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ORIGINAL ARTICLE

Using vignettes about racism from health practice in Aotearoa to generate anti-racism interventions

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Abstract

Racism is a key modifiable determinant of health that contributes to health inequities in Aotearoa and elsewhere. Experiences of racism occur within the health sector for workers, patients and their whānau (extended family) every day. This paper uses stories of racism from nurses – reworked into vignettes – to examine the dynamics of racism to generate possible micro, meso and macro anti-racism interventions. A critical qualitative design was utilised, informed by kaupapa Māori approaches. The five vignettes in this paper were sourced from a pair of caucused focus groups with nine senior Māori (Indigenous peoples of Aotearoa) and Tauiwi (non-Māori) nurses held in Auckland Aotearoa in 2019. The vignettes were lightly edited and then critically analysed by both authors to identify sites of racism and generate ideas for anti-racism interventions. The vignettes illustrate five key themes in relation to racism. These include (i) mono-cultural practice, (ii) everyday micro-aggressions; (iii) complexity and the costs of racism, (iv) Pākehā (white settler) privilege and (v) employment discrimination. From analysing these themes, a range of evidence-based micro, meso and macro-level anti-racism interventions were derived. These ranged from engaging in reflective practice, education initiatives, monitoring, through to collective advocacy. Vignettes are a novel way to reveal sites of racism to create teachable moments and spark reflective practice and more active engagement in anti-racism interventions. When systematically analysed vignettes can be utilised to inform and refine anti-racist interventions. Being able to identify racism is essential to being able to effectively counter racism.

KEYWORDS
advocacy, anti-racism, focus groups, health practice, New Zealand, racism, reflective practice, Vignette

1 | INTRODUCTION

Racism is about power and prejudice and often involves both overt and extreme acts. It also involves small mundane brutalities. White people's privilege often makes it difficult for them/us to notice or identify racism. Racism has a geographic specificity (Dunn & Geeraert, 2003). In the ongoing colonial context of Aotearoa it manifests as mono-culturalism; a legacy of European invasion, exploitation and appropriation (Mutu, 2019). It marginalises Māori (Indigenous peoples of Aotearoa) knowledge, beliefs and cultural practices and centres European preferences (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1988). Racism can manifest as action or inaction in the face of need; it can be unintentional or

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wilfully enacted. The negative outcomes occur either way aggregate over lifetimes and aggregating across populations as racial disparities in crucial domains of life: health, education, income, inclusion and social status.

Three key types of racism are discussed in this paper: (i) personally mediated, (ii) cultural and (iii) institutional racism. Personally mediated racism is exemplified in prejudicial attitudes, beliefs, norms, behaviours and practices such as verbal abuse and micro-aggressions (Jones, 2000). Cultural racism manifests as a racist ideology that can shape meaning and knowledge, and frame policy (McCreanor, 2009). Cultural racism is often fuelled by deficit discourses perpetuated by the mass media; it can manifest as monocultural practice. Institutional racism is about structures and systems and represents '...a pattern of differential access to material resources, cultural capital, social legitimation and political power that disadvantages one group while advantaging another' (Came et al., 2019, p. 62).

Racism is widely recognised as a modifiable determinant of health (Paradies et al., 2015). It has been linked to violence, compromised access to health care, employment, housing, chronic stress and poor mental health (Alang, 2019). Racism has long been recognised as a breach of Te Tiriti o Waitangi; the founding document of the colonial state of New Zealand. Recently, key agencies in the health sector (the Ministry of Health and the Health Quality and Safety Commission) and the Waitangi Tribunal (2019) report, are recognising the challenge of institutional racism in the health sector. The Waitangi Tribunal is a permanent judicial mechanism for hearing and settling alleged breaches of Te Tiriti o Waitangi.

Given the geographic specificity of racism (Dunn & Geeraert, 2003) localised solutions are required to address the systemic problem of racial discrimination in all its forms. Upholding Te Tiriti o Waitangi has always been a multi-level strategy to disrupt racism within the health system in Aotearoa (Berghan et al., 2017). Some argue that the development of Māori health providers in the 1990s was an expression of tino rangatiratanga (absolute authority) and a strategy to uphold Te Tiriti and disrupt racism.

Kawa whakaruruhau or cultural safety developed by Irihapeti Ramsden (2002) has been influential in promoting engagement with Te Tiriti o Waitangi. It has become embedded in tertiary curriculum and competency documents encouraging health practitioners to learn about their culture and bring an analysis of power to their engagement with patients, whānau (extended families) and communities. It has been a global contribution from Aotearoa to the world (Wepa, 2015). Likewise, Linda Tuhiwai Smith's (2012) writings on decolonisation have been instrumental in shaping how we systematically divest colonial power from structures, systems, and knowledge in a multiplicity of domains.

The majority of anti-racism interventions have been ad hoc localised education interventions with limited evaluation of the effectiveness of this work (Rankine, 2014). Often anti-racism work in health is workplace specific or discipline specific and championed by a charismatic individual and not been sustainable. The 'war stories' of anti-racism are rarely written up so in short there is a paucity of research on anti-racism generally and within the health sector in Aotearoa (Margaret, 2002).

What is known about this topic?

- Health practitioners experience and witness racism everyday within the health system.
- Existing anti-racism efforts within the New Zealand health sector have been largely ad hoc and ineffective.
- Racism has a geographic specificity, which requires localised solutions.

What this paper adds?

- Vignettes of racism from health practice can be used to support practitioners to identity sites of racism.
- This analysis of the vignettes can then be used to generate localised micro, meso and macro-level anti-racism interventions.
- Mobilising health practitioners to engage in anti-racism within their sphere of influence could be a systemic response to racism in all its forms.

To localise anti-racism interventions health practitioners, need to be able to identify racism and generate anti-racism interventions. They need to know when and how to intervene. Using data from part of a wider study into anti-racism, this paper examines how vignettes can be used to identify local sites of racism and generate evidence-based anti-racism interventions.

2 | MATERIALS AND METHODS

Vignettes are short scenarios, which allow the study of perceptions, beliefs and attitudes. They have been traditionally used in qualitative research to allow sensitive topics to be explored and influential variables to be elucidated (Hughes, 1998). Vignettes have also been used in health professional education (Hooper, 2014) to enhance understanding of clinical situations by providing access to patient's voice.

The vignettes in this paper were part of material gathered from a pair of caucused focus groups with senior Māori and Tauiwi (non-Māori) nurses in September 2019 at Auckland University of Technology in Aotearoa (Kidd et al., 2020). Participants were purposively recruited through the professional networks of the researchers to ensure information rich cases through social media and email. Four Tauiwi and five Māori nurses, were recruited to focus groups facilitated by (HC, SH and TM). Two participants were male the others female. The inclusion criteria included nurses with at least seven years of professional nursing experience.

Participants were asked peer-reviewed indicative questions about anti-racism praxis. Sessions were opened and closed with a karakia (blessing), recorded, transcribed and participants were able to review the transcripts. Focus groups lasted three hours including whanaungatanga (active relationship building). Relevant ethical committee approval was obtained from the institutional body (AUTEC).

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The research team's conduct and practice were also informed by the kaupapa Māori ethical framework Te Ara Tika (Hudson, Milne, Reynolds, Russell, & Smith, 2010).

The vignettes were selected from the rich data set as they reflected a cross section of racism experienced by nurses within the sample. The vignettes were lightly edited for clarity and pseudonyms introduced. Two authors (HC and JK) reviewed the vignettes and, drawing on their respective lived experience of racism and longstanding involvement in anti-racism generated evidence-based anti-racism interventions pitched at micro, meso and macro levels.

The Māori and non-Māori authors are all critical scholars and have close associations with the health sector.

3 | FINDINGS

The selected vignettes illustrate key themes in relation to racism. These include (i) mono-cultural practice, (ii) everyday micro-aggressions; (iii) complexity and the costs of racism, (iv) Pākehā (white settler) privilege and (v) employment discrimination.

3.1 | Vignette #1 – Mono-cultural practice

> *I had this young [Māori] guy, Rangi, who had a lot of complaints about his involvement with the mental health services. He explained everything in relation to Te Ao Māori (the Māori world). In his initial assessment he said he'd like to put his wairua (Māori spirit) out on the table and let them analyse it from all sides. The way he describes things was taken as evidence of his psychosis. I think he probably had psychosis but not to the level they thought. He described everything through metaphor. He had never once had a cultural support person nor was ever directed to Māori mental health services. He talked about only ever seeing white doctors.*

Wairua is central and essential to holistic wellbeing (Marsden, 2003). While a complex and culturally embedded concept, wairua is somewhat aligned with Western notions of spirituality or the soul but also encompasses the life force and the interconnectedness of all living entities (Valentine et al., 2017). It is unacceptable from a Māori worldview to not consider wairua when engaging in treatment planning.

Ideally when accessing health services Rangi should have had the option of working with someone with the same cultural background and/or someone with dual clinically and culturally competencies (Jansen et al., 2008). Despite the Ministry of Health's (2018) long stated commitment to growing the Māori workforce, Māori remain proportionally under represented across all key health disciplines (Waitangi Tribunal, 2019). Racism in the 'mainstream' schooling system and the Academy continue to present significant barriers to the achievement of equitable educational outcomes, which impacts on the quantity of Māori graduates (McAllister et al., 2019).

This vignette shows the practitioners' limited engagement with Te Ao Māori illustrated by their misuse of the request by Rangi to engage at a wairua level and their further misunderstanding of his use of metaphor. The health professionals not only have exposed their mono-cultural practice but have also been failed by curriculum designers of their academic qualifications, their tertiary teachers, the registration body of their profession, their line manager, senior colleagues and mentors, all of whom could have intervened.

3.2 | Vignette #2 – Everyday micro-aggressions

> *We just did some focus groups recently and one of the women was saying that when she goes to see her specialist he can never say her name. He literally never calls her by her name, but when she goes with her Pākehā friend, the specialist goes "oh hello Julie." So her name is [Mere] which is a really simple Māori name but he never calls her by her name. That really annoyed her.*

Micro-aggressions are commonplace verbal or behavioural indignities that communicate derogatory inflections, slights and insults towards marginalised groups (Sue, 2010). Alang (2019) argued poor treatment and micro-aggressions by health practitioners and institutions impact on health behaviours including future decisions about seeking treatment. Mispronunciation of names is a common micro-aggression (Pérez, 2007) which is dismissive, uncaring and culturally disrespectful, acting as a barrier to building an effective clinical relationship. Not attempting to pronounce a patient's name, as in this vignette, is equally problematic.

Micro-aggressions have a compounding effect on the health of those targeted. In colonial contexts Indigenous peoples are often forced to navigate the intergenerational impacts of the historic trauma of colonisation (Reid et al., 2014). The old adage 'sticks and stones may break your bones, but names will never hurt you' is inaccurate. Over time micro-aggressions have a biological effect on the person being targeted. Geronimus (1992) describes this effect as 'weathering', literally the premature aging or sickening of the body of the person/people targeted by racism.

3.3 | Vignette #3 - Complexity and the costs of racism

> *We had [Hirini] recently, who has spina bifida. He was 20 years old. Hirini has lost practically all function to one limb and so he's falling over all the time. He came in with this massive graze. [It was] just gross. I asked, "Why haven't you had the surgery?." He goes, "Oh they won't. The neurosurgeon said he will no longer accept referrals for me." I'm like, "Why not?" And Hirini said, "Because my family used to be homeless. We were always moving in and out of DHB (district health boards) areas, so*

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we didn't have an address to send letters to. Every time we had an appointment, we weren't there. So they said, "You've DNA'd (did not attend) too many times so you're never allowed to have surgery." Hirini ended up like getting septic arthritis from a fall and was in the hospital for several weeks.

Māori often live in circumstances that include significant health risks. This is a legacy of colonisation and the impact of systemic racism within the education, criminal justice and employment systems (Peters & Christensen, 2016). This has cascading effects with the average Māori household income in 2013 being $22,500 (Statistics New Zealand, 2013). This is significantly below the current living wage ($46,500) (Living Wage Aotearoa New Zealand, 2017), which represents the real costs of essential family needs including energy, health, communication and education costs. Public policy needs to re-orientated so Māori enjoy equitable access to the determinants of health.

Many Māori receive inadequate access to health care. Using the New Zealand health survey data, Harris et al. (2019) have argued that racism, enacted by health professionals, contributes to differential access to, and quality of, healthcare. They see this as a major driver of ethnic health inequities. Alang (2019) maintains structures such as gender, gender identity, sexual orientation, education, socioeconomic position, and disability status are also linked to unmet need.

3.4 | Vignette #4 - Pākehā privilege

Our service has a contract to provide nursing cover into a Kura Kaupapa (Māori immersion school) attached to a marae (Māori meeting place). It is 100% Te Reo (Māori language) speaking and the only nurse they'll accept is someone who's can speak Te Reo fluently. So, the nurse discovered that the health needs in the school are massive. They identified the needs and went to the DHB (district health board) and said, "We need you to better resource our service so we can have more Te Reo speaking nurses." The DHB said, "Thank you for identifying the health needs we'll get our Pākehā public health nurses to come in." The Kura Kaupapa say, "That's not what we want." So even when the need is identified by the community the intervention ends up being decided upon by a Pākehā structure.

The Waitangi Tribunal (2019) found a significant pattern of underfunding of Māori health services. In 2015/16 Māori providers received only 1.86% of Vote Health (Ministry of Health, 2017). This occurred despite Maori population levels being at 15%, and the disproportionately high Māori burden of disease (Marriott & Sim, 2014; Statistics New Zealand, 2013). A nationwide survey of public health providers by Came et al. (2017) identified inconsistent treatment of Māori health providers by Ministry of Health and DHB funders.

This vignette shows a funder disrespecting the core values of a Kura Kaupapa school by sending in non Te Reo speaking staff. After identifying unmet health needs the funder, invested in their own service, rather than investing in the existing Māori provider, invested additional resources in their own service. This speaks to the inherent conflict of interest within DHBs that are both a funder and provider of health services. Similar conflict of interests and examples of Pākehā privilege have been identified in the work of Came (2012) which examined institutional racism within policy making and contracting practices. Privilege is the other side of racism as when one group is being advantaged another is being disadvantaged.

At no point in this vignette is Te Tiriti o Waitangi, the founding document of the colonial state of New Zealand, upheld. This is a specific requirement of the health sector through the *New Zealand Public Health and Disability Act 2000*. It is unclear whether an equity analysis (Ministry of Health, 2004) has been undertaken or whether government procurement policy has been followed (Ministry of Economic Development, 2007).

3.5 | Vignette #5 - Employment discrimination

Māori often don't make it through the interview process. So we got a collective of us senior level nurses and we interviewed those ones that didn't get through. What it demonstrated was that we would have hired them. So why didn't they? This provided evidence to the leadership and so we were able to demonstrate that there was some level of bias.

In 2018, Māori nurses made up 7.4% of the nursing workforce (Waitangi Tribunal, 2019). Likewise, in 2010, Māori made up 8.3% of senior managers across the public sector (State Services Commission, 2010). These figures do not match the ethnic proportion of Māori in the population, nor does they reflect the government's stated commitment to equal opportunities practices (State Services Commission, 1997). The Human Rights Amendment Act 2001 made it unlawful to discriminate in all aspects of employment: hiring, training, promotion, compensation, transfers and so forth.

This vignette shows the potential impact of the collective action of senior staff to challenge racism. Allegations of racism are harder to dismiss when evidence is presented demonstrating the unequal treatment. This vignette could be made into a formal complaint to the Human Rights Commission, whose brief it is to investigate breaches of anti-discrimination legislation. It also highlights the importance of Māori input into all aspects of recruitment. Human resources personnel need to be held to the same ethical and legal standards as health professionals they serve.

4 | DISCUSSION

Anti-racism is an active commitment to upholding human rights, social justice and racial equity. It is both the art and science of engaging with people, systems, policies and practices to reconfigure

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ethnic power imbalances. Anti-racism interventions can range from small micro-level interventions through to macro-level structural interventions and strategic planning. Informed by our analysis of the vignettes, we prose anti-racism interventions for the health sector.

4.1 | Micro-level interventions

Micro level refers to interventions focused at the individual level; confronting one's own racism and interactions of individuals and small groups. The following interventions (see Table 1) could be undertaken by practitioners, policy makers, managers, administrators and researchers either alone or with others. Building one's anti-racism competencies (Came & Da Silva, 2011) can be embedded within one's professional development planning and/or as part of a personal lifelong learning commitment.

Having secured a base of anti-racism competence, another challenge is to take action within one's sphere of influence. All concerted anti-racism efforts by allies needs to be pursued in dialogue with those affected (Margaret & Came, 2019). Anti-racism interventions can lead to negative backlash against those targeted by racism; this needs to be actively considered in the planning of actions (Duckitt, 2001). Skills from all parts of one's life can be transferable into anti-racism interventions; it can be useful to play to existing strengthens. Some might be good at writing complaints or using humour to defuse a situation.

From the vignettes, micro-aggression and mono-cultural practice can be addressed through micro-level interventions.

4.2 | Meso-level interventions

Meso level interventions focus on groups, professional disciplines and institutions. At this level the work involves mobilising and retaining people to collaborate with, as collective action allows the generation of more robust and creative strategies (Selvanathan et al., 2018). Anti-racism at this level needs to be strategic and focussed on achieving intentional outcomes.

Often this work can be campaign based such as trying to ensure policy is changed so racial equity analysis occurs consistently in all strategic planning. It is advantageous to recruit people that have influence to champion the kaupapa (mission) and to explain and tautoko (support) the campaign. It is useful also to gauge the current racial climate and ensure your campaign will not undermine Māori initiatives.

Health activist network STIR: Stop Institutional Racism (Came et al., 2016) has been systematically working towards ending racism in the public health sector. Their focus has been on mobilising supports through engaging in decolonisation training, generating evidence of racism in policy making and contracting and using that evidence to inform submissions, media commentary, evidence briefs to the Waitangi Tribunal and United Nations human rights bodies. This network not only focuses primarily at meso level but also has ambitions to enter coalitions to operate at a macro level (Table 2).

4.3 | Macro-level interventions

Macro-level interventions focus on systems, policies and society at large. The following interventions (Table 3) could be undertaken by a committed band of skilled people. Success is more likely to occur through a planned course of action (Came et al., 2021; Came & McCreanor, 2015) rather than an ad hoc approach. Collective impact (Boyce, 2013) and systems change (Griffith, et al., 2007; Stroh, 2015) both hold great potential for their application to anti-racism. International human rights

TABLE 1 Micro anti-racism interventions

	Possible interventions
Micro interventions	• Engage in critical reflective practice (Alang, 2019). • Develop critical consciousness of race, racism and privilege, including unlearning colonial history (Huygens, 2007). • Spend time in Te Ao Māori (the Māori world) and learn (at least) basic Te Reo Māori me ōna tikanga (and protocols) (Paradies, 2005). • Learn non-violent conflict resolution (Kemp & Fry, 2014). • Engage in bystander interventions – call out racism while maintaining mana (esteem) of all involved (Nelson et al., 2011). • Manaaki (support) and engage in kotahitanga (solidarity) with those targeted by racism (Margaret, 2013).

TABLE 2 Meso-level interventions

	Possible interventions
Meso intervention	• Organise and evaluate professional anti-racist education initiatives (Berman & Paradies, 2010). • Monitor human resources practices to ensure they are configured so Māori are shortlisted, recruited, retained and promoted within the health sector (Monaghan, 2010). • Advocate for the trusting of Indigenous knowledge, evidence and solutions; including addressing the impact of historic racism and inter-generational trauma in service and care planning (Paradies, 2005). • Normalise racial equity analysis in service development and planning (Alang, 2019). • Engage in critical public policy analysis using tools such as Critical Tiriti Analysis (Came et al., 2020). • Mobilise to form anti-racist action networks in your workplace or discipline to transform racism (Came et al., 2016). • Engage in monitoring and reporting processes of United Nations human rights bodies (Came et al., 2016). • Generate empirical evidence of the dynamics of racism and anti-racism (Came et al., 2016).

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TABLE 3 Macro-level anti-racism interventions

	Possible interventions
Macro intervention	• Engage in advocacy to ensure the upholding of Te Tiriti o Waitangi and the implementation of the WAI 2575 findings (Waitangi Tribunal, 2019). • Advocate for the Waitangi Tribunal to have the resources it needs to timely process claims around breaches of Te Tiriti (Came & McCreanor, 2015). • Develop /resource and implement comprehensive national, regional and institution specific strategies to eliminate racism (Came & MCCreanor, 2015). • Form short-term and/or long-term coalitions to engage in collective advocacy to address the uneven access to the determinants of health. E.g. ethnic income/wealth disparities (Wallack, 2019). • Decolonise health, policy and management curriculum in western universities to ensure the Academy produces clinically and culturally competent staff (Hutchings & Lee, 2016). • Develop and resource a national action plan to end institutional racism in Aotearoa across the public sector that includes transparent reporting and monitoring mechanisms (United Nations, 2014).
	Possible interventions
Macro intervention	• Engage in advocacy to ensure the upholding of *Tiriti o Waitangi* and the implementation of the WAI 2575 findings (Waitangi Tribunal, 2019). • Advocate for the Waitangi Tribunal to have the resources it needs to timely process claims around breaches of te Tiriti (Came and McCreanor, 2015). • Develop/resource and implement comprehensive national, regional and institution specific strategies to eliminate racism (Came and McCreanor, 2015). • Form short-term and/or long-term coalitions to engage in collective advocacy to address the uneven access to the determinants of health. E.g. ethnic income/wealth disparities (Wallack, 2019). • Decolonise health, policy and management curriculum in western universities to ensure the Academy produces clinically and culturally competent staff (Hutchings & Lee, 2016). • Develop and resource a national action plan to end institutional racism in Aotearoa across the public sector that includes transparent reporting and monitoring mechanisms (United Nations, 2014).

frameworks and their reporting mechanisms are also potentially helpful political leverage to challenge racism at this level.

To address racism against Māori Te Tiriti o Waitangi needs to be central to any substantive anti-racism endeavour. Te Tiriti sets out the terms and conditions of the relationship between Māori and the Crown (government) to enable settlement. At an organisational level this means Crown agencies such as the Ministry of Health and DHBs; as well as health providers, professional disciplines and practitioners, need to take responsibility to address Te Tiriti (Berghan et al., 2017; Margaret, 2016). When Te Tiriti is upheld institutional racism will not be present in the health system (Came et al., 2019).

Pākehā privilege, employment discrimination, complexity and the cost of racism can all be addressed through macro-level interventions.

Vignettes are a useful tool for investigating sites of racism and reflexively generating anti-racism interventions. The inclusion of real-world data presented in vignette form enables a deeper engagement with the practice and consequences of racism and provides the opportunity for individuals and groups to devise anti-racism strategies that fit within their own practice settings. Health practitioners, administrators, policy makers, managers and researchers can all engage in anti-racism within their respective spheres of influence. Collective action allows mutual support, the fellowship of sharing strategies and insights to mobilise more effectively against racism.

The concept of using vignettes to generate in-house anti-racism interventions would benefit from further exploration. For maximum efficacy this technique would seem to sit best within the context of a planned system-based organisational change process. Regular vignette sessions as part of regular professional development sessions could support the establishment of an anti-racist learning culture within an organisation.

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

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Data are available from the authors on request.

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