (2014) confirmed that interventions targeting better indigenous health outcomes were consistently cost-effective. A study by Mills, Reid, and Vaithianathan (2012) quantified the five-year cost of health inequalities between Māori (indigenous) and non-Māori children at $NZ62 million. Investment in the health of indigenous people, who carry the highest burden of disease, can lift the health status of an entire population (Wilkinson & Pickett, 2011). Championing indigenous health is also consistent with public health principles of social justice and human rights, making it an imperative for public health (Llewellyn, 2015).

Starfield (2011) argues inequities are built into health systems and maintained by power differentials between dominant and marginalised groups. Given the entrenched nature of these disparities, health activism involving planned actions to provoke change, redistribute power, enhance social justice and advance health equity is called for (Smylie & Firestone, 2016). Braveman (2014) defines health equity as a commitment to eliminate inequities in health and the drivers of inequities.

Health activism takes an overt political focus using both research and creative, unconventional methods to challenge the status quo (Laverack, 2013). Examples include the Act Up campaigns of the 1990s (Colvin, 2014) and the global fight against big tobacco (Thomson, Dey, & Russell, 2015).

Our health activism group, Stop Institutional Racism (STIR) is striving to remove barriers to indigenous well-being in Aotearoa New Zealand by mobilising the public health sector, re-energising conversations around racism, building the evidence base and strengthening the capacity of public health professionals in this arena. This paper presents aspects of our processes, achievements and challenges as an exemplar to share our learnings and build links internationally.

New Zealand context

New Zealand is a small (4.5 million), geographically isolated island nation in the south Pacific, with a British colonial cultural infrastructure imposed by force on Māori in the decades following the 1840 signing of the colonial state's founding document Te Tiriti o Waitangi. Despite the promises of mutually beneficial partnership that were agreed to, it is a colonial society built on breaches of Te Tiriti that saw mass migration from the mid-nineteenth century by British settlers who asserted their independence through a brutal racial civil war (Belich, 1986; Byrnes, 2006). Settler society prospered, developing an economy powered by illicit acquisitions of resources from Māori coupled with exploitation of their labour (Ballara, 1986), undermining Māori culture, economy, philosophy and spirituality in the process (Hill, 2004; Poata-Smith, 2004).

Māori resistance has been resolute, and achieved government acknowledgement of health as a cultural treasure under Te Tiriti as well as recognition of the historical injustice of breaches of Te Tiriti. Despite the hard-won gains since the 1980s, public institutions in New Zealand have been critiqued comprehensively for their mono-culturalism and failure to engage with the values and perspectives of Māori (Smith, 2012; Walker, 1990). Came (2012, p. ii) argues that institutional racism, "pattern of differential access to material resources and power by race which advantages one sector of the population while disadvantaging another", has become normalised in the New Zealand health system.

For decades public health leaders have attempted to disrupt this mono-culturalism and used their influence to secure various policy commitments to promote and protect Māori health. Seminal among these was a 1988 memo from the Director General of Health George Salmond, which required the sector to honour the founding document of New Zealand, Te Tiriti o Waitangi. A series of constructive policy documents followed, including *He Korowai Oranga* (Ministry of Health, 2014) and *Whānau Ora* (Whānau Ora Taskforce, 2009).

The *New Zealand Health Strategy* (NZHS) (Ministry of Health, 2016a), the current health policy framework in New Zealand, does not embrace this progressive tradition. The central tenet of the NZHS reflects the neoliberal ideology that economic rationalism will 'trickle down' to eliminate disparities in all areas including health. Core assumptions, such as the level-playing field and consumer choice, call for citizens to take responsibility for their lifestyles and health outcomes. There is no consideration of the colonial devastation which has excluded Māori from the prerequisites of health, addressing the social
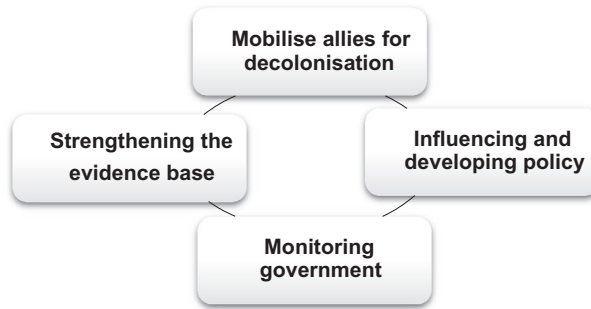
determinants of health, health as a human right or health equity. In the NZHS public health receives only 4.5% of Vote Health (Ministry of Health, 2016b) despite the potential enormous gains in social, cultural and fiscal terms through the prevention of morbidity and reduction of mortality among Māori.

Stop Institutional Racism

The existence of health inequalities with their links to institutional racism within the administration of the health sector is a breach of Te Tiriti o Waitangi that motivates STIR. Our network engages in activist scholarship traditions (Came, MacDonald, & Humphries, 2015) in pursuit of health equity through challenging power relations under which racism has been allowed to flourish. From this standpoint the promotion of Tiriti-based practice (Health Promotion Forum, 2000) is one pathway to end institutional racism within New Zealand.

STIR emerged in the context of a politically assertive Māori health sector formed in the 1990s that critiqued the racism of established systems. Key research studies including the *Hauora* series (Pōmare, 1980; Pōmare & De Boer, 1988; Pōmare et al., 1995; Robson & Harris, 2007), *Decades of Disparities* (Ajwani et al., 2003) and theoretical frames such as *Te Whakaruruhau* (Ramsden, 2002) and *Te Pae Mahutonga* (Durie, 1999) provided evidence and arguments. Came's (2012) research added to the evidence base supporting Māori claims of injustice and wide dissemination of findings raised awareness about racism in the public health sector.

In a turn to action, the initial vehicle was the New Zealand Public Health Association (PHA) where a remit was passed in 2012 which led to the formation of a Special Interest Group on Institutional Racism, later named STIR. The group consists of Māori and Tauiwi (non-Māori) practitioners and scholars from across New Zealand, with a core of around a dozen and a network of over 100 associates in an e-network. Members contribute according to their capacity, circumstances and expertise under co-leadership by Heather Came (Tauiwi) and Grant Berghan (Māori). Many have long-standing professional relationships with one another which allow STIR to work organically by consensus decision-making. Annual reports are used as an accountability mechanism back to the sector (Berghan & Came, 2015; Came, 2014).

STIR does not receive public health funding or indeed much funding of any kind[1] and most of the work done is mahi aroha (volunteered) which critically ensures independence. Public health providers and the practitioners that work within them in New Zealand are bound by contracts that restrict their ability to engage in advocacy directed at the government (Ministry of Health, 2003). STIR therefore provides a rare collective platform to challenge racism.

Political contributions

To challenge racism, Came and McCreanor (2015) argue a system-based approach is required. As depicted in Figure 1, STIR has developed a multi-level strategy to that effect. The elements are

(i) mobilising allies for decolonisation, (ii) influencing and developing policy, (iii) monitoring government and (iv) strengthening the evidence base. The following section reflects on STIR's contributions in these key areas.

Mobilise allies for decolonisation

To end racism, Paradies et al. (2009) and Jones (2003) suggest a critical mass of support is needed. Work by Denson (2009) and Paradies et al. (2009) reinforce the efficacy of strengthening political and cultural competencies to enhance anti-racism work. Mobilising allies or associates is a priority for STIR and we have led more than 50 presentations and workshops to build what Came and da Silva (2011) call political competencies. These trainings are framed around health equity, anti-racism praxis, Te Tiriti o Waitangi and/or decolonisation.

Since 2014 over 1500 people have attended these workshops, of whom more than 100 have become STIR associates. In addition to standard one or 2 hour sessions, half-day or full-day workshops, STIR is also involved in master classes and other anti-racism work, supporting those already engaging in anti-racism action to reconnect with like-minded peers to refresh and extend skills.

Initial outcomes from this decolonisation work include growing a network of professionals prepared to identify and call out racism within their spheres of influence. They can respond to calls to action, disseminate information and mobilise others in collective actions. Overall this is enabling anti-racism activism and our current message to STIR supporters is every conversation that challenges racism is a positive contribution.

STIR is hosting an inaugural symposium in September 2016 as an opportunity for associates and core members to meet face to face and strengthen planned efforts to end racism. International allies from Australia and United States are offering their solidarity and participation at this event to help expedite Jones (2016) and Labonté's (2008) challenge to make such conversations global. During the symposium, as part of our commitment to evaluation of outcomes, a mapping process will identify gaps and opportunities to strengthen the current work.

Influencing and developing policy

In 2013 key public health entities – PHA, Health Promotion Forum (HPF) and New Zealand College of Public Health Medicine – endorsed a policy statement agreeing to take action to eliminate institutional racism (Came & Doole, 2014a). Drafted by STIR this policy committed each organisation to take specific evidence-based actions to end racism. These included developing a systemic approach, promoting informed debate and championing anti-racism in international forums and we are keen to follow up on actions by the organisations. In 2015, the PHA agreed to a STIR remit to re-engage with Te Tiriti o Waitangi and is due to release an interim plan to become a Tiriti-based organisation as the HPF has already done (Simpson, 2015).

STIR makes submissions on health policy to government agencies to raise issues for debate and to influence policy, for example, around proposed changes to how public health services were purchased (Came & Doole, 2014b). We advocated for the development of kaupapa Māori service specifications to displace bio-medical-framed contracting processes that had previously been identified by Came (2012) as sites of racism. A kaupapa Māori specification would reflect a Māori worldview and understandings of hauora (health). Sector allies were mobilised for robust conversations with decision-makers about the alternative possibilities.

Monitoring government

Reid and Robson (2007) argue that Māori as treaty partners have the right to monitor the government. Inspired by this resolute standpoint, STIR has instigated a longitudinal study of public health providers' experiences of their government funders. Preliminary results of the second iteration of a five-year cycle this nation-wide survey shows significant variance in funder behaviour with generic as against Māori providers (Came, 2013). This variance includes shorter contract timeframes and more intense contract monitoring.

As STIR's capacity expands, we intend to take up Daes (2009) challenge to utilise United Nations covenants, in particular the (UN, 1966) *Convention on the Elimination of All Forms of Racial Discrimination* (CERD). Through the CERD monitoring processes, the New Zealand Government incorporates endorsed recommendations into the national human rights action plan (Human Rights Commission, 2015) enabling tracking of government performance.

Strengthening the evidence base

With a small research team, STIR has been pursuing research funding, conducting research and publishing around racism and Tiriti-based practice since its formation. The published papers and associated presentations include a mixture of empirical and conceptual pieces that have refocussed the conversation around racism and anti-racism praxis within the local public health sector.

Writing is frequently collaborative with a mixture of academics and senior practitioners. Those newer to research are supported by older hands, building capability. Cultural and political advice is freely exchanged. Several STIR members are now pursuing postgraduate study around aspects of racism and Māori public health. One student for instance is identifying sites of institutional racism to target future interventions.

STIR is producing a series of papers from new research around how senior health promotion practitioners apply the articles of Te Tiriti o Waitangi. These papers are innovative, as in contrast to much of the literature, their focus is on the application of Te Tiriti and they will inform a training programme to support practitioners extend their competencies.

Discussion

STIR's story is that of an emerging social movement with ambitious plans and strong commitment to mobilising colleagues to enable decolonisation training to leverage engagement from our modest base. We aim to influence the funding, planning and policy environment through monitoring government agencies and building an empirical evidence base to inform the work. A priority moving forward is to quantify the outcomes, planned and serendipitous of this work. Inaction in an environment where institutional racism is flourishing enables racism.

Members have professional relationships and much experience with many public health policy makers, funders and senior managers from decades of professional collaboration. These important relationships and long institutional knowledge bases position STIR well to encourage and challenge colleagues to address racism within their spheres of influence. Have we got the infrastructure to end racism? As Margaret Mead (cited in Lutkehaus, 2008, p. 261) is quoted as saying: "never doubt that a small group of thoughtful, committed citizens can change the world; indeed it's the only thing that ever has".

Note

1. STIR has received two small research grants from Auckland University of Technology and been commissioned by a range of organisations to run anti-racism training.

Acknowledgements

Disclosure statement

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