Tiriti-based anti-racism praxis of Pākehā critical allies during Aotearoa health system reforms

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Pākehā

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Abstract

The overall aim of this research is to provide guidance to Pākehā working towards a Tiriti-honouring, equitable health system. This thesis explores the role of Pākehā allies during the reform of the colonial health system from mid-2021 through to mid-2023. The promise and potential of these reforms to transform the system to be more Tiriti-focused created a unique opportunity to study how Pākehā allies within the system contribute towards change. This study specifically explores efforts to address anti-Māori racism, pursue Tiriti implementation and improve Māori health. By focusing on the experiences of Pākehā, this study seeks to examine how those of us who are privileged by colonisation, white supremacy and racism can use this power to dismantle the systems of oppression.

This study is a work of activist scholarship located in the transformative research paradigm and employing Te Tiriti as a methodology. As an activist scholar, I have remained connected and accountable to STIR: Stop Institutional Racism, the movement to end institutional racism in the public health system, and the Pākehā Tiriti workers movement through Network Waitangi Whangārei. I also had accountability to a critical research whānau who provided political, cultural and strategic advice throughout. The seven participants in this qualitative study were Pākehā (white New Zealanders of European descent), endorsed by the critical research whānau as allies (those committed to Tiriti justice, addressing anti-Māori racism and Māori health equity); all were leaders with influence in the health sector. The participants were interviewed three times, in late 2021, mid-2022 and mid-2023. The interviews were analysed using reflexive thematic analysis.

This study makes a unique contribution within research processes: through the articulation of a deliberate relational citational praxis implemented within the literature review, a description of Te Tiriti as a methodology within the transformative research paradigm, and the expansion of reflexive thematic analysis to incorporate the reflections of both critical research whānau and participants.

A significant contribution is the development of the Whiti Mai te Rā model which describes the Tiriti-based anti-racism praxis of Pākehā allies in the health system, building on existing work articulating Tiriti-based anti-racism. The Whiti Mai te Ra model contains five core concepts. The first is respect for, and action to uphold the rangatiratanga of Māori over Aotearoa. The second, ‘becoming consciously Pākehā’, involves a clearly articulated Pākehā cultural identity, formed and maintained in relation with Māori, accountable for Pākehā power and privilege recognising ourselves as beneficiaries of racism and colonisation, with an ethic of service orientation

purposefully working to address racism and improve Māori health. This conscientised Pākehā identity informs a strategic, Tiriti-based anti-racism praxis that is unique to Aotearoa, that upholds the intent of Te Tiriti, enacts the articles, and is conducted in relation with Māori. Ongoing critical reflection and critical thinking contributes to both a conscious Pākehā identity and Tiriti-based action, which together form an iterative, continuous journey of development. The praxis is embraced by hope, love and courage combined with a commitment to genuine, respectful relationships.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge, it contains no material previously published or written by any other person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

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Signed: Ngaire Rae

Dated: 5th August 2024

Co-Authored Works

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Mataroria Lyndon	Critically revising it to contribute to its quality and interpretation.

Dedication

This thesis is dedicated to:

my children Rihari Gary Martin Turoa Pehi and Tiria Pereti Tawhai Janita Rachel Neho Pehi, you were named after your ancestors so you would always know who you are

and

my mokopuna Royal, Isaiah and Noah, my nephews and nieces and the future generations to come, may you all be blessed to live a Tiriti-based future in Aotearoa.

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Ethics approval for this study was given by Auckland University of Technology Ethics Committee on the 1st of November 2021, application number 21/393 (Appendix A).

Chapter One: Introduction

There have been decades of activism in Aotearoa New Zealand[1] (hereafter referred to as Aotearoa) to improve Māori health and reduce health inequities. These efforts have resulted in increasing numbers of Māori in the health workforce, thriving Māori health providers who are improving Māori health outcomes (Gifford et al., 2018) and innovative Māori community and iwi-led responses to the COVID-19 pandemic (Cassim & Keelan, 2023). However, although there has been some improvement in Māori life expectancy, the gap between Māori and non-Māori is still unacceptable and on nearly every measure Māori experience worse health outcomes than non-Māori (Curtis et al., 2022). These inequities are unfair, preventable and can be changed (Reid et al., 2022). Ongoing colonisation and racism feature strongly in the causes of Māori health inequities. Pākehā, as the descendants of the white European colonisers and the beneficiaries of the ongoing racism and colonisation of Aotearoa, have a role to play in dismantling racism (Mikaere, 2011).

There have also been decades of activism leading to a variety of changes in and reforms of the colonial health system, some large-scale reforms, others smaller in nature, some led by Government, some initiated by Māori and community. The 2022 health reforms, implemented by the Labour-led Government, created Te Aka Whai Ora, a Māori Health Authority envisioned by Māori for over a century (Durie, 2023). A raft of other reforms also occurred including the dismantling of the 20 District Health Boards (DHBs) and the formation of super-agency Te Whatu Ora with an 80,000- strong workforce. In November 2023, the National/ACT/New Zealand First coalition Government was elected. One of their headline campaign promises was to disestablish Te Aka Whai Ora. This legislation was passed in February 2024.

This thesis explores the role of Pākehā allies in the health system, who were working to implement Te Tiriti, address anti-Māori racism, reduce Māori health inequities and ultimately improve Māori health, during the reforms from mid-2021 through to mid-2023. The promise and potential of these reforms to transform the health system to be more Tiriti-focused created a unique opportunity to study how Pākehā allies within the system can contribute towards change. Now, more than ever, as the system regresses to its monocultural foundation, the work of allies for Tiriti justice is required.

[1] The use of Aotearoa to name this country signifies support for Māori rangatiratanga over this whenua.

Research Question(s)

The overall aim of this research is to provide guidance to Pākehā working in the system to encourage further action towards a Tiriti-honouring, equitable health system. The study provides an in-depth and rich description of how Pākehā allies, people who are committed to a Tiriti-based future, work to improve Māori health and reduce health inequities from within the health system, in the context of health system reform.

The research questions are:

- What are the experiences of Pākehā allies advocating and acting for Tiriti implementation, improving Māori health and addressing anti-Māori racism during the health system reform?
- How does the complexity of navigating health system change impact on these efforts?
- How can their experiences inform further responses to anti-Māori racism and provide guidance to other Pākehā working to decolonise the health system, achieve health equity and end racism?

It is acknowledged that racism is prevalent throughout the health system and society generally in Aotearoa for all people of colour (Harris et al., 2012). However, this study specifically explores efforts to improve Māori health, reduce Māori health inequities, address anti-Māori racism and pursue Tiriti implementation. By focusing on the experiences of Pākehā, this study seeks to examine how we who are privileged by colonisation, white supremacy and racism can use this power to dismantle the systems of oppression.

Positioning Myself

> It's good that you Pākehā *are* who you are, and it's important that you *know* who you are … but you need to understand *how* you are who you are – and how *powerfully* you are who you are (Canon Hone Kaa, as cited in McCreanor, 2009, August 27, p. 1).

Two decades ago, I had this quote, hand-written in bold black felt pen on a large sheet of paper, hanging in my kitchen. When I started helping out with introductory workshops on the Treaty of Waitangi[2] as a member of the Pākehā treaty educators group, Network Waitangi Whangārei, this quote really impacted on me. I got it. I felt like Hone Kaa was talking directly to me. Yes, I

[2] In the mid-1990s, when I first joined Network Waitangi Whangārei, we were running 'Introduction to Treaty of Waitangi' workshops, although our focus was then, and continues to be now, the Māori text of Te Tiriti o Waitangi.

realised, we Pākehā *do* have a distinct culture, and there is no judgement on that, either right or wrong, it just is. Recognising and naming that culture is important. We need to understand our history and the history of this country and the resulting power and privilege that we Pākehā people hold – and, consequently, the responsibility we have as Pākeha to do something to make right the wrongs executed in our name. Not explicit within this quote, but implied, is the fact that the word Pākehā comes from te reo Māori: we are named by Māori. This naming denotes relationship. I identify as a Pākehā New Zealander, I see this as culturally locating and connecting me to the people of this land. I can only be Pākehā as named by Māori, here.

Knowing how I am who I am is still an unfolding journey. Not long after my mother died, I found an old diary of my grandmother's with the names and birth dates of family ancestors; this provided the missing clue and helped me explore more about the first settlers from my family in Aotearoa. In 1843, my third great-grandfather Eli Cropper was killed, just a year after arriving in Whakatū (Nelson) in 1842, in what is now known as the Wairau Incident. Eli left Liverpool in 1841 aboard the ship *Martha Ridgeway* with his wife Mary and daughter Mary-Ann. Mary-Ann, whom I am descended from, was three when her father died. Scattered through the story of my ancestor are significant figures and events that encapsulate some components of the colonisation of Aotearoa.

The Wairau incident, the first and only violent armed conflict in Te Wai Pounamu (South Island) and the start of the New Zealand Wars (O'Malley, 2019), occurred only three years after Te Tiriti o Waitangi was signed. Ngāti Toa, led by the rangatira Te Rauparaha and his nephew Te Rangihaeata, had peacefully resisted the taking of their land in the Wairau Valley by the New Zealand Company by removing survey pegs and burning surveyor huts. Arthur Wakefield, an agent for the New Zealand Company and brother to the infamous Edward Gibbon Wakefield, led a group of armed settlers to confront and arrest Te Rauparaha. During the confrontation a gun was fired and, subsequently, shots were fired from both sides. Te Rongo, wife of Te Rangihaeata, was killed, along with at least three other members of Ngāti Toa. On the settler side, Arthur Wakefield and my great-grandfather were among the 22 Pākehā killed (O'Malley, 2019).

Edward Gibbon Wakefield is a notorious figure in the history of Aotearoa and his name is littered throughout Aotearoa on streets, buildings, townships, plaques and monuments. Wakefield thought up the idea of 'systematic colonisation' from a jail cell in London, having been imprisoned for abducting a minor (Steer, 2017, March). My ancestor Eli was one of the thousands who settled in Aotearoa under the New Zealand Company colonisation scheme with

the promise of cheap land and a new life. Despite Article Two Tiriti provisions, private land sales continued, fuelled by mass migration from the United Kingdom. The population of Pākehā grew exponentially from about 2,000 people in 1840 to equalise with the Māori population at about 59,000, only 18 years after Te Tiriti was signed (Pool, 2013). This huge population explosion of Pākehā and our resultant quest for land was devastating for Māori. The Māori population plummeted, due to disease and the confiscation, theft and loss of land. By 1900, Pākehā outnumbered Māori 17 to 1, there were 770,000 Pākehā and only 45,000 Māori (Pool, 2013).

One of the telling components of this piece of family history is that I only found out about it through researching my ancestry via an online database. This story, a hugely significant moment for the history of New Zealand, was essentially and still is largely lost to my family. I still know very little about the involvement of my ancestor and have so many unanswered questions.

Figure 1
Photos of Memorial to the Pākehā who Died in the Wairau Affray, Tuamarino Cemetery, Wairau Valley

Note. Photos taken by author.

Prior to researching my family history, I had a typical Pākehā experience of 'historical amnesia' with little shared within the family about our story of arrival and settlement. I knew who my grandparents were but there was never any discussion about where we came from or why they came. As a working-class family there was an implicit message to always look forward not back, where we come from seemed largely irrelevant. Many sayings reinforce this perspective: 'what's done is done', 'leave the past alone', 'you can't change history', 'what happened in the past stays

in the past'; in other words, where we are going is what matters. Other strong messages from my family upbringing were to work hard, do your best, contribute to your community and, importantly, conform represented by the oft-quoted 'what will the neighbours say?' (i.e., don't stand out).

I grew up in a small seaside village on the east coast just south of Whangārei. My father was a builder, and my mother was a 'stay-at-home' housewife. I was one of four daughters. It was a monocultural, working-class, semi-rural upbringing. Everyone around me was Pākehā. It was a novelty for us to have, for a short period of time, neighbours who were Māori. I remember our delight as children when our new neighbour taught Mum how to make fry bread. There were a few Māori children in primary school, and a higher percentage at college but the whole environment was Pākehā. In my last few years at high school, the late 1980s, there was a kapa haka rōpū. There was very little te reo spoken anywhere. At the beginning of 1990, I left school and took the only course still taking enrolments at the local polytechnic, journalism. I don't remember anything about the sesquicentennial (150-year) Treaty of Waitangi celebrations or the Queen's visit. Whilst on that course I had my first te reo lessons and read *Ka Whawhai Tonu Matou* by Ranginui Walker (1990). My eyes, ears and heart had started to be opened.

At the end of that year though, life changed. I moved to National Park, met and fell in love with my husband who has whakapapa connections to Ngāpuhi and Atihau nui a Pāpārangi. Together we have two children and three mokopuna – all of whom identify as Māori. This experience, of being a member of a whānau and broader hapū for over 30 years, has influenced me and given me insights into te ao Māori that I would possibly never have had if not for this relationship. My husband, children, mokopuna and wider whānau have, and continue to, experience racism and colonisation.

As a Pākehā (white), middle-class (home-owning), heterosexual, able-bodied, cis-gender woman, I have multiple layers of privilege. I feel like I also have another layer of privilege in which I benefit from the learning, experiences, insights and aroha I've received in being part of a Māori whānau. Awareness of these unearned privileges compel me to take action to support a just world where all people are enabled to thrive.

My first real job was as a sexuality educator for the Family Planning Association. In my professional life I have worked as a health promoter for over 25 years in Tai Tokerau, mostly within primary health care. During that time, I have worked on many projects always alongside, and for Māori, in the pursuit of health equity. I remain a member of Network Waitangi Whangārei and have been a member of STIR – Stop Institutional Racism, since its inception, although my

contributions to these groups have waxed and waned over the years. Over these years I've had a growing frustration at the intractability of the institutional racism inherent within the health system and the systems that contribute to health and wellbeing, in particular housing, education, justice.

In 2019, I was appointed to the Northland DHB, as Deputy Chair. I thought this would be an opportunity to use the privilege I have (inherent within, and reflective of, the process of my appointment to the Board) to affect change. However, my frustration increased. The system is so complex, with various layers of decision-making, that I felt even at a governance level the ability to change the system is limited. At best it seemed at times that we were holding the line on an equity or Tiriti position rather than making substantial progress. This study arises from my realisation that unless we address the institutional racism in the system, all our other efforts will be diminished. It also arises from my wish to be more effective and learn from others how best to do this work for change.

Positioning the Research

Activist Scholarship

As a health promoter, my orientation has been to work alongside communities adopting a people-centred (Raeburn & Rootman, 1998) community development approach. This work has been largely focused on reducing health inequities in diverse areas such as food security, healthy housing, and tobacco control, and reducing harm from alcohol and gambling, always with the aim of working towards social and Tiriti justice. This approach aligns with activist scholarship (Came et al., 2015).

This study is intended as a piece of activist scholarship. More details about this are discussed in Chapter Five, the methodology chapter, but it is important to identify early on that my orientation and motivation has always been to 'make a difference', to contribute something to the community that informs, supports, and develops our practice. Joseph-Salisbury and Connelly (2021) described anti-racism activist scholarship as working in service to the movement, and this is my intention.

Choudry (2020) emphasised the importance of relationships between research and activist movements as a characteristic of activist scholarship. My practice of health promotion has always been a collaborative endeavour, and this approach is continued through this study, with my collaborators being my critical research whānau, my STIR and Network Waitangi Whangārei friends, and also the study participants.

Came and Humphries (2014, p. 106) invited "recognition of responsibility to expose and transform institutional racism wherever it is to be found by those who have it in their capacity to do so." As someone who has the recognition and the capacity to do so, I take up this responsibility.

Defining Racism

Race and racism is centuries old and has deep roots throughout the world (Mendoza, 2020). Inspired by the work of Fanon (1963), Grosfoguel (2016, p. 10) defined racism as "a global hierarchy of superiority and inferiority along the line of the human that have been politically, culturally and economically produced and reproduced for centuries by the institutions of the capitalist/patriarchal western-centric/Christian-centric modern/colonial world system." Those who are categorised as being above the human line (the zone of being) are socially acknowledged for being human, and therefore have access to material resources, social recognition of their subjectivities, identities, epistemologies, and spiritualities, as well as rights (human, civil, women's, and/or labour rights) (Grosfoguel, 2016). Those who are below the line (the zone of non-being) are seen as subhuman, their humanity is questioned and negated, and the granting of rights, the provision of material resources, and the acknowledgement of their identities and subjectivities, spiritualities and epistemologies are denied (Grosfoguel, 2016).

This definition of racism accommodates how the hierarchy of superiority/inferiority is constructed through various racial markers (colour, ethnicity, language, culture, religion) dependent upon diverse colonial histories (Grosfoguel, 2016). Racism is therefore specific to place and history. Here in Aotearoa, the hierarchy constructed the white European colonisers as superior and Māori, as the Indigenous peoples, inferior.

The intersectionality of oppressions (class, sexuality, gender, disability) and the lived experienced of these oppressions is different in the zone of being and below the zone of being (Grosfoguel, 2016). People who live in the zone of being are subject to class, gender, sexual oppression; however, they also experience racial privilege not racial oppression and accordingly "live all those oppressions *mitigated* by racial privilege. … In the zone of non-being, the multiple oppressions are *aggravated* by racial oppression" (Grosfoguel, 2016, pp. 11-12) (emphasis in the original). In Aotearoa, this helps to explain why health inequities remain for Māori after adjusting for socio-economic positioning (Reid et al., 2000). This definition of racism makes it clear that racism is not "just a question of prejudice or stereotypes, but above all an institutional/structural hierarchy related to the materiality of domination" (Grosfoguel, 2016, p. 11).

Jones (2000) described three types of racism, institutional or structural racism, interpersonal or personally mediated racism, and internalised or intrapersonal racism. Institutional racism is defined as "differential access to the goods, services and opportunities by race" (Jones, 2000, p. 1212). Access to power and material conditions are two ways that institutionalised racism manifests (Jones, 2000). Differential access to education, healthy housing, employment, quality health services are examples of material conditions (Jones, 2000). Differential access to power includes: resources, like the ability to access financial instruments; information, like history; and voice, like voting rights, representation in government, and media control (Jones, 2000). Institutional racism is "often evident as inaction in the face of need" (Jones, 2000, p. 1212). Personally mediated racism is defined as "prejudice and discrimination" and "can be intentional as well as unintentional and it includes acts of commission as well as acts of omission" (Jones, 2000, p. 1213). This type of racism is what most people understand as racism and is what many anti-racist interventions focus on. Internalised racism is defined as "acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth" (Jones, 2000, p. 1213).

Colonisation and Racism in Aotearoa

For Māori, the experience of racism is ubiquitous, 93% of Māori report experiencing racism daily (C. Smith et al., 2021). The reality of life for Māori in Aotearoa is that racism is prevalent and experienced when engaging in daily settings such as education, workplaces, health and justice (Cormack et al., 2020).

Racism is deeply rooted in the history of Aotearoa and 'stepped ashore', along with sexism and classism, with the colonisers (Jackson, 2018, February 25; McCreanor, 1997). Racism provided the justification for and the foundation of colonisation here (Jackson, 2018, February 25). The colonisers came believing Indigenous people were inferior, savage, and lacked the capacity to govern themselves and although these blatantly racist ideas may be dismissed now, the impact still lingers (Jackson, 2018, February 25). The colonisers also came with the belief that their values and institutions were superior, dismissing the existing political and constitutional structures, replacing them with their own and declaring their systems universal and normal (Jackson, 2018, February 25). This supplanting of existing systems with colonising ones is now seen as "reality rather than an imposition" and although institutional racism is acknowledged, such recognition often concerns the racist actions of the institution "rather than the racist grounding of the institution itself" (Jackson, 2018, February 25, p. para. 33).

Institutional racism is present throughout the 'standard story' of Pākehā race talk and perpetuates the naturalisation of racism throughout Aotearoa (Nairn & McCreanor, 2022). The 'standard story' is a set of themes identified within Pākehā discourses that form a set of racist, self-serving ideas about Māori and Pākehā relationships (McCreanor, 2020). These themes include Pākehā as the norm, One People, Māori Privilege, and Good Māori/Bad Māori, and are visible throughout 'mainstream' media as a common sense way to discuss and understand what occurs within Māori/Pākehā relations (McCreanor, 2020). Contrary to the Anglophone saying 'sticks and stones may break your bones but words will never hurt you', these discourses are indeed harmful and play a significant role in maintaining colonial power and "unjust and exploitative relationships between Māori and Pākehā" (McCreanor, 2020, p. 12).

One of these clusters of talk, 'Pākehā as the norm' (Nairn & McCreanor, 2022), is particularly relevant for this study considering the role of Pākehā allies addressing anti-Māori racism in the health sector. One of the features of this cluster is unspecifying the cultural origins of institutions so, for example, the 'health system' is not named the Pākehā health system, it just is the norm, the natural, the ordinary. Black et al. (2023) identified 'Pākehā as norm' within submissions to the Pae Ora (Healthy Futures) Bill (New Zealand Government, 2022b). Not naming Pākehā and Pākehā institutions is problematic. Firstly, it affirms the monocultural New Zealand systems while concealing the power, control, and influence of the unidentifiable majority, rendering Pākehā domination invisible; the Pākehā majority are represented as "we" or "ours," while Māori are referred to as outsiders as "you," "they," "them," or "theirs." Secondly, the pattern establishes a feeling of cultural deficiency among Pākehā that is articulated as "I am not included because I am not named" and therefore "I am disadvantaged", although the opposite is true (Black et al., 2023). This study names the role of Pākehā in the maintenance of racism within the Pākehā health system and explores the role of dismantling anti-Māori racism.

Naming and taking action on institutional racism in Aotearoa goes back to as early as the 1970s with the Nelson Māori committee providing legal advice to Māori as an attempt to mitigate the institutional racism in the judicial system (Consedine, 2018). A report on the institutional racism within the Department of Social Welfare, *Puao-te-ata-tu* (Ministerial Advisory Committee on a Māori perspective for the Department of Social Welfare, 1988) described three faces of racism: personal, cultural and institutional. The *Puao-te-ata-tu* report was informed by two earlier reports, one by a Māori advisory unit, and another by the Women's Anti-racist Action Group, which both found the department was institutionally racist (Berridge et al., 1984). Institutional racism was described as "the most insidious and destructive form of racism" (Ministerial Advisory Committee on a Māori perspective for the Department of Social Welfare, 1988, p. 19)

reflective of the racism within the community and within other national institutions. Institutional racism was evident in monocultural policy formation, service delivery, communication, workforce appointment, promotion and training (Ministerial Advisory Committee on a Māori perspective for the Department of Social Welfare, 1988). Although this report was written 35 years ago, the findings are replicated today. An urgent inquiry by the Waitangi Tribunal (2021b) looked at the disparity between the number of Māori and non-Māori children taken into state care. They found:

> Since the 1850s, Crown policy has been dominated by efforts to assimilate Māori to the Pākehā way. This is perhaps the most fundamental and pervasive breach of Te Tiriti / the Treaty and its principles. It has also proved to be the most difficult to correct, in part due to assumptions by the Crown about its power and authority, and in part because the disparities and dependencies arising from the breach are rationalised as a basis for ongoing Crown control (Waitangi Tribunal, 2021b, p. xv).

Racism and Health

The influence of the *Puao-te-ata-tu* report can also be found in another Waitangi Tribunal (2019) report, *Hauora*, which quoted the description of institutional racism from *Puao-te-atu-tu*:

> The outcomes of mono-cultural institutions which simply ignore and freeze out the cultures of those who do not belong to the majority. National structures are evolved which are rooted in the values, systems and viewpoints of one culture only. Participation by minorities is conditional on their subjugating their own values and systems to those of 'the system' of the power culture (Ministerial Advisory Committee on a Māori perspective for the Department of Social Welfare, 1988, p. 19)

It was not until the mid-1990s, following the *Puao-Te-Ata-Tu* report, that racism as a determinant of Māori health was recognised in *He Matariki*, a strategic plan for Māori public health released by the short-lived Public Health Commission (Talamaivao et al., 2021). There then followed several publications over some years naming racism and the ongoing impacts of colonisation on the health of Māori.

It is clear that the health system is racist (Selak et al., 2020; Waitangi Tribunal, 2019) and produces inequitable health outcomes (Steyn et al., 2021). The effects of racism and the entrenched health inequities created are well described (Harris et al., 2018); however, there is less evidence for effective interventions to address the impacts of racism on health (Talamaivao et al., 2020).

Racism is a determinant of health inequities and, consequently, addressing health inequities requires addressing racism (Phelan & Link, 2015). Racism contributes to inequities in health in three main ways: differential access to the determinants of health and differential exposures leading to difference in disease incidence; differential access to health care; and differences in the quality of health care received (Reid & Robson, 2007). For each of these pathways there is a multitude of evidence (Reid & Robson, 2007).

The experience of colonisation, as an ongoing structure not a one-off event (Wolfe, 2006), has also been identified as contributing to Indigenous health disparities (Reid et al., 2014). A multi-level model that explains the impact of colonisation on Māori health was described by Reid et al. (2014). The first stage is the initial mass trauma event of colonisation, that is the suppression of a population by the colonisers (Reid et al., 2014). The most fundamental element of subjugation is the loss of land and it is through this "that the seeds for the transgenerational transmission of the trauma of colonization are sown" (Reid et al., 2014, p. 522). The colonisation of Aotearoa resulting in the taking of land and the "power to self-determine, combined with a massive decline in population due to poverty and disease, essentially left Māori a disenfranchised and relatively impoverished minority in a land they once held dominion over" (Reid et al., 2014, p. 524). Stage two outlines the trauma response of the first generation and the "unremitting stress" from colonisation causing debilitating and severe psychological reactions (Reid et al., 2014, p. 524). This psychological distress has impacts throughout whānau and exacerbates alcohol and drug misuse (Reid et al., 2014). The third stage is the transmission of trauma through generations. Although biological, psychological and psychosocial individual-level factors do contribute to the transmission of trauma, Reid et al. (2014, p. 526) suggested that

> what keeps the trauma of colonization alive are the fundamental societal-level structural and systemic changes brought about by the process of colonization—foremost among these being the loss of economic and political power and the loss of culture and traditional ways of life wrought by the loss of land.

Racism within the health system also impacts Māori health practitioners, with studies identifying the interpersonal and institutional racism experienced by Māori nurses within the health system (Giddings, 2005; Huria et al., 2014). Despite decades of rhetoric to increase the proportion of Māori nurses within the health system to the same as the population, about 17%, it remains at about 7% (Wilson et al., 2022). Institutional racism also manifests within the health workforce with ethnic pay disparities apparent for Māori and Pasifika staff, and fewer

Māori and Pasifika staff employed in the health sector than their population proportion (Came, Badu, et al., 2020).

There has been scholarly work exploring how institutional racism manifests within the public health system (Came, 2012) and how it can be disrupted (Came, 2014; Came & Humphries, 2014; Came & McCreanor, 2015), including through system change (Came & Griffith, 2018). Colonial and racist systems are maintained by people with power (McGuire-Adams, 2021); however, as complex as these systems may be, they can be transformed (Came & Griffith, 2018).

Anti-racism in Aotearoa

This study is part of a Marsden-funded project looking at 're-imagining anti-racism for the health sector' centred on Te Tiriti and the Matike Mai tricameral model of constitutional change (Came et al., 2022). Over the last few years several other high-profile national anti-racism initiatives have commenced. The Whakatika project looked at the extent and impact of everyday experiences of racism faced by Māori in Aotearoa (C. Smith et al., 2021), and national and international literature reviews were conducted to inform the project (Tinirau et al., 2021a, 2021b). WERO (Working to End Racial Oppression) is a research programme that is exploring institutional and interpersonal racism in Aotearoa. The project has more than 30 researchers undertaking a range of research projects, alongside partners in community, government and the private sector, combining expertise from Māori studies, Pacific studies, anthropology, economics, human geography, psychology and sociology (WERO, 2024).

Another significant development is Ao Mai Te Ra, an anti-racism programme of work within the Ministry of Health (Ministry of Health, 2022a). Previous health sector responses to racism have been described as ad hoc or characterised by inaction, being focused largely on educational initiatives to support individual change rather than systemic or structural responses (Came et al., 2022). This programme of work has produced three literature reviews (Ahuriri-Driscoll, Williams, et al., 2022; Williams, 2022; Williams & McMeeking, 2022), a summary paper (Tarena et al., 2022), and a model for systems change (McMeeking et al., 2022). It is noteworthy that, whilst the documents commissioned by Ao Mai Te Ra were published on the Ministry of Health website, a disclaimer was also published which advised the documents do not represent policy advice, and that the content within did not necessarily reflect the views of the Ministry of Health or the government (Ministry of Health, 2023). It is also of note that this work is being led by the Māori health team; however, it is unclear what role Pākehā, as the main perpetrators of racism, and indeed the 'problem' that requires fixing, have in supporting the programme.

Alongside this research and Ministry-of-Health-initiated projects, the Ministry of Justice is developing a National Action Plan on Racism (Ministry of Justice, 2021). The plan was a recommendation from the United Nations Committee on the Elimination of Racial Discrimination (2017) finally acted upon by the Labour-led coalition Government after the 2019 Christchurch mosque terror attacks. The Human Rights Commission (2022a, 2022b) produced two reports providing recommendations for the plan development. The reports were unequivocal in their recognition of the ongoing impact of colonisation on racism and the significant role that honouring Te Tiriti plays in addressing racism. The National Iwi Chairs Forum was involved in the development of the plan but, in April 2024, withdrew its support due to concerns about a reduction in focus on colonial and institutional racism, and the ongoing anti-Māori, anti-Tiriti, anti-equity actions of the National/Act/New Zealand First Government (Ngata, 2024, April 7).

Initially set up in 2013 as a Special Interest Group of the New Zealand Public Health Association (NZPHA), STIR: Stop Institutional Racism, is a small but committed group of public health workers and scholar activists that aims to eradicate anti-racism in the public health sector (Came et al., 2017). I have been the secretary of STIR for the last five years. Based on a systems approach to addressing racism, STIR has four key political strategies: activating allies for decolonisation, influencing and developing policy, monitoring the government, and strengthening the evidence basis for anti-racism (Came et al., 2017). In 2017, STIR published a guide to Tiriti-based health promotion practice (Berghan et al., 2017) and in 2021, STIR called together anti-racism practitioners from across the country to develop a briefing paper (STIR: Stop Institutional Racism & New Zealand Public Health Association, 2021) to contribute to the national action plan against racism. Both these documents provide early articulations of a Tiriti-based anti-racism praxis and inform this study.

A long-time Pākehā Tiriti activist, Jenny Rankine (2020), studied anti-Māori online racism and how this could be disrupted using anti-racist graphics. The images used were designed to evoke emotions such as empathy with Māori, anger at injustice and hope for a Tiriti-based future. The study concluded that to be effective, anti-racism interventions must account for discursive and affective practices.

Since the 1970s there has been decolonisation training and Te Tiriti training occurring throughout Aotearoa. Although there has been little evaluation of this work, Rankine (2014, p. 25) asserted that this training had resulted in “Treaty-based structural change within institutions in education, social services; health promotion; libraries; international development agencies;

and city councils." An example of this is the restructuring of feminist organisations such as Women's Refuge to reflect Te Tiriti (Huygens, 2001).

Just as racism occurs at multiple levels (personal, institutional, cultural, amongst others), so must the strategies to address racism be implemented at multiple levels (Pedersen et al., 2010). Reviews of effective anti-racism campaigns find that few of them seek to change systemic or institutional racism and most anti-racist interventions are focused on individual behaviour change (Paradies, 2016; Pedersen et al., 2010). Paradies (2016) also contended that there is a lack of consensus among scholars about what defines anti-racism in theory and in practice. However, in Aotearoa it is clear that anti-racism must engage with Te Tiriti o Waitangi (STIR: Stop Institutional Racism & New Zealand Public Health Association, 2021).

Anti-racism in Aotearoa also requires work on decolonising. The next section explores this in more depth.

Decolonisation

In 1961 the United Nations Special Committee on Decolonisation was established to support sovereignty for colonised nations (Banivanua Mar, 2016). However, for Indigenous peoples who were in the minority in settler-colonial states, including Aotearoa, there was no United-Nations-sanctioned path to decolonisation (Lopesi, 2018). This process, of deciding which peoples get to decolonise, is in itself an imperial colonising mindset (Lopesi, 2018) and inherently unjust (Jackson, 2020).

Banivanua Mar (2016) discussed Pacific decolonisation and noted the common imperial narrative of decolonisation as situated within territories rather than peoples. With settler-colonial states, such as Aotearoa and Australia, decolonisation efforts are centred in people and require decolonisation of the mind (Banivanua Mar, 2016). Smith (2012) said that decolonisation is a process which requires an understanding of and engagement with the "reach of imperialism into 'our heads'" and observed that the challenge is "to understand how this occurred, partly because we perceive a need to decolonize our minds, to recover ourselves, to claim a space in which to develop a sense of authentic humanity" (p. 24). Jackson (2018) also identified the need for Indigenous people to go through a process of decolonisation which requires an interrogation and dismantling of "all that it has meant and still means to the way we think and live our lives" (p. 2). Alfred (2017, October 13, p. para. 1) described the 'colonial mentality' as the cause of all problems within Indigenous communities as it "frames, animates, shapes and constrains all thinking". Recent work by Emery-Whittington and Davis (2023) proposed healing from internalised oppression requires the development of critical

consciousness, a relational ethic of manaaki (support, care, hospitality), and community building. Also crucial to this decolonisation approach is the everyday role of critical allies working in solidarity to disrupt racism where and when they encounter it.

Hokowhitu (2010) stated that decolonisation centres the coloniser and reinforces colonial power structures; instead, he argued for affirming sovereignty and a re-centring of Indigenous resistance to colonisation. Hokowhitu conceived of power as held within people and advocated for the importance of the "existentialism of the Indigenous subject, the immediacy of indigeneity that lies beyond the limiting recourse to the pre-colonial or colonial past" in realising this "Indigenous choice, responsibility and freedom [as] a worthier project than 'decolonisation'," (Hokowhitu, 2010, pp. 224-225). Smith (2017) shared the concerns that Hokowhitu raised about decolonisation centring the coloniser and identified the Māori sovereignty movement that arose in the 1970s as shifting the talk from decolonisation toward conscientisation which ensures Māori interests and aspirations are advanced. This is a view shared by Durie (1998a), who said the task of decolonisation is to develop a pathway for the future. Writing about decolonisation, Jackson (2020, p. 149) suggested that the term decolonisation

> be replaced with the ethic of restoration. The use of this term would seek to replace colonisation not by merely deconstructing or culturally sensitising the attitudes and power structures it has established, but by restoring a kawa that allows for balanced relationships based on the need for iwi and hapū independence upon which any meaningful interdependences must rest.

This process of restoration "will require a change of mind and heart as much as a change of structure" (Jackson, 2020, p. 149). This sentiment is echoed by Te Karu (2021, p. 100) in writing about the health reforms and noting "a change of mind and heart alongside a change of structure is well overdue for Māori, but for all peoples of Aotearoa, surely it is also time."

Pākehā anti-racist scholars Came and da Silva (2011, p. 120) defined decolonisation as "both an individual and collective process of revealing and actively analysing the historic and contemporary impact of colonisation, mono-culturalism and institutional racism combined with political movement towards the restoration of sovereignty." Four key practices of decolonisation work for Pākehā, ideological, emotional, cultural, and constitutional, comprise an integrated decolonisation practice developed by Huygens (2011). The ideological work for decolonisation involves critically revisiting the violent history of our colonial past with an emphasis on the experience of Indigenous peoples. When coming to terms with coloniser

behaviour, settler-colonisers can experience “intellectual and emotional shockwaves” (p. 75) which mean providing emotional support whilst working through feelings of responsibility and guilt is a role for Pākehā educators. Cultural work for decolonisation requires building a conscious collectivity. “Ideologies and practices, such as indifference and individualism, need to be recognised as cultural and as collectively maintained – hence the need for deliberately collective processes to change them” (p. 76). Thinking about ourselves as part of a cultural collective helps us to take responsibility for the impact of colonial settler culture on Māori (Huygens, 2011). The final practice of political and constitutional work for decolonisation requires preparing for an accountable, mutually agreed relationship. “The entire development of a decolonisation practice for settler colonisers relies on responsiveness to the indigenous party” (Huygens, 2011, p. 76).

Any discussion on decolonisation requires clarity on the definition of the term (Bell et al., 2022). How we decolonise is dependent upon consideration of what ‘colonialism’ is, recognising that it is not the same everywhere (Bell et al., 2022). Wolfe (2011) and Veracini (2011b) both made a case for the importance of settler colonialism as distinct from exploitation colonialism. Settler colonialism eliminates the native, whereas exploitation colonisation is focused on exactly that – exploiting the resources of the colony including its people. Settler colonialism is one aspect of the global phenomenon of colonialism; however, the settler form of colonialism must be considered as the global perspective silences the Indigenous viewpoint (Wolfe, 2011). Veracini (2011a) contended there are no narratives for settler decolonisation because settlers never intended to return, so they must achieve total victory (elimination or assimilation of Indigenous people) or total failure (revolution). Narratives that support reconciliation are required, work that is still to be fully developed (Veracini, 2011b). Mendoza (2020) critiqued the binary of settler colonisation and exploitation colonisation and maintained that this dual construction is only possible if the history of Iberian colonisation is ignored. She argued that settler colonialism theorists need to “abandon their provincialism and Anglo-centrism to understand their history” (Mendoza, 2020, p. 57). Colonisation and racism are prevalent throughout the world and therefore decolonisation must also be “global, and it must be total” (Mendoza, 2020, p. 57). Tuck and Yang (2012) agreed that colonialism must be considered in the global and historical context; however, the answer to decolonisation is not global. Mignolo and Walsh (2018) stated there is no universal answer to the question ‘What does it mean to decolonise?’ Rather, this question requires answering other questions about who, where, why and how. Decolonisation is specific to the context of its colonisation (Mignolo & Walsh, 2018; Tuck & Yang, 2012).

Tuck and Yang (2012) reminded us that decolonisation is not a metaphor; rather, it is about the return of Indigenous land and self-determination. They described settler appropriation of the language of decolonisation, superficially adopted without discussion of Indigenous peoples, their rights or sovereignty. They described several "settler moves to innocence" which serve as "excuses, distractions, and diversions form decolonisation" (Tuck & Yang, 2012, p. 10). One such move to innocence is to emphasise the development of critical consciousness and this becomes the "stand in for the more uncomfortable task of relinquishing stolen land" (Tuck & Yang, 2012, p. 19). The return of Māori land has been central to Māori calls for decolonisation. Forty years ago Donna Awatere (1984, p. 10) wrote *Māori Sovereignty* and was clear that this required "nothing less than the acknowledgement that New Zealand land is Māori land, and further seeks the return of that land." Māori are still waiting for land to be returned and the right to "once again govern themselves in their own lands"(Jackson, 2020, p. 135). Pākehā working towards decolonisation must be aware of Māori aspirations and use these to guide our strategic goals (Huygens, 2011).

He Wakaputanga me Te Tiriti o Waitangi

On the 28th of October 1835, He Wakaputanga[3] o te Rangatiratanga o Nū Tireni (the Declaration of Independence) was written and signed by the rangatira (chiefs) of Te Wakaminenga o ngā Hapū o Nū Tireni (the general assembly of the hapū of New Zealand) (Healy et al., 2012). The Wakaminenga had been established several decades earlier to consider how to collectively deal with the new arrivals (Healy et al., 2012). Contact with Europeans brought new technology, resources and trade, and required international diplomacy, such as the visit by Hongi and Waikato to England in 1820 (Healy et al., 2012). However, it also brought Pākehā lawlessness, a major concern for rangatira (Mutu, 2020). In 1831, after a ship owned by rangatira Patuone and Taonui was seized in Sydney, the Wakaminenga chose a flag to further international trade, and this flag was recognised by the British, Australia, America, Canada and France (Healy et al., 2012). He Wakaputanga was a declaration of unity and a declaration of sovereignty (Healy et al., 2012). It is a document of such significance it is considered by many as the written constitution of Aotearoa (Mutu et al., 2021).

He Wakaputanga is regarded as the tuakana (elder) to the teina (junior) document of Te Tiriti (Mutu et al., 2021). Te Tiriti o Waitangi is the founding document of the colonial state of New

[3] I have chosen to use the spelling Wakaputanga as this is the spelling used on the actual document and that used within *Ngāpuhi Speaks* (Healy et al. 2012), the independent report written into the Ngāpuhi claim. The other spelling that can be seen is He Whakaputanga.

Zealand, a peaceful agreement negotiated in 1840 between hapū rangatira and representatives of the Queen of England. There is Te Tiriti o Waitangi (the authoritative Māori text) and the Treaty of Waitangi (the English draft). Although there are some similarities between documents, the versions are distinct and incompatible. The core issue of contention is that the Māori text guaranteed and re-affirmed Māori sovereignty, whilst the English version is considered to have ceded sovereignty to the British crown (O'Sullivan, 2019). Jackson (2020, p. 144) described the possibility of rangatira surrendering their independence as "legally impossible, politically untenable and culturally incomprehensible". There are several arguments as to why the Māori text of Te Tiriti is authoritative. Over 500 rangatira signed the Māori text, the Māori population was about 80,000 compared with about 2,000 Pākehā, and in international legal doctrine the rule of contra proferentem "provides that, in situations of conflict about treaty interpretation, the treaty (contract) is interpreted against those who proposed or drafted the treaty. In this instance, the Māori text is recognised" (Berghan et al., 2017, p. 16). Significantly, the Waitangi Tribunal (2014, p. xxii) affirmed the understanding that Māori had articulated for generations, and concluded that in February 1840 the rangatira who signed Te Tiriti did not cede their sovereignty. Since the signing there have been numerous breaches of Te Tiriti by the Crown. These breaches have been, and are to this day, actively resisted by Māori (Mutu, 2019; O'Sullivan, 2019; Walker, 1990).

It has been posited that if Te Tiriti ō Waitangi is implemented fully within the health sector then institutional racism would be eliminated, and health equity would be achieved (Came & McCreanor, 2015; Came et al., 2019). Te Tiriti is seen as the basis of ethical practice for health promotion and public health in Aotearoa (Berghan et al., 2017; Crengle et al., 2023; Health Promotion Forum, 2002; Kewene et al., 2024) and a vehicle to improve Māori health outcomes (Whitinui, 2011).

Although Te Tiriti has always been a document about wellbeing (Health Promotion Forum, 2002), it is only over the past 20 years or so that the field of public health and health promotion in Aotearoa has provided guidance on how to engage and practice in accordance with Te Tiriti in the pursuit of health equity for Māori (Berghan et al., 2017; Came, Kidd, Heke, et al., 2021; Came & Tudor, 2016; Health Promotion Forum, 2002; Signal et al., 2004). This work follows the hugely influential development of cultural safety practice within nursing, which had the implementation of Te Tiriti at its core (Ramsden, 1993).

Another means of supporting Te Tiriti o Waitangi implementation within health is Critical Tiriti Analysis (CTA) (Came, Kidd, et al., 2020). CTA is a tool for reviewing health policy using the

preamble and the four articles (three written and one oral) of Te Tiriti. The process involves five distinct parts: orientation; close reading; determination; strengthening practice and Māori final word (Came, O'Sullivan, et al., 2020). In a later iteration, a table identifying knowledge and skills for non-Māori in relation to the components of Te Tiriti was developed (Came, Kidd, Heke, et al., 2021). This work builds upon work from the influential publication by Berghan et al. (2017), published by STIR, describing actions for health promotion practice in regard to Te Tiriti. Recently hauora-ā-iwi public health competencies for Aotearoa have been developed with Te Tiriti, equity and cultural safety at the heart (Crengle et al., 2023). The first foundational competency is to be able to practice in accordance with Te Tiriti (Crengle et al., 2023). Understanding colonisation and the contemporary experience of colonisation for Māori, being able to describe white privilege and how racism contributes to health inequities, critically analysing the difference between decolonisation and anti-racism, and taking action to decolonise and address racism within the health system, are all core public health competencies (Crengle et al., 2023). Critically reflective practice for allies is also central, with a core competency being able to reflect on non-Māori societal and personal beliefs and values and how they impact on their own practice. This requires critically analysing systems and structures and how the underlying ideology informs the system and outcomes (Crengle et al., 2023).

Matike Mai Aotearoa, the independent working group on constitutional transformation, led by the Iwi Chairs Forum, envisioned a Tiriti-based future for Aotearoa (Matike Mai Aotearoa, 2016). Between 2012 and 2015 over 300 hui and wānanga were held across the country to develop a constitution for Aotearoa. Constitutional values were described, and six indicative constitutional models were envisaged. These models describe three spheres of influence: a rangatiratanga (sovereignty) sphere, a kāwanatanga (governorship) sphere and a relational sphere. Came, Baker, et al. (2021) proposed how implementation of Matike Mai[4] is a way of addressing structural racism within the health sector. There is much work to be done by Pākehā in the kāwanatanga and relational spheres.

The Study of Privilege

As a Pākehā (white), middle-class (home-owning), heterosexual, able-bodied, cis-gender, educated woman, I have multiple layers of privilege. My recognition of this unearned privilege, and my belief that the privilege I have been 'granted' behoves me to act for social justice, is

[4] Although widely referred to as Matike Mai, the full name of the document is *He Whakaaro Here Whakaumu mō Aotearoa*

counter to the 'standard story' of New Zealand media and dominant culture about supposed Māori privilege (Barnes et al., 2012; McCreanor, 2009, August 27; McCreanor, 2020).

Belinda Borell and the work she led on the Privilege Project has been instrumental in naming Pākehā privilege as a manifestation of racism and that "inequity truly is a systemic issue and not about good and bad people" (Borell, 2017, p. 127). Structural analysis is applied to privilege at four levels using a framework that is commonly used to describe racism: societal, institutional, interpersonal and internalised. At each of these levels, privilege operates to provide an unearned benefit to Pākehā.

The invisibility of Pākehā privilege reinforces the meritocracy myth that we can all achieve on our own merits and the victim-blaming narrative that people facing adversity are to blame, or did not work hard enough (Borell, 2017). Efforts aiming to redress this disadvantage (albeit piecemeal and paltry, e.g., Treaty settlements) are consequently seen as special rights or privileges. Reframing disparities to consider privilege may support self-awareness among those privileged and lead to a commitment to equity (Borell, 2017). Addressing Pākehā privilege challenges a collective Pākehā value of 'a fair go' and can support discussion with Māori about self-determination (Borell, 2017). Borell (2017) also theorised about the concept of historical privilege. Historical privilege is defined as "the complex and collective structural advantages experienced over time and across generations by a group of people who share an identity, affiliation, or circumstance" (Borell, 2017, p. 107). It is posited that, for each of the key elements of historical trauma, the flipside can be conceptualised as historical privilege. For example, act(s) of trauma experienced through colonisation for Māori become acts of historical privilege for Pākehā through the dramatic increase in wealth, power, and social status. If we are serious about addressing the impacts of colonisation upon Māori then the privilege conferred upon Pākehā through the process of colonisation must also be equally acknowledged (Borell, 2017). The work of allies is to acknowledge this privilege and actively work to disrupt it (Crawford & Langridge, 2022; Margaret & Came, 2019). The invisibility of privilege is a core component in its maintenance (Borell et al., 2009; Pease, 2010), as we cannot change what we cannot see.

Throughout the world, where there is systemic racism there is corresponding systemic white privilege. McIntosh (1992) described white privilege as an "invisible weightless knapsack of special provisions" which can be cashed in throughout daily life but remain oblivious. White researchers have been challenged to focus on addressing white privilege and the need to decolonise health systems, instead of studying "others as problems to be fixed" (McGuire-Adams, 2021, p. 9).

Pākehā Allies

Pākehā health professionals, who hold institutional and cultural power within the system, have a responsibility to alleviate Māori colleagues from the experience of facing racism and responsibility for fighting racism (Berghan et al., 2017; Te Huia, 2016; Yensen et al., 1989).

The role of Pākehā allies supporting anti-racism is valued by Māori (Emery-Whittington & Davis, 2023; Hunter & Cook, 2020) and allies are "essential to the effectiveness of anti-racism efforts" (Came & Griffith, 2018, p. 182). Through gaining greater clarity about the experiences of Pākehā as allies involved in implementing change, we can understand more about what works. As Came and Griffith (2018, p. 184) stated, "understanding the values and behaviour of the people who can most effectively get things done and who are gatekeepers for others are critical to explicating the problems and solutions in a given system."

One of the key requirements for members of a dominant group to engage in anti-racism work is to be aware of their own culture, identity and privilege. There are several significant studies of the development of Pākehā identity (Black, 2010; Forsyth, 2018; Gray et al., 2013; Terruhn, 2015). Originally, Pākehā referred to the new arrivals to this land, those who were strangers to Māori – the whalers, sealers and traders (Walker, 1990) – but over time it has become specific to white people of European origin. Terruhn (2019, p. 2) cited Spoonley (1993, p. 57) in defining Pākehā as "New Zealanders of a European background, whose cultural values and behaviour have been primarily formed from the experiences of being a member of the dominant group of New Zealand." Bell (2014, p. 6) said that white people in settler colonial nations are structurally positioned by colonisation: "We still constitute the dominant culture of our societies, and our political and economic institutions are largely governed by people like us"; although we may or may not be descended from settlers, we "have inherited the political, material and symbolic privileges secured by their practices of colonization." Margaret (2017, p. 2) defined Pākehā as "white European, particularly of British descent … what we have in common is our privilege as beneficiaries of colonisation." Inherent within all these definitions is the recognition of the power and privilege that the colonisation of Aotearoa New Zealand bestows upon Pākehā.

All ally work is "contextual and relational" (Margaret, 2013, p. 117). There is no 'tick-box' list of how to be a good ally; however, core ethical principles of anti-racism praxis for allies have been identified: "respect (for those directly impacted by racism), recognition (of the destructive impacts of racism), and responsibility (to act to mitigate racism)" (Margaret & Came, 2019, p. 317). It is important to recognise that being an ally is not an identity; rather, it is about what people do, how they act, in relation and connection with others, and it is about understanding

power and privilege (Margaret, 2013; Margaret & Came, 2019). Margaret and Came (2019, p. 317) identified three interrelated aspects of ally practice: "(1) understanding and addressing power, (2) skills for working across difference, and (3) building and sustaining relationships."

In their study of enacting Te Tiriti o Waitangi in health promotion practice, Berghan et al. (2017) also emphasised the role of relationships. Most important for the work of allies was, after learning about injustice, the responsibility to take action (Berghan et al., 2017). The strategies employed included using the access allies had to decision makers and resources to shape policy, practices, and strategies to address racism and colonisation. Barnes (2013) identified several interrelated themes from his research about how relationships between Indigenous and non-Indigenous people develop. These include: self-reflection about identity and intentions; being conscious of power dynamics, especially in regard to having institutional or expert knowledge; having respect for mātauranga Māori; being comfortable with complexity and the unknown; and acknowledging the benefits of the relationship.

Te Huia (2016) described Pākehā allies as those who have learnt about and acknowledge the role of Pākehā culture's contribution to injustices against Māori and engage in Pākehā decolonisation. Further to this, an important role for a Pākehā ally is "to support and inform their own Pākehā peers and communities who are in the process of Pākehā decolonisation [and] relieve Māori from the emotional resources needed to undertake such tasks" (Te Huia, 2016, p. 14). Emery-Whittington and Davis (2023) highlighted how important critical allies were within small health professions, such as occupational therapy, that have a very low proportion of Māori workforce. Critical allies can support and amplify marginalised voices, undertake Tiriti education with colleagues, challenge institutional racism and speak up to address racism (Emery-Whittington & Davis, 2023).

Guide to the Thesis

Following the principles of activist scholarship to ensure research is accountable to the people and cause it seeks to serve, and with the intent of making a timely contribution for others working in this area, this thesis comprises some chapters consisting of papers written for publication. Accordingly, these chapters can be read as standalone documents; however, the format is sequential, starting with the health reforms as context of the study, then two literature reviews, one focused locally, the other international, followed by methodology, methods, findings, discussion and conclusion. Further details of each of the chapters are provided below.

Chapter Two provides an overview and history, starting in 1900 and going through to the health reforms implemented in 2022. This chapter highlights Māori resistance and innovation, and traces the history of the Māori health authority to the early 20th century. Reviewing the history of health system reform in Aotearoa enables consideration of recent reforms, and the latest regressive developments, within this context.

Chapter Three is the first of two publications included in the thesis. This paper outlines what the literature tells us about Tiriti-based anti-racism praxis for Pākehā allies in the health sector. A novel deliberate citational practice which prioritised Indigenous scholarship from Aotearoa is outlined. It is argued that this approach considers the relational work of allyship and the historical, socio-political, and geographic dimensions of racism and anti-racism. The findings are organised according to the five elements of Te Tiriti o Waitangi: whanaungatanga (development of relationships); kāwanatanga (taking action within the system); tino rangatiratanga (Indigenous sovereignty); ōritetanga (prioritising equity); and wairuatanga (doing the work with heart). The chapter concludes with a model outlining four cornerstones for Tiriti-based anti-racism praxis: first, a required commitment to Te Tiriti and Māori sovereignty; second, clarity on Pākehā positionality, privilege and power; third, relationships with and respect for Māori leadership; and, finally, values-based action at the individual, collective and system level.

Chapter Four provides an overview of the international literature with a focus on literature from colonial settler nations that covers anti-racism approaches within health addressing the racism experienced by Indigenous peoples, the role of white allies in health systems, and the role of white allies addressing racism and working to decolonise. Three themes are identified from the review: first, the importance of clarification around the terminology of allies and allyship; second, the structure and the system; and, third, the role of allies.

Chapter Five presents the second of my publications as I outline how Te Tiriti o Waitangi can be considered as a methodology within the transformative research paradigm and describe the application to this study. A discussion of how Te Tiriti as a methodology can be a useful frame for non-Indigenous researchers seeking ethical and just research practices is provided.

Chapter Six describes the research methods. A close description of how the reflexive thematic analysis of the interviews was undertaken is provided here, along with a discussion of my self-reflexivity.

Chapter Seven presents the findings of the interviews. Three themes are described: the first is about transforming systems, with five subthemes: politics, power, performativity, people and potential in moving towards a pro-Tiriti, pro-equity, anti-racist health system. The second theme is 'becoming consciously Pākehā' which includes four subthemes: Pākehā cultural identity, connection and contact with te ao Māori, accountability for Pākehā power and privilege, and an ethic of service. Becoming consciously Pākehā is essential to and informs the third theme. Tiriti-based anti-racism praxis entails subthemes of honouring Te Tiriti, respecting rangatiratanga, acting in relation with Māori, acting strategically and critically reflecting.

Chapter Eight discusses the findings of the research and presents a model based on the study findings, called Whiti Mai te Rā. Five key concepts for the Tiriti-based anti-racism praxis of Pākehā critical allies are depicted in the model: a deep respect for and relationship with Māori, and acceptance of rangatiratanga; an iterative cycle of 'becoming consciously Pākehā'; combined with Tiriti-based action; informed by critical reflection; all enveloped with hope and love.

Chapter Nine concludes the thesis and summarises how this study contributes to local and international understandings and the implications for research and practice.

Chapter Two: Health Sector Reform in Aotearoa

This chapter provides a brief overview of the history of health reforms in Aotearoa along with significant socio-political events that contributed to shaping health reforms. The somewhat arbitrary starting point of 1900 acknowledges the establishment of the Department of Health, the first formal efforts of national health organisation. Beginning here does not suggest that systems to regulate or govern health were not present in Aotearoa prior. However, it is beyond the scope of this chapter to explore these matters in depth; suffice to say, mātauranga (Māori ways of knowing) and tikanga (Māori principles, beliefs, values and practices) are the basis for Māori health and wellbeing (Mead, 2003; Reweti et al., 2023). For Durie (2003), the concepts of tapu (risk) and noa (safety) provided a framework for public health decision-making, and the societal rules essential for survival and, ultimately, flourishing.

This chapter provides a summary, rather than a comprehensive review, mainly of key Māori initiatives to further Māori health autonomy and Te Tiriti implementation within the monocultural health service. Consequently, it also provides a summary of Crown responses to these initiatives. A summary of two papers provide a critical Tiriti perspective on the 2022 health reforms: a CTA (Came, O'Sullivan, et al., 2020) of the Pae Ora Bill that established the parameters for the health reforms (Rae et al., 2022), and a subsequent CTA looking at Te Pae Tata, the interim New Zealand health plan (Rae et al., 2023). The chapter concludes by providing an update on the most recent developments that have again destabilised the health system – the disestablishment of Te Aka Whai Ora, the Māori Health Authority. This chapter provides a narrative of Māori resistance, resilience, persistence and determination in the face of tremendous pressure and overwhelming odds.

The Century Begins

Prior to 1900 the government saw no need for "concerted official action" to address the perilous state of Māori health (Lange, 1999, p. 68). This is despite the Māori population having plummeted from a healthy population of about 80,000 in 1840 to 42,000 in 1896 (Moewaka Barnes & McCreanor, 2019). For Māori, this period was one of "extreme trauma and loss" largely due to the ravages of colonisation and war which introduced infectious disease, and confiscated land and resources essential to wellbeing and life (Moewaka Barnes & McCreanor, 2019, p. 22).

Durie (1998b) described the period between 1900 and 1930 as a time of mana rangatira: Māori leadership in the development of health policies and health delivery, ultimately leading to the recovery of Māori health. During this time, Maui Pōmare, Apirana Ngata, Hamiora Hei and Te

Rangi Hiroa (Peter Buck) were all influential leaders in Māori health (Cram et al., 2019). They campaigned for autonomous Māori health systems and were driven to improve Māori health (Laing & Pomare, 1994). The aim of their work was "Māori autonomy and the development of a modern Māori health-care system that combined the principles of oranga with western health practices" (Cram et al., 2019, p. 60).

The Department of Public Health Act and the Māori Councils Act were both passed into legislation in 1900. The Māori Councils Act established 19 elected Māori Councils and was a compromise between Māori calls for autonomy and Crown willingness to accommodate this (Durie, 1998b). The councils had significant public health responsibilities and introduced Māori community health workers to address issues such as housing, alcohol sales, water supply and sanitation, but insufficient funding and power over policy limited their effectiveness (Cram et al., 2019). Māori efforts to establish autonomy within the government system, like the Māori Councils, were balanced against the "Pākehā majority and the state's own need to retain power and stability" (Cram et al., 2019, pp. 81-82).

In 1901 the Native Health Nursing Scheme was established, envisaged by Hamiora Hei and Akenehi Hei (the first Māori women registered as a nurse) as an autonomous health system for Māori by Māori (McKegg, 1992). Although the scheme was intended to support Māori nurses to work within Māori communities, the scheme became dominated by Pākehā nurses due to the racism directed towards Māori nurses (McKegg, 1992). This racism included the refusal of hospital boards to train Māori nurses or, if they did accept them, an insistence upon the provision of racially segregated accommodation for Māori nurses (McKegg, 1992). By 1911 the scheme was a tool of assimilation with the central role of Māori Health Nurses (who were largely Pākehā) being to educate Māori on cleanliness and sanitation (McKegg, 1992).

In 1907 the Tohunga Suppression Act was passed, which effectively outlawed Māori healing knowledge and practices (Woodard, 2014). Tohunga means a person "chosen or appointed by the gods to be their representative and the agent by which they manifested their operations in the natural world by signs of power (tohu mana)" (Marsden, 2003, p. 14). The Tohunga Suppression Act was another tool of assimilation and attacked significant elements that defined Māori cultural practices, destabilising the "heart of Māori society and, consequently, resistance to colonisation" (Woodard, 2014, p. 43). Hokowhitu et al. (2022, p. 109) explained that because tohunga retained "pre-colonial metaphysical belief systems through practices, ritual and systems of knowledge transferral", they had to be banished to cut the "crucial tie between knowledge and power".

The origins of the current conceptualisation of a Māori health authority are traced over a hundred years ago to the 1920 Health Act when Te Rangi Hiroa established a Māori Advisory Committee for the Department of Health (Durie, 2023). However, this was short lived, with the Division of Māori Hygiene disestablished in 1930. The demise of the Division of Māori Hygiene and the reduction in the scope and influence of Māori Councils was seen as "an unequivocal move away from the active participation of Māori, at least as providers of health care" (Durie, 1998b, p. 46). Responsibility for Māori health was handed over to Pākehā medical officers of health and public health nurses (Durie, 1998b). Cram et al. (2019, p. 61) summarised this period as characteristic of government's failure to adequately fund and commit to a plan to improve Māori wellbeing; however, "the overarching factor was the persistence of an assimilation agenda, underscored by racism and an unwillingness to devolve power to Māori communities."

The Welfare State, Urbanisation and Assimilation

The 1938 Social Security Act has been described as the foundation of the current health system (Gauld, 2013) and prior to this point in time the government role in funding and providing health care was minimal (Laugesen & Salmond, 1994). Before 1938, free hospital care was available to Māori "for compassionate and assimilation reasons" (Laugesen & Salmond, 1994, p. 14). The Act was widely viewed as the establishment of the welfare state in Aotearoa through the provision of social welfare benefits; however, Māori received lower rates of widow's benefit and the old age pension (Cram et al., 2019). The vision of the Act was a free universal health service for all, but the powerful influence of general practitioners, supported through the organised efforts of the British Medical Association, ensured this was never realised, and fees for general practice visits were retained (Gauld, 2009).

From about 1930 onwards, as a proactive response to poverty, unemployment, lack of housing, education and health services, Māori began a move to the cities (Cram et al., 2019). By 1966, 62% of Māori were living in urban areas, of whom a third were living in Auckland (Cram et al., 2019). Urban living required Māori "to dwell in the world of biculturalism or surrender to the Pākehā imperative of assimilation" (Walker, 1990, p. 198). The vast majority rejected assimilation and instead committed to cultural continuity (Walker, 1990). Walker (1990) asserted that voluntary association with Māori organisations such as the Māori Women's Welfare League was key to successful urban living. The League formed in 1951 and focused on family, women, children, health, housing, education and justice (Cram et al., 2019). Discrimination and disparities between Māori and Pākehā were the focus of discussion at regional and national conferences (Durie, 1998b). The League was seen as championing the

cause for Māori women and as a strong advocate for accessible and culturally safe health care (Durie, 1998b).

In 1961 the Hunn Report was released which described a range of injustices and inequities experienced by Māori. The report classified Māori into three groups: a) "completely detribalised minority whose Māoritanga is only vestigial", b) the majority of Māori at "home in either society", and c) "another minority complacently living a backward life in primitive conditions" (Hunn, 1961, p. 16). The report recommended various policies would be required to "eliminate Group C by raising it to Group B, and to leave it to the personal choice of Group B members whether they stay there or join Group A – in other words, whether they remain 'integrated' or become 'assimilated'" (Hunn, 1961, p. 16). The solution proposed was the integration of Māori into Pākehā culture, which included the practice of 'pepper potting' by providing small numbers of houses for Māori in Pākehā neighbourhoods (Harris, 2004). The Hunn Report characterised the overall policy orientation of successive governments in the first half of the 20th century as "paternalistic, ethnocentric and culturally oppressive" (Cram et al., 2019, p. 86).

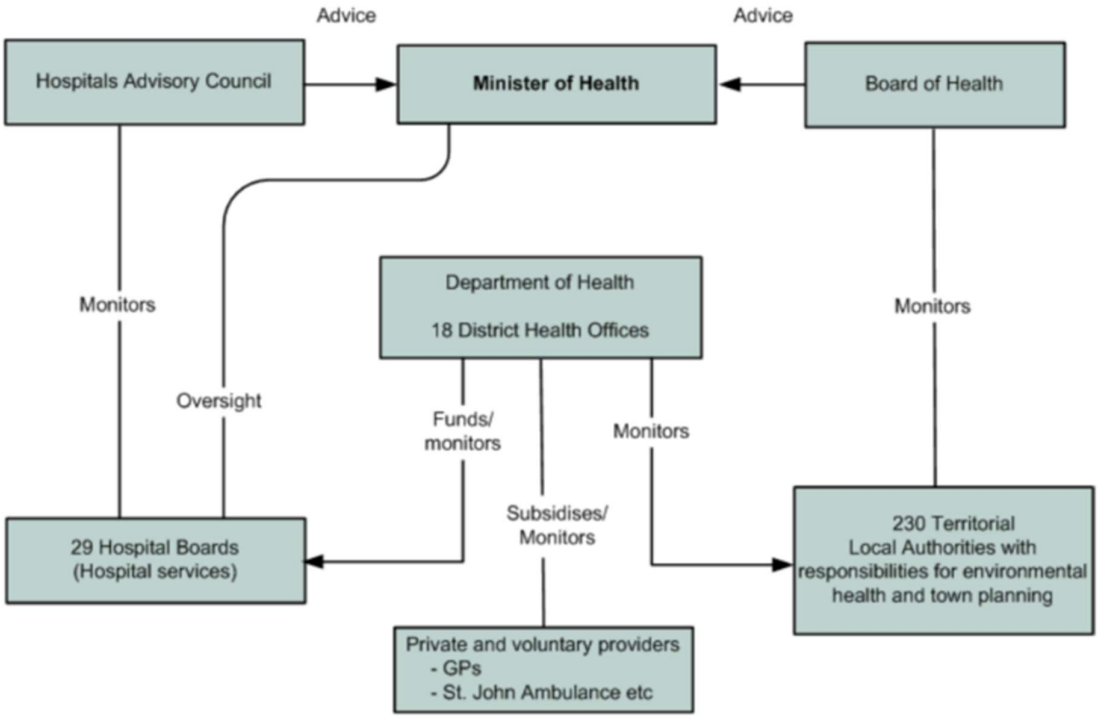
Urbanisation also supported the Māori cultural renaissance which began in the 1970s (Walker, 1990). In 1975, two events occurred almost simultaneously, the Land March and the passing of the Treaty of Waitangi Act. Led by Whina Cooper, the battle cry of the march was 'not one more acre'. 40,000 joined on the march which started in Te Hapua. When it arrived in Wellington a 60,000 signature petition was presented to Prime Minister Bill Rowling (Harris, 2004). The Treaty of Waitangi Act was championed by Māori Labour MP Matiu Rata and saw the establishment of the Waitangi Tribunal to investigate contemporary breaches of the Treaty[5] (Cram et al., 2019). A core limitation of the Treaty of Waitangi Act was the requirement to give both the English version and the Māori text equal weight in deliberations. Both events asserted a strong Māori agenda, bringing to the attention of Pākehā New Zealand the relevance of the Treaty and Māori land. Walker (1990, p. 214) described the consequence of the Land March as the unprecedented politicisation of Māori united in purpose "in the endless struggle against colonisation". The assimilation agenda of the state was abandoned and biculturalism was emerging (Durie, 1998b).

Up until this time the structure of the health system had remained stable. In the 1980s the Minister of Health oversaw the system and received advice from the Hospitals Advisory Council,

[5] When Treaty or Treaty of Waitangi is used in the text it refers to the English version and the usage is consistent with the original authors' usage. Te Tiriti or Te Tiriti o Waitangi is used when specifically referring to the Māori text.

which monitored 29 Hospital Boards providing hospital services (Quin, 2009). The Minister also received advice from the Board of Health which had 230 territorial local authorities with environmental health and town planning responsibilities (Quin, 2009). The Department of Health had 18 district health offices which funded and monitored all other services (Quin, 2009).

Figure 2
The structure of New Zealand's health system, 1980



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In 1983, the Area Health Boards (AHBs) Act was passed that established 14 AHBs with local elected and appointed board members. This Act decentralised Department of Health responsibilities including hospital services, health promotion, health protection, and environmental health to AHBs. The Act had no explicit reference to Māori interests nor the Treaty. In an attempt to cap the rising costs of hospital budgets, where 70% of the health budget was spent, population-based funding was introduced in 1983 (Quin, 2009). There was an attempt to make primary care more affordable, and therefore accessible, by capping the amount general practice could charge in co-payments (Quin, 2009). However, the highly organised general practice association pushed back and the proposal was dropped. Primary

health care remained at arm's length from government although still partially funded through the General Medical Services (GMS), a scheme which had been in place since the late 1930s.

The Neo-liberal Era

The Labour Government elected in July 1984 implemented a set of neo-liberal reforms that radically altered New Zealand society. The size of government was reduced, state-owned enterprises were sold, income tax was reduced, a regressive consumption tax introduced, welfare support slashed, barriers to international trade removed and traditional government services devolved (Tobias et al., 2009). These neo-liberal reforms continued for over a decade, resulting in income inequality increasing from one of the lowest in the OECD in the mid-1980s to one of the highest by the mid-1990s (Tobias et al., 2009). Since the 1980s, Aotearoa has had a neo-liberal approach to health service provision characterised by a focus on contracts-based funding, limited publicly provided services and an emphasis on individual responsibility (Gifford et al., 2018). This environment did bring new opportunities for Māori health providers "precisely because of the neo-liberal preference for devolution of service provision beyond the state sector" (Gifford et al., 2018, p. 59). The "burgeoning" number of Māori health providers in this period was seen as some acknowledgement by the state that for-Māori-by-Māori services are best to meet the needs of Māori (Crengle, 2000).

1984 was also significant in other ways for the Treaty and health. The Hui Whakaoranga Māori health conference was held which endorsed Māori health frameworks and advocated for a 'by Māori for Māori approach' (Durie, 1998b). The hui also called for marae-based health initiatives and for more Māori to be involved throughout the health sector – as practitioners and decision-makers (Ngata & Dyall, 1984). Also in 1984, the decade of Māori development was launched at Hui Taumata and the Treaty of Waitangi was affirmed as the basis for interaction with Government (Durie, 1998b). Although the main focus was on economic development, health and social policies were also identified as crucial to the Māori development agenda and control of resources (Durie, 1998b). A report by the Māori Women's Welfare League, *Rapuora: Health and Māori Women*, was published. This report added another voice to calls for culturally responsive health services incorporating Māori values, perspectives and participation in health, and provided practical solutions towards biculturalism (Cram et al., 2019). Several thousand people, including Māori, Pākehā, Tangata Pasifika, church groups, student groups, protested on Waitangi Day 1984 calling for the government to address Treaty breaches (Cram et al., 2019). This anti-racist social movement was mobilised after the anti-apartheid protests of the

Springbok rugby tour in 1981 where Pākehā were challenged by Māori to address anti-Māori racism and to honour Te Tiriti (Huygens, 2007).

Fulfilling an election promise, and hoping to appease the growing protest at a lack of action on Te Tiriti, the Labour Government elected in July 1984 passed the Treaty of Waitangi Amendment Act (Kelsey, 1996). The amendment extended the jurisdiction of the Tribunal to 1840, increased its membership from three to seven, and allowed for Māori majority membership on the Tribunal (Walker, 1990). A core issue that remains unresolved is that Tribunal decisions are not binding on the government (Durie, 1998b). In 1988, a report produced by the Parliamentary Commissioner for the Environment found that, of 59 Tribunal recommendations made to the Crown, only 13 had been fully implemented and eight partially, and most Tribunal recommendations made to the Crown are not fully implemented (Kelsey, 1996).

The momentum of change towards considering the Treaty within policy and legislation, including health, was underway. In 1985 a Standing Committee on Māori Health, reporting to the Board of Health, was established. The committee was supported by a small Māori health project team. The committee advised there were six challenges to the development of a bicultural health system:

1. The articles of the Treaty are the foundation of health.
2. Māori tribal authorities are the proper trustees for Māori.
3. Resources are made available to tribal authorities to enable them to develop health programmes; Māori health will be improved through whānau, hapū and iwi development.
4. Māori health will be addressed through increasing the number of Māori people in the design, decision-making and delivery of health.
5. The health team must include Western-trained people and people trained in te ao Māori.
6. Training programmes should reflect biculturalism (Salmond, 1986).

It is noteworthy that by 1987 the Māori health project team working for the Standing Committee resigned. It is not clear why the project team resigned, though Durie (1998b) suggested it may have been dissatisfaction with role clarity, and lack of autonomy, but the resignation did raise questions about the commitment to Māori health within the system (Durie, 1998b).

In 1986, the Cabinet agreed that all future legislation should consider Treaty principles and departments should consult with Māori on matters affecting Treaty application (Durie, 1998b;

Salmond, 1986). Following this Cabinet minute the Director-General of Health, George Salmond, sent a circular memorandum to AHBs emphasising the significance of the Treaty to health (Salmond, 1986). By 1986, six AHBs had Māori health education liaison officers, the role being to support whānau accessing hospital services and to provide Māori cultural advice to support health staff to work with Māori (Durie, 1998b). In 1988, the State Sector Act required government departments to develop plans based on Treaty of Waitangi principles, biculturalism and equity for Māori (Came, 2012). This signalled biculturalism as official government policy, a policy "which operated as a contemporary form of assimilation, incorporating Māori cultural practices and advisory officers into the fringes of existing state agencies" (Kelsey, 1996, p. 185).

Also in 1988, at the Hui Waimanawa in Ōtautahi, the National Council of Māori Nurses agreed upon a model for cultural safety training in nursing education (Ramsden, 1990). Cultural safety was a radical departure from biculturalism, which sought to incorporate some Māori cultural practices into the health system. Instead cultural safety advocated strongly for Tiriti-based structural change within health (Ramsden, 1990).

A year later, in 1989, the Ministerial Advisory Committee on Māori Health was established replacing the Board of Health Standing Committee on Māori health, with the main role being to provide advice to the Minister of Health and inform Māori health policy (Durie, 1998b).

In 1990, the 150-year commemoration of Te Tiriti, a Māori health committee was established by the Health Research Council (Durie, 1998b). Also in this year, Te Wāhanga Hauora Māori, a Māori Health Policy Unit was established within the Department of Health to provide policy advice. These were small, significant and long overdue steps towards providing a Māori worldview and contribution to health policy. In 1993, only three years later, the staff within Te Wāhanga Hauora Māori all resigned, echoing what had occurred only six years previously to the Māori health project team. Reasons for the "dispirited staff" included competing and unrealistic demands to meet the needs of the Department (policy, Māori cultural and Treaty advice), iwi (information, resources, guidance) and the Ministerial Advisory Committee (national hui participation, responding to members) (Durie, 1998b, p. 106).

By the late 1980s Māori claims to the Waitangi Tribunal were increasingly focused on political power, the pre-eminence of the Māori text of Te Tiriti and consequent limits to the kāwanatanga of the Crown (Kelsey, 1996). The Labour Government responded unilaterally by attempting to redefine Te Tiriti with a set of Treaty principles that "sidelined the Māori text and affirmed the superior position of the Crown" (Kelsey, 1996, p. 184). This was met with universal Māori outrage. Bishop Whakahuihui Vercoe said on Waitangi Day 1990:

> What I have come here for is to renew the ties that made us a nation in 1840. I don't want to debate the Treaty, I don't want to renegotiate the Treaty, I want the Treaty to stand firmly as the unity, the means by which we are made one nation. … The Treaty is what we are celebrating. It is what we are trying to establish so that my tino rangatiratanga is the same as your tino rangatiratanga. And so I have come to Waitangi to cry for the promises that you made and for the expectations of our tupunas [sic] made 150 years ago. … I want to say to the government: don't produce principles of the Treaty – the Treaty is already there (Vercoe as quoted in Kelsey, 1996, pp. 184-185).

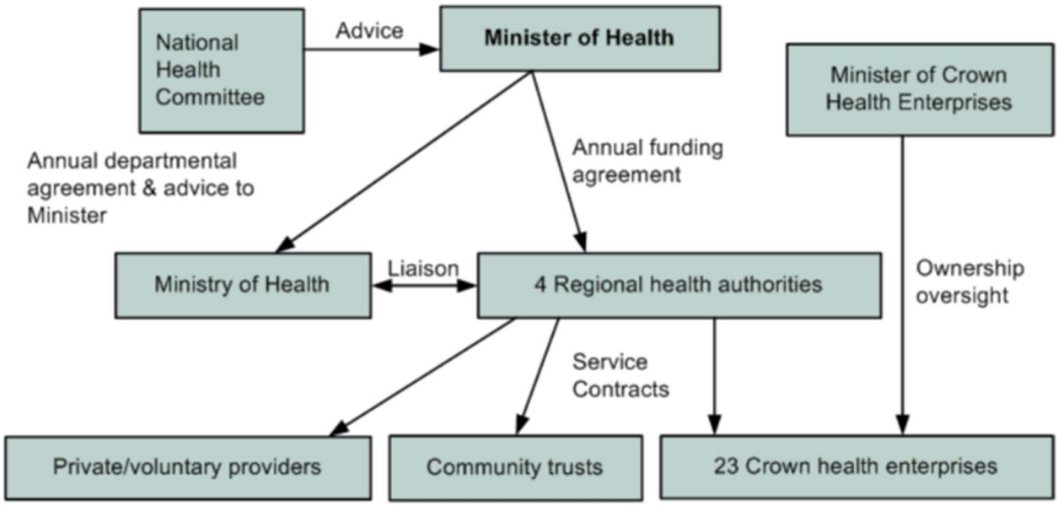
The legacy of the unilateral creation of 'Treaty principles' by the Crown, and the resulting dilution of tino rangatiratanga they created, remains within the health system today. The ubiquitous use of such principles, particularly the three P's[6] (participation, partnership and protection), although helping to provide a language, mainly to non-Māori, to discuss the application of Te Tiriti to health, has undermined genuine engagement with the Māori text.

The election of the National Government in 1990 heralded a set of health reforms focused on controlling health expenditure (Quin, 2009). One of the first steps taken was to disestablish AHBs and appoint government commissioners (Goodyear-Smith & Ashton, 2019). Māori responded to these reforms by calling for a Māori Health Authority (Laing & Pomare, 1994). It was proposed the authority would enable Māori control over Māori health, enable the inclusion of Māori healing systems, and reduce fragmentation by integrating segregated parts of the health system (Laing & Pomare, 1994).

In 1993, the Health and Disability Services Act created four Regional Health Authorities (RHAs) and 23 Crown Health Enterprises (CHEs) (Quin, 2009). The four RHAs, funded by a population health formula by the Ministry of Health, were responsible for purchasing health and disability services, and monitoring population health needs and the performance of providers (Quin, 2009). The locally elected members of AHBs were replaced by non-elected government appointed boards for RHAs and CHEs (Quin, 2009). CHEs were set up to make hospital care more cost-efficient, they were autonomous publicly owned businesses and were funded on contract by the RHAs (Quin, 2009). Durie (2005, May, p. 13) described these reforms as emphasising "deregulation, devolution and contestability".

[6] The three P's referred to here are three principles of partnership, participation and protection which were first articulated by the Royal Commission on Social Policy (1988) as principles to guide social policy development. The use of these principles to explain Tiriti responsibilities has been ubiquitous throughout health and social services.

Figure 3
The structure of New Zealand's health system, 1996



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Māori Health Provider Development

Prior to the formation of RHAs and CHEs there was limited involvement of Māori in providing primary care services, with one primary care practice based on a marae (Crengle, 2000). However, the deregulated, contract-for-services model provided Māori with opportunities to develop and provide kaupapa Māori health services (Crengle, 2000; Masters-Awatere, 2017). Also, in 1993, Te Kete Hauora, an internal business unit focused on Māori health, was established and for the first time, a Deputy Director-General of Māori Health position was created in the Ministry of Health senior leadership team (Durie, 1998b).

Rob Cooper (2000, p. 101), a rangatira of Ngātihine closely involved in Māori primary health care development in Tai Tokerau, described this era as "indisputably the greatest post-colonial 'near decade' of unique Māori development New Zealand has ever experienced". Cooper (2000, p. 106) listed significant achievements for Māori during this time including the expansion of Māori-owned and Māori-operated health services "from a mere handful to over 200". However Durie (1998b, p. 147) described a dilemma for Māori:

> Tino rangatiratanga and its promise of greater Māori autonomy could be construed as offering implicit support for privatisation or at least for reduced State provision of

> services. Having made a case for greater Māori control, Iwi and other Māori authorities were faced with the prospect of using meagre resources derived in part from the State and in part from their own coffers, to provide a range of economic, social and cultural programmes. The State, in turn, seemed poised not only to encourage the private provision of some social services but also to curb the level of State spending on health, education, housing and employment.

Masters-Awatere (2017) described how the promise of Māori health autonomy was hampered by inadequate funding, inequitable contracts and unequal treatment of Māori health providers. Came (2014) identified historical funding allocations, monocultural frameworks, uneven access to Crown officials, inconsistent practice and lack of leadership as sites of racism experienced by Māori providers and, conversely, sites of privilege experienced by Pākehā.

As well as spawning Māori health providers, these reforms also initiated the development of Independent Practitioner Associations (IPAs). However, initially, general practitioners (GPs) were reluctant to join IPAs because of concerns that their professional and economic autonomy would be compromised (Barnett et al., 2009). There were about 30 IPAs in 1996, the largest, Procare Health, had 340 GP members (Quin, 2009). By 1999, 80% of general practices were IPA members (Barnett et al., 2009). The main purpose of the IPA was to protect the status of GPs, acting as a negotiating body with government rather than demonstrating any concern with issues of access to care (Barnett & Barnett, 2004). Some IPAs, however, did deliver population-based initiatives, such as targeted immunisation outreach, with funding from savings made from budgets held for referred services such as laboratory and pharmaceuticals. Often, these savings were held as accumulated funds, resulting in large cash reserves. By 2010, large Primary Health Organisations (PHOs), which formed out of large IPAs, had cash reserves of $42 million (Apa, 2011).

Māori health providers, along with union health centres and other community-based primary care services, were part of the third sector, the non-government and non-profit health organisation sector that emerged in the 1990s. Common to all third-sector health organisations was a broad understanding of primary health care, social rather than commercial objectives, involvement of communities in the delivery and governance of the health service, employment of salaried GPs, and funding through capitation (Crampton et al., 2001). Generally located in low-income areas, these providers charged minimal, if any, fees for service to address geographic and financial barriers to access and represented a proactive effort to address equity and access issues for low-income New Zealanders and Māori (Crampton et al., 2001).

The formation of IPAs, Māori health providers and third-sector health centres laid a platform for further change in the sector. Without such a basis, the government's proposals for change in primary health care would not have been feasible (Barnett & Barnett, 2004). In a small recognition of the challenges facing Māori health providers, in 1997 the Māori Provider Development Scheme was established. This was a contestable grant to support the development of Māori health and disability support providers which also provided for Hauora Māori scholarships for tertiary studies. The budget was about $9 million per annum, and up until 2022 (New Zealand Government, 2022a) the budget had not changed materially since establishment (Waitangi Tribunal, 2019).

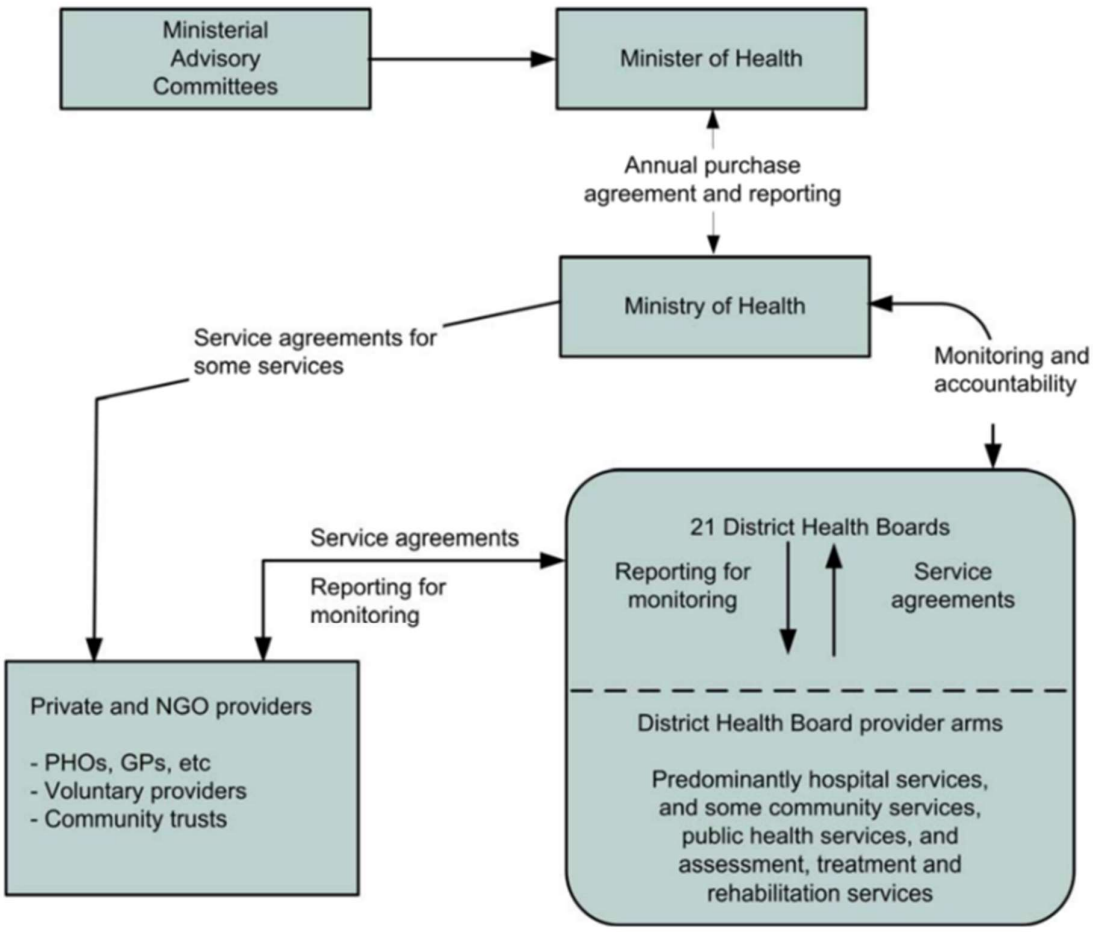
Another Century Begins

With the election of the Labour/Alliance Government in 1999, another set of health reforms was set in motion. Public disquiet about ongoing neo-liberal reforms, sharp increases in inequality, concerns about social violence, and a meningococcal outbreak mainly affecting Māori and Pacific children focused attention on health determinants and the racism that overlaid deprivation (Matheson et al., 2024). The Labour/Alliance Government had a clear policy of 'closing the gaps' based on the Māori policy election manifesto *He Putahitanga Hōu* (Humpage, 2002). The reform of the health system was seen as one way to give effect to the closing the gaps policy (Humpage, 2002). The New Zealand Public Health and Disability Act 2000 decentralised the health system and established 21 DHBs. This legislation was the first health legislation to recognise the Treaty of Waitangi (Durie, 2005, May). The Treaty clause in the New Zealand Public Health and Disability Act 2000 said:

> In order to recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Māori, Part 3 provides for mechanisms to enable Māori to contribute to decision making on, and to participate in the delivery of, health and disability services.

These reforms were described as "light-years ahead of anything that had gone before" and a "great hope" for the improvement of Māori health (Waitangi Tribunal, 2019, p. 22). However, the Treaty clause was described by the Waitangi Tribunal (2019) as a reductionist effort and that more imperative wording such as "give effect to" the principles was required rather than "recognise and respect". Improving health outcomes is also weak compared with achieving health equity for Māori (Waitangi Tribunal, 2019).

Figure 4
The structure of New Zealand's health system, 2008



Note. From "*New Zealand Health System Reforms* (Research paper 09/03)," by P. Quin, 2009, p. 20. Copyright 2009 by NZ Parliamentary Library. Used under the Fair Dealing exceptions of the NZ Copyright Act 1994.

Of note is the fact that Figure 4, above, does not name Māori providers, an example of the minimising and lack of visibility given to Māori health within the system.

The impact of politics and the compromises required on the formation of legislation and what wording ultimately ended up in the Treaty clause was commented on by John Tamihere, a member of Parliament during the Act development:

> Politics is sort of the art of the do-able and when you're in a difficult negotiation situation as we were … you've got to do the best you can in the worst possible circumstances for your people and so that's the difficulty that Māori MPs in the house [face] as a minority group. (Waitangi Tribunal, 2019, p. 76)

Further to this, although there was a sentence about tino rangatiratanga in the foreword to the 2002 version of *He Korowai Oranga* (the Māori health strategy), a claimant for the Māori PHOs, Taitimu Maipi, told the Waitangi Tribunal:

> You can print something onto a page, but you've got to breathe life into it, and I think that was missing. You breathe life into what you believe tino rangatiratanga looks like but there was no breath of life in that, there was just a lot of words in my view. (Waitangi Tribunal, 2019, p. 82)

As well as establishing DHBs, the reforms of the early 2000s radically restructured primary health care. Although there had been changes in the previous decade, the introduction of Primary Health Organisations (PHOs) and capitation-based funding was groundbreaking. Although the *Primary Health Care Strategy* (King, 2001) had 'reducing inequalities' as a core aim, the capitation funding did not include an ethnicity weighting, thereby entrenching funding inequities for Māori health providers and third-sector community providers who predominantly serviced Māori and Pacific populations (Waitangi Tribunal, 2019). Further, the capitation funding financially incentivised enrolling healthy patients, rather than patients with complex high health needs, among whom Māori are disproportionately represented (Came, O'Sullivan, et al., 2020). Whilst establishing PHOs, the Ministry did not account for the variable resources available to IPAs and Māori health providers (Waitangi Tribunal, 2019). IPAs had infrastructure, large capital bases and large enrolled populations, the opposite applied to Māori health providers (Waitangi Tribunal, 2019). The failure of the Crown to recognise, support and fund Māori PHOs disadvantaged them from the outset, and this disadvantage compounded over time (Waitangi Tribunal, 2019). Economic imperatives were privileged over Māori health equity, and universal service provision was privileged rather than focused Māori-centred primary health care (Came, O'Sullivan, et al., 2020).

During the mid-2000s, several key political incidents occurred that reduced a Tiriti and equity focus within government and the health system. In 2003, the Court of Appeal ruled that the Māori Land Court had jurisdiction over the foreshore and seabed (Bargh, 2006). Almost immediately the Prime Minister, Helen Clark, announced the Government would "enshrine in law Crown ownership of the foreshore and seabed" (Otago Daily Times, June 24, 2003, as cited in Ruru, 2004, p. 64). Despite the largest protest seen in a generation (Paewai & Natanahira, 2024, May 5), the legislation went ahead and the Foreshore and Seabed Act extinguished Māori customary rights and title to the foreshore and seabed. The Associate Health Minister, Tariana Turia, refused to vote for the legislation, resigned from the Labour Party and started the Māori

Party. The same year, Don Brash, the leader of the right-of-centre National Party, in what is now widely known as the 'Orewa speech', attacked the Labour Government's approach to addressing inequalities, challenging affirmative action for Māori, which he described as "special privileges". The speech had a "seismic impact on the political landscape" and Don Brash had a "meteoric rise in political polls" (Towns et al., 2004). The Labour Government managed to hang on for another term but the damage to pro-equity and Tiriti policy initiatives was done.

In 2006, direction was given to DHBs to "no longer make any direct reference to the Treaty of Waitangi or its principles in any new policy, actions, plans or contracts" (Waitangi Tribunal, 2019, p. 93). Teresa Wall, the then Acting Director-General of Māori Health, "highlighted the political context of the day, including the 2004 Orewa speech, the seabed and foreshore hikoi, and the government of the day's fear of a backlash from the New Zealand public" as reasons for the instruction to remove Treaty references (Waitangi Tribunal, 2019, p. 94).

The primary health care capitation funding formula was also reviewed in 2006. Despite an analysis that revealed ethnicity and deprivation were factors in unmet need, and the recommendation that age, gender, ethnicity and deprivation be included in the funding formula, the Minister of Health did not proceed with the recommendation (Waitangi Tribunal, 2019). Instead, the Very Low Cost Access (VLCA) scheme was introduced. Participating practices were offered a 'top-up' to the base capitation funding in return for limiting patient fees for all adults. This policy was an attempt to address rising costs within primary health care and increasing levels of unmet need.

In 2008 a coalition government consisting of National, ACT, United Future and the Māori Party was elected and remained in power until 2017. The focus on Māori health was reduced in this period; in 2013, PHOs were no longer required to produce Māori health plans, and three years later Te Kete Hauora (the Māori health policy unit within the Ministry of Health) was disestablished along with the Deputy Director-General Māori Health position and DHBs were no longer required to produce Māori health plans. These measures were a breach of Te Tiriti and significantly undermined the ability of the Ministry to address Māori health equity (Came & Tudor, 2017). Alongside these measures, a refreshed *New Zealand Health Strategy* was released with five strategic goals: people-powered, closer to home, value and high performance, one team, smart system (Coleman, 2016). Equity for Māori was not featured strongly nor was the Treaty, let alone Te Tiriti: the foreword said the "strategy pursues equitable outcomes for all New Zealanders" and "recognises and respects the principles of the Treaty of Waitangi with more support to participate in the sector and in making decisions on services" (Coleman, 2016, p. iii).

This statement appears to limit the Treaty to 'support to participate' and decision-making limited to services, but it is not even clear that this is specifically for Māori.

Another important development for Māori during this period was Whānau Ora[7] policy. The Māori Party, a coalition partner within the government, through Tariana Turia, led out the development of Whānau Ora, the result of a confidence and supply agreement with the National Party (Boulton, 2019). Durie (2023, p. 198) described Whānau Ora as a "a Māori health and wellbeing movement built on mātauranga Māori and transcending a range of socio-economic sectors." Whānau Ora has been influential throughout the health sector, but particularly for Māori health providers who were involved in the first phase of Whānau Ora implementation (Boulton, 2019). Smith et al. (2019, p. 507) described the political implementation of Whānau Ora as "strikingly successful policy entrepreneurship". They said:

> The fact a policy approach explicitly designed around Indigenous concepts, practices and values was established within a political environment that had proved itself to be indifferent to Māori initiatives at best, and outright hostile at worst, is remarkable.

On the 14th of October 2014, the Waitangi Tribunal released their findings on *He Wakaputanga me Te Tiriti, the Declaration and the Treaty – Report on Stage 1 of the Te Paparahi o Te Raki Inquiry, Wai 1040*. They concluded

> that in February 1840 the rangatira who signed Te Tiriti did not cede their sovereignty. That is, they did not cede their authority to make and enforce law over their people or their territories. Rather, they agreed to share power and authority with the Governor. They agreed to a relationship: one in which they and Hobson were to be equal – equal while having different roles and different spheres of influence. In essence, rangatira retained their authority over their hapū and territories, while Hobson was given authority to control Pākehā. (Waitangi Tribunal, 2014, p. xxii)

After 164 years, the truth Ngāpuhi had known for generations had been affirmed.

Also in 2014, *He Korowai Oranga*, the Māori health strategy, was refreshed (Ministry of Health, 2014). The overall aim shifted from whānau ora to pae ora – healthy futures. The language of

[7] When capitalised, Whānau Ora is referring to the specific policy/programme Durie, M., Cooper, R., Grennell, D., Snively, S., & Tuaine, N. (2010). *Whānau ora: Report of the taskforce on whānau-centred initiatives*. Ministry of Social Development. . When 'whānau ora' is used uncapitalised, it refers to the concept of family wellbeing more generally.

‘reducing inequalities’ that was prevalent in the 2002 version of the strategy was changed to achieving equity, otherwise there is very little discernible difference between the strategies.

When the Labour/NZ First/Green Party Government was elected in 2017, yet another reform of the health sector was signalled. Early changes made in 2018 re-established Te Kete Hauora, the Māori health directorate, and the Deputy Director-General Māori Health position. This directorate has since published *Whakamaua, Māori Health Action Plan 2020-2025* (Ministry of Health, 2020b), a Te Tiriti o Waitangi framework guide for the health sector (Ministry of Health, 2020a) and commenced work on Ao Mai Te Ra, an anti-racism initiative for the health sector (Ministry of Health, 2022a).

In 2019, the Cabinet Office released a circular, agreed to by Cabinet, to provide guidance on how to consider the Treaty of Waitangi in policy development and implementation (Cabinet Office, 2019, October 22). The circular notes the significance of the Treaty of Waitangi as a major source of New Zealand’s constitution and a founding document of government in New Zealand (Cabinet Office, 2019, October 22). For each of the three written articles, the circular provides a simple one-line interpretation, the text of the English version, the Māori text, and a translation of the Māori text into English. For each article, several questions to guide policy development are provided. A CTA found that although the Cabinet circular “is an important evolution in government policy thought”, the continued privileging of the English version of the Treaty over the Māori text of Te Tiriti demonstrates the Crown positioning itself as dominant over Māori political authority (O'Sullivan et al., 2021).

This concludes a brief review of some of the significant events that contributed to, or detracted from, the application of Te Tiriti within the Aotearoa health system prior to the current period of health reforms. Although references to *Hauora: The Health Services and Outcomes Kaupapa Inquiry, Wai 2575* (Waitangi Tribunal, 2019) are threaded through the above account, a summary of major findings is provided below along with a summary of the *Health and Disability System Review* (2020), both key documents that influenced the shape of the 2022 . A CTA (Came, O’Sullivan, et al., 2020) of the Pae Ora (Healthy Futures) Bill is discussed (Rae et al., 2022) before providing a summary of the Pae Ora (Healthy Futures) Act. Finally, a CTA of the interim national health plan, *Te Pae Tata*, is summarised (Rae et al., 2023).

Wai 2575

Unlike the earlier reforms of the 1990s which were significant for the development of Māori health providers (Cooper, 2000), the reforms of the 2000s led to more than 200 claims to the Waitangi Tribunal. The first stage of the hearings involved claims by Māori health providers that

primary health care had failed to achieve health equity for Māori. The claim also included the role and resourcing of Māori PHOs and health providers, "arguing that Māori are not able to exercise tino rangatiratanga in the design and delivery of primary health care" (Waitangi Tribunal, 2019, p. xii).

In July 2019 the Waitangi Tribunal released their findings from stage one of their investigations into Wai 2575. The inquiry focused on four main themes: (1) Treaty-compliance of the Public Health and Disability Act and framework; (2) funding for primary health care; (3) accountability arrangements for primary health care; (4) Treaty partnership arrangements in the primary health care sector (Waitangi Tribunal, 2019).

The Tribunal found:

> the overall failure of the legislative and policy framework of the New Zealand primary health system to improve Māori health outcomes since the commencement of the New Zealand Public Health and Disability Act 2000. (p. 170)

In 2006, the *Māori Health Chart Book* stated that Māori have on average the poorest health status of any ethnic group in New Zealand. In 2018, at the Tribunal hearings Director-General Dr Bloomfield repeated this statement word for word (Waitangi Tribunal, 2019). There can be no doubt that the reforms of the 2000s failed to achieve the goal of increasing equity for Māori. The Tribunal found that institutional racism is present throughout the New Zealand health system and is a determinant of wellbeing (ill health) for Māori.

Specifically, the Tribunal found, in relation to Treaty compliance, that the health system is not compliant with the Treaty and its principles. The Treaty clause in the New Zealand Public Health and Disability Act was a "reductionist effort" and the use of the three Treaty principles (partnership, participation and protection) was "out of date" (Waitangi Tribunal, 2019, p. xiii). As was pointed out, "influencing decisions or participating in them is not the same as making decisions" (Waitangi Tribunal, 2019, p. 80). The Tribunal recommended five principles for the health sector:

1. **The principle of equity,** which requires the Crown to commit to achieving equitable health outcomes for Māori.
2. **The principle of partnership,** which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of primary health services.

3. **The guarantee of tino rangatiratanga**, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of primary health care.
4. **The principle of options**, which requires the Crown to provide for and properly resource kaupapa Māori primary health services. Furthermore, the Crown is obliged to ensure that all primary health care services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
5. **The principle of active protection**, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents, and its Treaty partner are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity. (Waitangi Tribunal, 2019, pp. 163-164).

Although these 'principles' are closer in meaning to the articles of the Māori text of Te Tiriti, the use of principles still obfuscates and does not engage directly with the Māori text. Re-interpreting Te Tiriti, a document held as a sacred covenant by Māori (Healy et al., 2012), is unnecessary, discourteous and continues to erode efforts to honour and implement Te Tiriti.

Regarding funding, the Tribunal found Māori primary health providers were underfunded from the beginning, and providers servicing high-needs populations (mostly Māori health providers) were consistently underfunded; moreover, the Crown knew about this for over a decade but did not act. Considering accountability, the system was purported to be "deliberately permissive", intending to support local innovation and control but instead had "grave impacts on both Māori organisations and Māori patients" (Waitangi Tribunal, 2019, p. xiv). Data collected within primary health is not used effectively, is inaccessible and not easily understood, and despite Māori health outcomes being known to the Crown as persistent, "urgent and serious" (although poorly measured and reported on), the Crown did not inform itself about how to change and improve the performance of primary health. Finally, when reviewing Treaty partnership arrangements in primary health, the Tribunal found:

> Māori primary health organisations and health providers are intrinsic to sustaining Māori health and wellbeing and are expressions of tino rangatiratanga. That the Crown fails to adequately resource these organisations, and further fails to govern the primary health care system in a way that properly supports them to design and deliver primary health care to their communities, is a serious Treaty breach. Overall, we concluded that the primary health care framework does not recognise and properly provide for tino

> rangatiratanga and mana motuhake of hauora Māori. (Waitangi Tribunal, 2019, p. xv). (Emphasis added).

The claimants sought, and the Tribunal agreed with, the establishment of an independent Māori health authority (Waitangi Tribunal, 2019). This authority would provide for the "recognition of tino rangatiratanga and mana motuhake in the design, delivery, resourcing, and control of Māori primary health" (Waitangi Tribunal, 2019, p. 165).

The Health and Disability Review

The analysis, findings and recommendations of Wai 2575 informed and influenced the *Health and Disability System Review* (2020), hereafter referred to as the Review. The Review was commissioned in 2018 by the Minister of Health and the final report, published in March 2020, contained 86 recommendations to Government on the transformation of the health sector. Some of the headline recommendations relating to the structure of the system included retaining the Ministry of Health as the 'chief steward' of the health and disability system, the creation of a Māori Health Authority (MHA) and Health NZ, reducing the number of DHBs and removing the requirement for DHBs to contract with PHOs. Notably, the Review contained a limited view of the scope and responsibility of the MHA which was counter to that of the Māori Expert Advisory Group (MEAG). The MEAG view, described in the report as the 'alternative view' on Māori commissioning, advocated for a Tiriti-compliant Indigenous commissioning framework, designed by Māori, which would be applied across all levels of the health system and include broader population health responsibilities (Health and Disability System Review, 2020).

The conclusion of the 'alternative view' stated:

> A comprehensive indigenous commissioning framework should be developed, which uses every enabler and lever, at every level, to ensure the system successfully delivers improved health and wellbeing outcomes for whānau. The commissioning framework should be Tiriti compliant and designed by Māori as an active expression of rangatiratanga and mana Motuhake, in a way that is not possible within mainstream organisations, such as HNZ and DHBs, with broader population responsibilities. (Health and Disability System Review, 2020, p. 174)

The process of the Review was critiqued from its inception. In the Wai 2575 report, the shortcomings of the partnership approach within the health and disability review process were noted, stating that the MEAG established by the Review did not meet the Crown's obligation to

the principle of partnership (Waitangi Tribunal, 2019). Came, Kidd, McCreanor, et al. (2021) critiqued the Review against key elements of Te Tiriti and found that, instead of furthering the opportunity to address Māori health disparities, the Review created additional Tiriti breaches. The failure of the Review to adopt the MEAG view of the MHA is described as "the defining moment of the Simpson-led review. The decision wilfully blocked Māori expressions of tino rangatiratanga" (Came, Kidd, McCreanor, et al., 2021, p. 79) and diluted the potential to enact a Tiriti-compliant health system.

COVID-19 and Haumaru

In February 2020 the first case of severe acute respiratory syndrome coronavirus 2 and the disease known as COVID-19 (World Health Organization, 2020) was detected in Aotearoa. This sparked a national public health response which involved border closures, cancelation of large public gatherings, and 'lockdowns': orders to stay at home for all non-essential workers. Early in the pandemic, concerns about the potential for Māori to experience greater harm from the virus were raised. Concerns included the current burden of disease experienced by Māori, barriers to health care, differential treatment by health services and risk of exposure to the virus through, for example, household overcrowding (King et al., 2020; McLeod et al., 2020). The warning from the 1918 flu epidemic was also a caution, with historical records showing that Māori were seven times more likely to die than Pākehā (King et al., 2020).

Devastatingly, as predicted, Māori experienced greater harm from COVID-19 than the Pākehā population. Māori were more likely to be hospitalised and those aged under 60 years were 3.7 times more likely to die from COVID-19 than Pākehā or other ethnicities (Curtis et al., 2024). In November 2021, the New Zealand Māori Council asked the Waitangi Tribunal to inquire into the Tiriti-compliance of the vaccination strategy and the protection framework used to establish and communicate social contact decisions (known as the traffic light system). In late December 2021, the *Haumaru* report was released by the Waitangi Tribunal (2021a). Multiple Treaty breaches were identified. Regarding vaccination, the Tribunal found the decision by Cabinet to dismiss advice from health officials to adopt an earlier age for Māori in the vaccine rollout breached the Treaty. Considering the protection framework, the Tribunal found that the rapid pace of implementation, against official advice, and with vaccination thresholds unmet, put Māori at greater health risk. Māori health providers were also placed under extreme pressure and their ability to provide equitable care was undermined. Finally, the Tribunal found that the decision to implement the protection framework was made despite unanimous opposition from Māori health leaders, breaching the principle of partnership.

Pae Ora Healthy Futures Bill

During the initial phase of this study the Healthy Futures (Pae Ora) Bill (New Zealand Government, 2022b) was released. A CTA of the Bill was carried out by the STIR collective, with myself as lead author, along with Māori and Pākehā public health activist scholars (Rae et al., 2022). We found that the influence of Wai 2575 on the Bill is evident in that the health system principles are those proposed within the *Hauora* report. However, this is problematic as the 'principles' were weakened, particularly in the case of the 'tino rangatiratanga principle' which had Crown limitations imposed on its application. The Bill described the 'principle of tino rangatiratanga' as being to "provide opportunities for Māori to exercise decision-making authority on matters of importance to Māori and for that purpose, have regard to both (i) the strength or nature of Māori interests in a matter; and (ii) the interests of other health consumers and the Crown in the matter" (New Zealand Government, 2022b, pp. 11, clause 17 (c)). The Bill also provided for opt-out clauses for the application of Treaty principles, for example the Ministry of Health and listed health entities must be guided by these Treaty principles only "as far as reasonably practicable, having regard to all the circumstances, including any resource constraints" (New Zealand Government, 2022b, p. 35 clause 37 no. 32) (emphasis added). The danger here is that when resourcing becomes constrained, as is inevitable it seems from the history of health sector reforms, Treaty principles will lose priority.

In the regulatory impact statement on form, governance and accountability arrangements, it was stated that the "Māori Health Authority is not the Treaty partner for the purpose of the health and disability sector, and it does not hold or exercise tino rangatiratanga or mana motuhake – this authority resides with iwi and hapū" (Department of Prime Minister and Cabinet, 2021, p. 14). Māori can, however, express tino rangatiratanga within and outside the Crown (O'Sullivan et al., 2021). Significant emphasis was placed on Iwi Māori Partnership Boards as enabling Māori decision-making at regional and local levels. Many of these boards were already in place as 'partners' to the previous DHB structure and operated with limited influence and decision-making power. The regulatory statement also noted that the Māori Health Authority "will operate in the space where the exercise of kāwanatanga and rangatiratanga overlap" (Department of Prime Minister and Cabinet, 2021). This leaves many questions about who the Crown is partnering with because, as we noted, "Te Tiriti responsibilities must extend to every level of the health system" (Rae et al., 2022, p. 109).

Overall, the Bill is framed with an intent to reflect equity throughout the system; however,

> this all sits within a frame of ultimate power and decision-making residing with the Minister and the Crown. This reflects a Crown understanding that privileges the Treaty and incorrectly interprets the kāwanatanga granted to non-Māori to apply across all New Zealanders. (Rae et al., 2022, p. 109)

Although there was optimism over the proposed reforms, the Pae Ora Bill needed to live up to its name through clarifying how Pae Ora will impose its influence throughout the system (Rae et al., 2022). There are fundamental concerns about Tiriti compliance and genuine Māori and Crown relationships. Finally, we concluded:

> The Bill needs to be reworked so that Māori are not structurally the junior Tiriti partner. The Bill does not engage Māori tino rangatiratanga. Transformation needs to occur within the health system, but also in how the Crown engages with Māori in system design. The Pae Ora Bill has the potential to be an influential policy instrument in support for a Te Tiriti centred health and disability system in Aotearoa. (Rae et al., 2022, p. 110)

Pae Ora Healthy Futures Act

Over 4,500 submissions were received on the Bill, the majority from individuals opposing the Bill, particularly the provisions regarding Māori health (Department of Prime Minister and Cabinet, 2022). In a study looking at 'anti-Māori' talk in the Pae Ora Bill submissions, it was noted that of 3,000 individual submissions, 2,536 had explicit references to race and further analysis revealed entrenched racist views (Black et al., 2023). The study concluded that the prevalence of this racism "sustains opposition to and hinders implementation of health equity initiatives for Māori" (Black et al., 2023, p. 67). The Pae Ora legislation committee received a report responding to the submissions which dismissed the submissions claiming Māori were privileged by the health system, stating clearly they "do not accept that the provisions constitute an inherent advantage for Māori, but will rather address longstanding disadvantage that has arisen from a failure of the system to tailor services to culturally specific needs" (Department of Prime Minister and Cabinet, 2022, p. 11).

The report also noted that most of the organisational/professional body submissions were in favour, and many suggested the proposed Māori Health Authority should have more power and be more independent of the Crown (Department of Prime Minister and Cabinet, 2022).

Ultimately there was little change between what was proposed within the Bill and the final 2022

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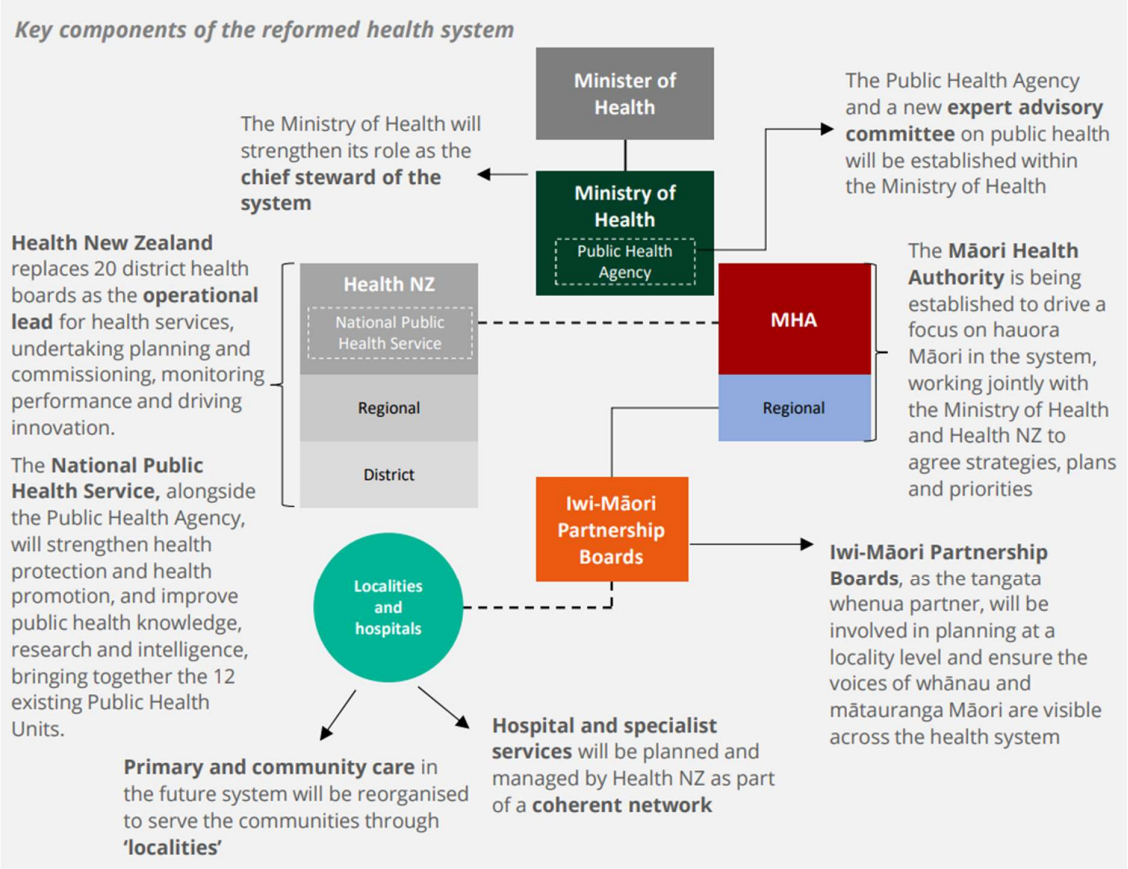
Figure 5
Structure of Reformed Health System



Note. From *Update on the National Operating Model and High-Level Structure*, Interim Health New Zealand & Interim Māori Health Authority, 2022. p. 6. Copyright 2022 by Te Whatu Ora. Used under the Fair Dealing exceptions of the NZ Copyright Act 1994.

Te Pae Tata

Te Pae Tata Interim New Zealand Health Plan (hereafter referred to as the Plan) was published in 2022, and as such was the first plan published under the Pae Ora legislation (Te Whatu Ora & Te Aka Whai Ora, 2022). Considering the intent of the Pae Ora legislation to achieve health equity for Māori and adhere to Te Tiriti principles (2022), a critical review of the Plan provided a useful check on whether these intents were being adhered to. Again, working with STIR colleagues, I, along with Māori, Pasifika, and Pākehā critical scholars, conducted a CTA of the Plan (Rae et al., 2023).

The Plan was written by Health New Zealand, the Māori Health Authority and the Ministry of Health. The Plan committed to developing a health system with Te Tiriti as the foundation; this is outlined in the document by a table describing Te Tiriti application. However a level of confusion

remained as the Plan referred to Te Tiriti and the Treaty and engaged with Tiriti articles and principles. The phrase ‘tino rangatiratanga’ was only used once within the plan. The Plan was unclear on how Māori influenced the Plan, nor was it clear how Māori aspirations at a national level will be achieved other than through the Māori Health Authority. There was nothing in the Plan to address the historic under-funding of Māori health identified by the Waitangi Tribunal (2019).

As we noted in our conclusion, decolonisation requires dominant structures and systems to change. We observed that

> the true transformative potential of the Māori Health Authority will depend on its consistent ability to operate within this complex environment and influence the operationalisation and achievement of the health system with reference to documents such as Te Pae Tata. (Rae et al., 2023, p. 91)

Disestablishment of Te Aka Whai Ora – A Great Leap Backward

During the national election campaign of 2023 the National, ACT and New Zealand First parties all campaigned to abolish Te Aka Whai Ora (Neas, 2023; Wall, 2023, September 5). In February 2024, the National-led coalition Government carried out their election campaign pledge. In a bitter irony Te Aka Whai Ora was disestablished exactly 40 years after the Hui Whakaoranga, described by Mason Durie as the hui where the ‘by Māori for Māori’ approach to health was conceived (Cugley, 2024, March 19). The 2024 removed all references to the Māori Health Authority and instead said that Māori input into decision-making would occur through the limited authority of the Hauora Māori Advisory Committee and Iwi Māori Partnership Boards.

There was substantial opposition to the disestablishment of the Māori Health Authority, including a letter signed by 740 doctors and urgent claims to the Waitangi Tribunal. A petition initiated by STIR gathered 17,000 signatures within two weeks. A Waitangi Tribunal priority inquiry has been scheduled for October 2024 as part of the existing Wai 2575 kaupapa inquiry ("Waitangi Tribunal to Hear a Claim", 2024, May 15). The inquiry will investigate the processes undertaken by the Crown to disestablish Te Aka Whai Ora and how the Crown proposes to improve Māori health now ("Waitangi Tribunal to Hear a Claim", 2024, May 15).

Unsurprisingly, a CTA of the 2024 found the Act was “firmly oriented to the destruction of tino rangatiratanga embodied within Te Aka Whai Ora” and “steps health policy backwards into the colonial assumptions that have created and maintained disparities since the records of health outcomes began in the 1950s” (Came et al., 2024, p. 96).

Conclusion

This chapter has covered over a century of Māori health development in the pursuit of Tiriti justice within the colonial health system. Each time the health system is reformed, Māori have to renegotiate a relationship with that system, an effort that is often unrecognised and unresourced (Laing & Pomare, 1994). The reforms started in 2021 were a step forward in a long march towards Tiriti justice. The disestablishment of Te Aka Whai Ora takes us several steps back.

The history tells a story of Māori leadership and innovation in seizing opportunities, and Māori tenacity to carry on. History provides a powerful lesson that the best way to improve Māori health is for Māori to lead Māori health (Gurney & Koea, 2023). It is mainly Māori staff within the health system that champion addressing Māori health equity. This leadership, a minority often working at the edges of the system, repeatedly bear the brunt of health reform change. The dissolution of entire Māori health teams, or self-preservation actions to resign en masse reveal the significant harm inflicted on Māori health staff during system reform.

This history is also a story about a colonial health system within a state that seeks to maintain political stability but ultimately retain power. This has meant, at times, due to overwhelming pressure from Māori, that the state has made concessions to allow for limited and short-lived Māori autonomy (Cram et al., 2019). For example, in the early 1900s, this was evident in Māori councils and the Māori nursing scheme which both developed from Māori leadership, were implemented by Māori but ultimately subsumed within the colonial machinery. They provide an illustration of how the state remains "inflexible to real and meaningful power sharing" (Cram et al., 2019, p. 8).

The history also reveals the power of Pākehā-organised opposition to change. For example, primary care lobby groups who blocked the adoption of universal health care in 1938. Later, these same groups seized the opportunity and resources to form IPAs which wielded and, through their reinvention as large corporate PHOs, continue to wield significant power within the primary health care sector.

For at least the first half of the 20th century, assimilation of Māori into Pākehā culture was the colonial agenda. The huge population shift of Māori into urban areas, however, facilitated Māori revival and resistance. Māori-led organisations such as the Māori Women's Welfare League directed a Māori response to issues such as poverty and lack of affordable housing and health. The Māori protest movement of the early 1970s and the 1975 Land March firmly placed Māori political demands on the agenda. The government response was a shift from assimilation

towards biculturalism and the beginnings of acknowledgement of the Treaty in legislation and health policy. Although it demonstrates progress, the inclusion of the Treaty in legislation or policy is limited with the Crown favouring the English version and the use of principles rather than direct reference to the Māori text and articles.

The neo-liberal reforms of the 1980s had a huge impact on life in Aotearoa socially and politically. Out of this turmoil, however, arose Māori health development. Māori health providers emerged and championed 'by Māori for Māori' health service provision. It was Māori health providers united in their conviction to progress Māori health that led the Waitangi Tribunal primary health kaupapa claim. The findings from this claim had some influence on the reforms implemented in 2021 – reforms described as "once in a lifetime opportunity to address Māori health inequities" (Came et al., 2024, p. 97).

This chapter has highlighted the point that the concept of a Māori Health Authority is not a 21st century articulation. Durie (2023) traced this idea back to the early 1900s and Māori advocated strongly for a Māori Health Authority in response to the health reforms of the 1990s (Laing & Pomare, 1994). Although the most recent iteration of a Māori Health Authority has been removed from legislation, the idea of a Māori Health Authority will never diminish.

Chapter Three: Informing Te Tiriti-based Anti-racism Praxis for Pākehā Allies in the Aotearoa Health Sector: A Literature Review

This chapter is the first of two papers within this thesis submitted for publication. The paper is essentially the same as that submitted for publication except for some clarification around the focus on Māori specific racism and anti-racism. Table and figure numbers have been amended to remain in sequence within the thesis. This paper was co-authored with research team members from the Marsden-funded re-imagining anti-racism theory for the health sector project, my PhD supervisors and critical research whānau.

Abstract

The evidence that racism is a cause of ill-health for racialised, and Indigenous peoples is significant. However, there is much less evidence about effective anti-racism strategies within the health sector, particularly the efforts of allies who hold power within institutions. This article reviews literature about anti-racism praxis within the context of the Aotearoa New Zealand health system, with a focus on the role of allies who are Pākehā (white settlers in Aotearoa). The once-in-a-generation structural change occurring in the health system provides an opportunity to address entrenched institutional racism and health inequities for Māori (the Indigenous peoples of Aotearoa). The review followed a deliberate relational citational practice of prioritising Indigenous scholarship from Aotearoa. This approach recognises the relational work of allyship and the historical, socio-political, and geographic dimensions of racism and anti-racism. The findings are organised according to the framework of Te Tiriti o Waitangi under sections: whanaungatanga (development of relationships); kāwanatanga (taking action within the system); tino rangatiratanga (Indigenous sovereignty); ōritetanga (prioritising equity); and wairuatanga (doing the work with heart). This article provides a timely contribution to providing guidance for allies seeking to contribute to a Te Tiriti based anti-racist health system for Aotearoa. Although specific to Aotearoa, these findings may also be relevant to allies in other colonial settler nations working to eradicate anti-Indigenous racism and address pervasive health inequities.

Key Words

Te Tiriti o Waitangi, anti-racism praxis, health system, allyship, Pākehā, inequities

Introduction

Aotearoa New Zealand (hereafter referred to as Aotearoa) was colonised by the British during the mid-19th century and remains a colonial settler state despite sustained resistance by Māori who are the tangata whenua (the Indigenous peoples of Aotearoa) (Walker, 1990). The colonisation of Aotearoa was not benign, despite contrary colonial settler myths (Huygens, 2011). Jackson (2020, p. 145) describes how the colonisers "deliberately misremembered and obscured the injustice" of their actions and rebranded colonisation from a "violent home invasion" to a "grand if sometimes flawed adventure".

Through the actions of the colonial state, 95% of land was alienated from Māori by 2017 (Thom & Grimes, 2022). The loss of land has been among the greatest contributions to the ongoing trauma of colonisation (Moewaka Barnes & McCreanor, 2019). The transfer of resources from Māori to colonial settlers has resulted in unearned benefits and privilege bestowed upon Pākehā (white settlers in Aotearoa) who control and hold the majority of the country's wealth (Rashbrooke et al., 2021) whilst Māori experience racism resulting in high morbidity and mortality statistics (Health Quality & Safety Commission New Zealand, 2019), high incarceration and family harm (McIntosh, 2022).

This was not the future envisaged when the Māori text of Te Tiriti o Waitangi (hereafter referred to as Te Tiriti) was negotiated in 1840. This peacetime agreement established a formal relationship between Māori and the British Crown, re-affirmed Māori sovereignty over Aotearoa (previously asserted in 1835 within He Wakaputanga, the Declaration of Independence) and allowed for British kāwanatanga (governorship) to control unruly non-Māori subjects (Mutu, 2011). Te Tiriti also allowed the Crown to buy land, gave Māori the same rights as British subjects, and promised religious and spiritual freedom for all (Mutu, 2011). The intent of Te Tiriti was to bind relationships between the Crown and hapū (sub-tribes) recognising the independence of Māori with hopes for an interdependence between the peoples (Jackson, 2020).

Sustained Māori political action has resulted in some recognition of Te Tiriti in legislation and policy, providing partial redress of the devastation that colonisation continues to visit upon Māori society (Moewaka Barnes & McCreanor, 2019). Negotiations with the colonial settler government have resulted in the return of some land, small amounts of financial compensation and some co-governance mechanisms established over land, lakes and rivers. However this process is strongly critiqued as it does not address Māori grievances nor provide for a full, fair or final settlement (Mutu, 2018). Māori sovereignty remains marginalised with the imposition of colonial settler government and monocultural institutions (Ngata, 2022).

Anti-racism work is currently seeing unprecedented interest within Aotearoa (Came et al., 2022) and requires engagement with Te Tiriti (STIR: Stop Institutional Racism & New Zealand Public Health Association, 2021). It is well established that racism impacts on health (Harris et al., 2006) and that racism operates throughout the health system in Aotearoa (Waitangi Tribunal, 2019). Racism is a significant determinant of health (Williams et al., 2019) although this acknowledgment did not occur in Aotearoa until the late 1990's (Ahuriri-Driscoll, Williams, et al., 2022). It wasn't until 2020 that the Ministry of Health prioritised addressing racism and discrimination as one of four high level outcomes within Whakamaua, the Māori health action plan (Ministry of Health, 2020b). The Ministry positions this anti-racism work as crucial to fulfilling commitments under Te Tiriti o Waitangi (Ministry of Health, 2020a) and is, in part, a response to the Hauora report produced by the Waitangi Tribunal, a standing commission of inquiry that investigates Treaty and Te Tiriti breaches (Waitangi Tribunal, 2019). This has resulted in a programme of work called Ao Mai Te Ra: the anti-racism kaupapa (strategy), which has, in the first phase, produced three literature reviews (Ahuriri-Driscoll, Williams, et al., 2022; Williams, 2022; Williams & McMeeking, 2022), a summary document (Tarena et al., 2022), a position statement with working definitions for racism and anti-racism (Ministry of Health, 2022b), a podcast and video series (Ministry of Health, 2022a) and a preliminary model based on systems change to implement anti-racism in the Aotearoa health system (McMeeking et al., 2022). The working definition of anti-racism proposed by Ahuriri-Driscoll, Williams, et al. (2022, p. 35) is:

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

This significant and comprehensive work does not explicitly outline the role of Pākehā allies nor specifically name the privileged and powerful position that Pākehā hold within the sector. Existing anti-racism efforts have not yet been adequately resourced nor noticeably improved health outcomes for Māori (Came et al., 2022). Recent efforts by the Ministry of Health seem to locate the anti-racism strategy clearly within the realm and responsibility of Māori health (Came et al., 2022).

Other sectoral developments have included a review identifying the perpetuation of inequity in the health sector (Health and Disability System Review, 2020), a Waitangi Tribunal finding that

health governance and funding was not Tiriti compliant (Waitangi Tribunal, 2019), and the subsequent Pae Ora (Healthy Futures) Act which centralised the twenty district health boards into one national entity called Te Whatu Ora (Health New Zealand) and established Te Aka Whai Ora (Māori Health Authority). While these largely structural reforms have been critiqued for not emphasising required cultural change (Reid, 2021) or function (Ahuriri-Driscoll, Lovell, et al., 2022), they are nevertheless seen by some as an opportunity for change (Baker, 2021, April 22).

As stated by Margaret and Came (2019) "(a)llies' work is about understanding how racism works to privilege White ways and identifying racism in our own practice and in the systems we are part of. It is about addressing a White-made problem." This view is shared by Bell et al. (2022, p. 4) who are clear that as settlers are "the source of the problem, it behoves us to be part of the solution". The role of settler allies is to "*dismantle* structures and habits of domination – the 'decolonising' work – and work must be done to *replace* these colonising structures with Indigenous-led ones – the 'restoration' work (emphasis in original)" (Bell et al., 2022, p. 5).

Came, Warbrick, et al. (2020) use the metaphors of gorse, an invasive weed, and ngahere (native bush) and describe how it is the role of Pākehā to work on ourselves, eradicate the gorse, whilst supporting Indigenous-led restoration to nurture the ngahere. Barber (2020) views colonisation as an ongoing event which is amenable to intervention, and there are actions that Pākehā need to lead. He describes the failure to do so as an evolved type of paralysing guilt. There is a role for Pākehā and non-Indigenous people in addressing racism (Huria et al., 2014). As Pākehā are the main perpetrators of racism and also benefit from its continuance, there is an ethical responsibility for Pākehā to address racism in the health sector (Came et al., 2022).

This paper is focused on the particular role Pākehā allies have in disrupting racism, due to the privileged and powerful position they hold with New Zealand society, and asks: how does the literature inform Te Tiriti based anti-racism praxis of Pākehā allies in the New Zealand health system?

Researcher Standpoint:

This paper is led by a Pākehā activist scholar with a background in public health and co-written with other Pākehā and Māori activist scholars who are committed to a health system free of racism and a Tiriti o Waitangi based future for Aotearoa.

Methodology

This paper aims to inform Te Tiriti based anti-racism praxis of Pākehā allies in Aotearoa with a focus on the health system. Two databases, CINAHL and SCOPUS, were searched for English language articles from 2000 to November 2022. The table below provides details of the six layered searches used – starting with a tight focus on literature from Aotearoa and then broadening to international literature.

Table 1
Literature Search Strategy

Search terms	CINAHL	SCOPUS	Reason for	Kept
First search *Health*; and *Allies* or *ally* or *allyship* or *solidarity* or *accomplice*; and *Racism* or *discrimination* or *prejudice* or *racial bias* or *race* or *stereotypes* or *racial inequality* or *equity* or *inequity* or *anti-racism*; and *Zealand* or *Aotearoa* or *NZ* or *Waitangi*	3	2 (Same as CINAHL)	All kept for further review	3
Second search *Health*; and *Anti-racism* or *antiracism* or *antiracist* or *anti-racist*; and *Zealand* or *Aotearoa* or *NZ* or *Waitangi*	12 (all were found in SCOPUS search)	18	All but one kept as abstract was focused on UK	17
Third search *Health*; and *Anti-racism* or *racism* or *decolonisation* or *decolonization*; and *Zealand* or *Aotearoa* or *NZ* or *Waitangi*	116	209	Several articles on evidence of racism with health system, article kept if abstract provided information on anti-racist strategies	79
Fourth search *Health*; and *Allies* or *allyship* or *solidarity* or *accomplices*; and *Racism* or *anti-racism* or *decolonization*	60	121	Focused on settler colonial nations of Australia, Canada, U.S and Pacific Nations	16
Fifth search *Allies* or *allyship* or *solidarity* or *accomplices*; and *Racism* or *anti-racism* or *decolonization*	119	41	Focused on settler colonial nations of Australia, Canada,	8

			U.S and Pacific Nations	
Sixth search Allies or allyship or solidarity or accomplices; and *Racism* or *anti-racism* or *decolonization*; and *Zealand* or *Aotearoa* or *NZ* or *Waitangi*	5	18	All had previously been identified and selected	0
			Total number of articles kept for full text further review	**123**

A Google scholar search was also undertaken using the terms health and allies and anti-racism and Zealand, which generated over 6,900 results. The search was revised to health and allies and anti-racism and Waitangi, returning 359 results, most of which were already identified. After review only 14 further articles were retained for consideration. A core aim of this literature review was to listen to the voices of Māori scholars and activists about the role for Pākehā undertaking anti-racism work in the health sector. However most of the relevant knowledge in Aotearoa is held in the Māori sovereignty and anti-racism movements with elders, not in books or academic journals (Came et al., 2022). Also, academic databases do not consistently identify Indigenous journals. Therefore, literature was also reviewed in the form of blogs, media articles, books or book chapters. The reference lists of useful articles were scanned to identify other studies of interest. Over 200 documents were identified as available for review. The literature was sourced from various disciplines including health, education, sociology and political science.

Deliberate Relational Citational Practice

The specific roles of Pākehā working to create a Te Tiriti-based anti-racist health system can best be understood by revisiting the work of scholars writing from perspectives in Aotearoa. Heke et al. (2022) advise caution in using anti-racism interventions from other countries because anti-racism has cultural, political, social and historical contexts. As experts within te ao Māori (the Māori world) and survivors of the intergenerational trauma of racism, Māori can provide guidance and advice on approaches and interventions to overcome racism (Came et al., 2022).

Cognisant of 'being relational' to people and place, this literature review adopts a deliberate citational practice of focusing foremost on the work of Māori scholars. A secondary focus is on the writings of Pākehā, Pacific and Tauiwi (non-Māori) scholars from Aotearoa – particularly when exploring the role of allies. This deference to local literature aligns with Connell (2007) in her important work Southern

Theory, where she seeks to counterbalance the dominance of knowledge coming from the 'global metropole' as universal.

This deliberate citational practice is inspired by the work of Hana Burgess et al., (2021) who describes a kaupapa Māori relational and whakapapa (genealogical) based citational practice to only cite the work of Māori, to consider who, how, and why particular people are cited. Tynan and Bishop (2023, p. 3) two (ab)Original women, propose applying decolonising methodology to literature reviews through a relational approach that starts with relationships to people, places and knowledge, a consideration of who is writing and where they are writing from. Todd (2016, p. 7) also considers our relationality to whom we cite within academia and encouraged "citing and quoting Indigenous thinkers, directly, unambiguously and generously." Todd quotes Donald's 2009 concept of ethical relationality:

> that does not deny difference, but rather seeks to more deeply understand how our different histories and experiences position us in relation to each other. This form of relationality is ethical because it does not overlook or invisibilize the particular historical, cultural, and social contexts from which a particular person understands and experiences living in the world. It puts these considerations at the forefront of engagements across frontiers of difference (Donald, 2009 as quoted in Todd, 2016, p. 19).

This ethical relationality "invokes a reciprocity of thought" which "requires us to pay attention to who else is speaking alongside us"(Todd, 2016, p. 19).

Settler colonial scholarship can take space from Indigenous scholarship and take up space within the academy more widely, and can be presented as new knowledge without acknowledging the Indigenous work upon which it is based or to which it responds (Bell et al., 2022). Learning *from* Indigenous people not learning *about* Indigenous people is also an important distinction, and these cautions require "constant vigilance and self-reflection" (Bell et al., 2022, p. 6). This literature review is purposeful in engaging with Indigenous scholarship to ensure allies listen to, and act upon, Indigenous directions.

Inclusion Criteria

Following this deliberate relational citational practice, the literature was considered giving regard to six inclusion criteria. The first three were based on relevancy to core concepts contained within the literature search question: 1) allyship 2) anti-racism 3) context (Aotearoa health system). The other three criteria were authorship, date, and type of publication.

For each of these six criteria a description of relevancy was developed considering high, medium or low relevancy to the literature search question. Regarding allyship, high relevancy was assigned to discussions of Pākehā allyship, medium relevancy to other colonial settler allies, and low relevancy to allyship outside a colonial settler relationship. Regarding anti-racism, high relevancy was assigned to discussions of anti-racism in alignment with Te Tiriti, while medium relevancy was assigned to general descriptions of anti-racism actions/strategies along with adjacent topics like decolonisation, Indigenisation, cultural safety or health equity. The third inclusion criteria was context, with high relevancy assigned to contexts in the Aotearoa health system, while medium relevancy was found in non-health contexts in Aotearoa (e.g. environmental justice) or health contexts among other colonial settler countries.

Some writing made clear that the authors were Māori (particularly when tribal affiliations were named), in other cases positionality statements were read to identify the authors ethnic and cultural identity. Often articles were co-written between Māori and Pākehā, Pacific and Tauiwi authors. If an article had a lead or contributing Māori author, the article was considered highly relevant. Writing from other Indigenous peoples (not Māori), Pacific, Pākehā and Tauiwi were considered medium relevancy. For date of publication, high relevance was given to literature published or written in the last five years, medium relevance to literature published after 2012 and low relevance to publications prior to this date. The final criterion was type of literature, original research and literature reviews were highly relevant, viewpoints, conceptual articles, opinion pieces, grey literature were all medium relevancy. The table below describes the six criteria and relevancy descriptors.

Table 2
Inclusion Criteria and Relevancy

Criteria	Relevancy
Allyship	
Role of Pākehā allies described	High
Role of settler colonial allies described	Medium
Allyship outside context of settler colonial relationship	Low
Allyship not explicitly discussed	Low
Anti-racism	
Anti-racism discussed in relation to honouring Te Tiriti o Waitangi	High
Anti-racism actions described	Medium

Decolonisation and / or Indigenisation described	Medium
Cultural safety described	Medium
Health equity actions described	Medium
Context	
Aotearoa health system focus	High
Situated within Aotearoa	Medium
Situated within health system in other settler colonial countries	Medium
Situated within other settler colonial countries	Low
Authorship	
Lead Māori author	High
Māori contributing author	High
Indigenous author(s)	Medium
Pākehā author(s)	Medium
Tauiwi author(s)	Medium
Unknown (U)	Low
Timeframe	
Between 2018-2022 (last five years)	High
Between 2013-2017	Medium
2012 or previous	Low
Literature type	
Original research	High
Literature review	High
Viewpoint / opinion piece / conceptual article / book chapter	Medium
Grey literature	Medium

Literature Reviewed

The literature identified was read briefly (the abstract and discussion and / or findings) and items considered relevant were ranked by the six criteria above. Initially 124 articles were ranked and 46 were given a high overall relevancy rating. Generally, articles that had four or more ratings of high, out of the six criteria, were given an overall relevancy of high. Only six articles were rated high relevancy on all criteria (Ahuriri-Driscoll, Williams, et al., 2022; Came, Kidd, Heke, et al., 2021; Heke et al., 2022; Hunter & Cook, 2020; Kidd et al., 2020; Kidd et al., 2022). In addition to these six there were another 10 articles that rated high on all three core concepts: allyship, anti-racism, Aotearoa health system. These 17 articles were considered the

'start here' list and were read in depth and notes taken of common ideas and concepts. The remaining articles (29) that had initially been rated overall as high were then engaged with and included in the review. An additional 19 articles, although ranked medium, were also included as they rated highly on two or more of the three core concepts. This broad and inclusive approach was taken due to the sparse literature specific to the role of Pākehā allies undertaking Te Tiriti based anti-racism within the health sector. Two main groups of literature were reviewed, literature focused on anti-racism within the Aotearoa health sector and literature that focused on Te Tiriti based anti-racism Pākehā allyship (outside of a health context).

This process resulted in a total of 65 articles for inclusion in the final review. 42 of the 65 articles reviewed had a lead or contributing Māori author. The table below provides the ranking on the six criteria for each of these articles and the overall relevancy.

Table 3
Reviewed Literature and Determination of Relevancy

Article	Allyship	Anti-racism	Context	Author	Timeframe	Literature type	Overall relevancy
Ahuriri-Driscoll, Williams, et al. (2022)	High	High	High	High	High	High	**High**
Barber (2020)	High	High	Medium	High	High	Medium	**High**
Beausoleil (2022)	High	High	Medium	Medium	High	Medium	**Medium**
Bell (2022)	High	High	Medium	Medium	High	Medium	**Medium**
Berghan et al. (2017)	High	High	High	High	Medium	High	**High**
Borell (2017)	Medium	High	High	High	Medium	High	**High**
Brewer and Andrews (2016)	Medium	High	High	High	Medium	Medium	**Medium**
Came and da Silva (2011)	High	High	Medium	Medium	Medium	Medium	**Medium**
Came and Humphries (2014)	High	High	High	Medium	Medium	Medium	**Medium**
Came and Griffith (2018)	High	Medium	High	Medium	High	Medium	**Medium**
Came and Tudor (2016)	High	High	High	Medium	Medium	Medium	**Medium**
Came et al. (2019)	Low	High	High	High	High	Medium	**High**
Came, Warbrick, et al. (2020)	High	High	High	High	High	Medium	**High**
Came, Kidd, Heke, et al. (2021)	High	High	High	High	High	High	**High**
Came et al. (2022)	High	High	High	High	High	Medium	**High**
Chin et al. (2018)	High	Medium	High	High	High	High	**High**

Article	Allyship	Anti-racism	Context	Author	Timeframe	Literature type	Overall relevancy
Clark et al. (2022)	Low	Medium	High	High	High	High	**High**
Cormack et al. (2018)	Low	High	High	High	High	High	**High**
Crawford and Langridge (2022)	High	High	High	Medium	High	Medium	**High**
Curtis et al. (2019)	Low	Medium	High	High	High	High	**High**
Emery-Whittington and Te Maro (2018)	High	High	High	High	Medium	Medium	**High**
Espiner et al. (2021)	Low	Medium	High	High	High	High	**High**
Graham and Masters-Awatere (2020)	Low	Medium	High	High	High	High	**High**
Gurney et al. (2020)	Low	High	High	High	High	Medium	**High**
Haitana et al. (2022)	Low	High	High	High	High	High	**High**
Hancock and Newton (2022)	High	High	Medium	High	High	High	**High**
Heke et al. (2022)	High	High	High	High	High	High	**High**
Hoskins (2017)	High	High	Medium	High	Medium	Medium	**Medium**
Hoskins and Jones (2022)	High	Medium	Medium	High	High	Medium	**Medium**
Hotere-Barnes et al. (2015)	High	High	Medium	Medium	Medium	Medium	**Medium**
Hunter and Cook (2020)	High	High	High	High	High	High	**High**
Huygens (2011)	High	High	Medium	Medium	Medium	High	**Medium**
Ingham et al. (2022)	Low	High	High	High	High	High	**High**
Jackson (2020)	High	High	Medium	High	High	Medium	**High**
Kidd et al. (2020)	High	High	High	High	High	High	**High**
Kidd et al. (2022)	High	High	High	High	High	High	**High**
Lee et al. (2021)	Low	High	High	Medium	High	Medium	**Medium**
Mako et al. (2022)	Low	High	High	High	High	Medium	**High**
Margaret (2013)	High	High	Medium	Medium	Medium	Medium	**Medium**
Margaret and Came (2019)	High	Medium	High	Medium	High	Medium	**Medium**
Martin (2000)	High	High	Medium	Medium	Low	Medium	**Medium**
Masters-Awatere et al. (2020)	Low	High	High	High	High	High	**High**
McCreanor (2020)	High	High	Medium	Medium	High	Medium	**Medium**
McKegg (2019)	High	High	Medium	Medium	High	Medium	**Medium**
Newcombe and Amundsen (2022)	High	High	Medium	Medium	High	High	**High**

Article	Allyship	Anti-racism	Context	Author	Timeframe	Literature type	Overall relevancy
Ngata (2020)	High	High	Medium	High	High	Medium	**High**
Palmer et al. (2019)	Low	Medium	High	High	High	High	**High**
Ramsden (1990)	Low	High	High	High	Low	High	**High**
Reid et al. (2019)	Low	High	High	High	High	Medium	**High**
Rolleston et al. (2020)	Low	Medium	High	High	High	High	**High**
Scott et al. (2020)	High	High	High	High	High	Medium	**High**
Selak et al. (2020)	High	High	High	High	High	Medium	**High**
Showden et al. (2022)	High	High	Medium	Medium	High	High	**High**
Silcock and Hocking (2021)	High	High	High	Medium	High	Medium	**High**
Silcock (2020)	Low	Medium	High	Medium	High	High	**Medium**
STIR: Stop Institutional Racism and New Zealand Public Health Association (2021)	High	High	Medium	High	High	Medium	**High**
Tarena et al. (2022)	High	High	High	High	High	Medium	**High**
Te Huia (2016)	High	High	Medium	High	Medium	High	**High**
Thomas (2020)	High	High	Medium	Medium	High	Medium	**Medium**
Walker et al. (2023)	Low	Medium	High	High	High	High	**High**
Wilkinson et al. (2022)	Low	Medium	High	High	High	High	**High**
Williams and McMeeking (2022)	Low	High	High	High	High	High	**High**
Williams (2022)	Low	High	High	High	High	High	**High**
Wilson et al. (2021)	Low	Medium	High	High	High	High	**High**
Wilson et al. (2022)	Low	High	High	High	High	Medium	**High**

Findings

This section begins with a brief description of how the literature described Tiriti based anti-racism praxis, then uses the five parts of Te Tiriti to frame the findings from the literature specific to what is required of Pākehā allies in the health sector.

Tiriti-based Anti-racism Praxis

> *(W)hile anti-racist practice in Aotearoa New Zealand might extend beyond Te Tiriti-based action, it cannot proceed without it*. (Ahuriri-Driscoll, Williams, et al., 2022)

> *In Aotearoa our superpower is Te Tiriti o Waitangi. An authentic commitment to Te Tiriti is how we address systemic racism and realise the potential of an equitable health system where all people are valued and everyone gets what they need.* (Tarena et al., 2022, p. 3)

Te Tiriti is the foundational constitutional document of the colonial state of New Zealand that sets out terms for Pākehā and tauiwi settlement (Came & Tudor, 2016). It is also the foundation for good health (Brewer & Andrews, 2016). Jackson (2020) said that Te Tiriti offers a way for justice to emerge through the right relationships envisioned within it. Bell (2022) argued that Te Tiriti provides a 'place' within Aotearoa for Pākehā, however alongside this right is a responsibility to "support Māori difference and sovereign status as foundational to the Pākehā right to be and belong" (Bell, 2022, p. 14). "What does justice demand of us?" is the question tangata Tiriti (people committed to a Tiriti based future) must ask as a good Tiriti partner in Aotearoa (Ngata, 2020, July 17).

Honouring of Te Tiriti o Waitangi must be central to address racism against Māori (Heke et al., 2022; Kidd et al., 2022) and Te Tiriti o Waitangi is central to the achievement of equitable health outcomes for Māori (Ahuriri-Driscoll, Lovell, et al., 2022). It is fundamental to anti-racism praxis in Aotearoa (Came et al., 2019; Heke et al., 2022; Kidd et al., 2020; Kidd et al., 2022; STIR: Stop Institutional Racism & New Zealand Public Health Association, 2021). When Te Tiriti is fully implemented within the health system racism against Māori will become unlikely (Came et al., 2019).

He Kupu Whakataki (preamble)

The preamble of Te Tiriti provides context and intentions. The preamble "envisages relationships of care and protection as well as autonomy and self-determination for hapū and limited authority for the Crown" (Berghan et al., 2017, p. 19). Berghan et al. (2017) used the term 'whanaungatanga' to encompass the intent of the preamble and define it as "the active process of building relationships through shared experiences and connections, critical to Tiriti-based practice and a prerequisite of authentic engagement" (Berghan et al., 2017, p. 19).

Whanaungatanga.

"(T)e ara whanaunga, the relational path, is the only sustainable path" (Hoskins, 2017, p.12).

For Māori "the relation is everything, it is ontologically privileged" Hoskins (2017, p. 4). This relational way of being is grounded in Māori practices such as "tiaki (guardianship and protection), manaaki (hospitality and care) and aroha (love and compassion), and regard for the mana (unique force/identity) of others" (p.4). In contrast, Western thought "has advanced the

self-positing autonomous individual as the dominant model of personhood" (p.4). Hoskins (2017) described how the philosopher Levinas argued for an ethical encounter of responsibility where the "other is never fully knowable and cannot therefore be made into an object of the self" (p.5). Hoskins (2017) advised Pākehā to:

- "embrace discomfort and uncertainty in the face of the extraordinary comfort that power allows";
- to let go of our inclination to treat everybody the same and intolerance of diversity and instead recognise that it is impossible to fully know the 'other';
- to realise our obligations and responsibility to the 'other' and be alert to "the demand for justice coming from the other".
- "It asks for an attentive orientation to others that opens us to learning from and being altered by other, by difference itself"(p. 12).

Martin (2000) also engaged with the philosophy of Levinas and outlined an ethics of cultural difference as a way for Pākehā and Tauiwi to engage relationally with Māori. The ethical relation positions Pākehā and other non-Māori, all those who came after Te Tiriti was signed, as manuhiri (guests), this "brings the need to recreate our subjectivity and relocate ourselves in relation to Māori" (Martin, 2000, p. 89). Repositioning Pākehā from having a 'right' to be here to a status of being a guest on Māori land will enable Pākehā to "encounter cultural difference positively and ethically" (2000, p. 90).

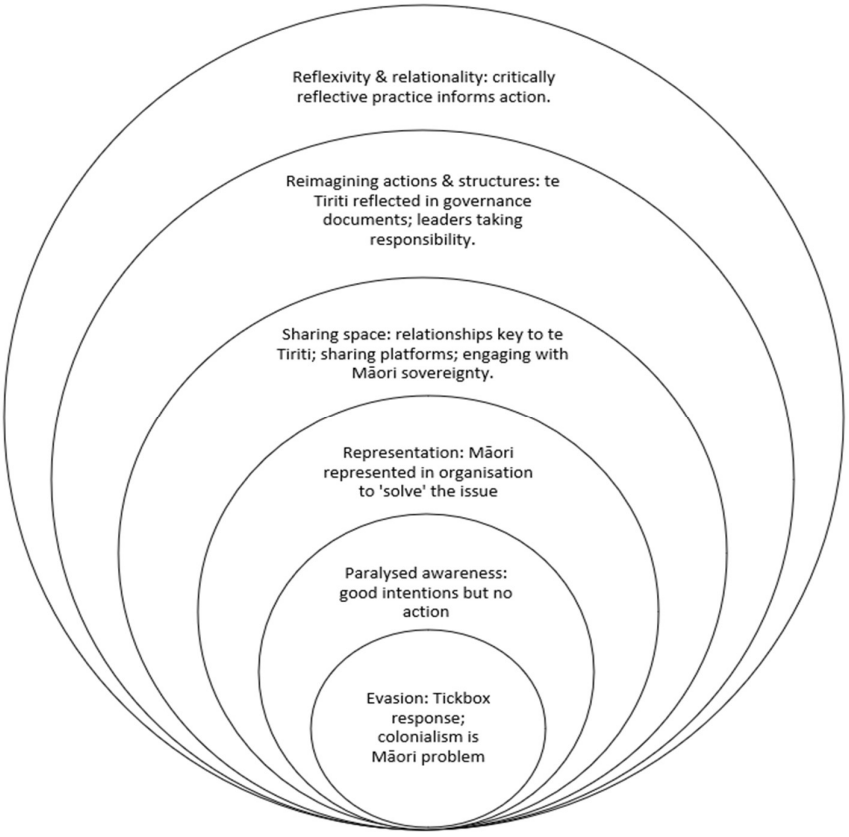
In later work Beausoleil (2022) uses the metaphor of the waharoa (gateway) and calls for non-Māori / settlers to come together to 'wait at the gate'. In this coming together we embrace collectivity but also become prepared to be welcomed, to be manuhiri (Beausoleil, 2022). Barber advises that when Pākehā go through the waharoa and enter "te ao Marama, the world of light and relationships, Pākehā will have to relinquish an authority that was both never ours to take and damaging for us to hold" (2020, p. 167). Borell (2017) argued that Pākehā collective identity is foregone due to the invisibility of our dominant cultural positioning. Only when Pākehā understand ourselves as part of a cultural group with a distinct community rather than as separate individuals will they achieve emotional and spiritual authenticity (Borell, 2017).

Building and sustaining relationships with Māori is the basis and heart of Tiriti based anti-racism allyship (Came, Kidd, Heke, et al., 2021; Came & Tudor, 2016; Hotere-Barnes et al., 2015; Huygens, 2011; Margaret, 2013; Margaret & Came, 2019). Socially just relationships mean that difference in world view is accepted and expected, and respectful and reflexive communication occurs without dominance or Pākehā assuming 'expert status' (Hotere-Barnes et al., 2015). To

have effective relationships with Māori, Pākehā must overcome professional aloofness or ‘objectivity’ and focus on building and maintaining relationships of honesty, respect and reciprocity (Came & da Silva, 2011). Relationships of trust are built over time (Heke et al., 2022; Scott et al., 2003) by doing ordinary things together (Berghan et al., 2017) and prioritising relationship development (Crawford & Langridge, 2022).

In their research with settler activists, Showden et al. (2022) identified a six stage ‘continuum of engagement’ (adapted for this study in figure six) which reflects the importance of leadership, critical reflection informed by listening to Māori, and organisational/structural commitments. The sixth level ‘reflexivity and relationality’ focused on being relational and maintaining a critically reflective practice that informs action. The movement from the smaller to the larger circles in a sustainable way required “turning a decolonising lens on settlers rather than continuing to make Indigenous people the ‘other’ to be studied” (Showden et al., 2022, p. 18). Doing this work required a responsibility to learn from the history and work of previous Indigenous and settler activists (Showden et al., 2022).

Figure 6
Continuum of Engagement



Note: Adapted from "'So people wake up, what are we gonna do?': From paralysis to action in decolonizing activism". C. R. Showden, K. Nairn, & K.R. Matthews, 2022, *Ethnicities*. p.670 *10.1177/14687968211062916.* Copyright 2022 Sage.

Scott et al. (2020) also identified that quality relationships require constant reflection and reciprocity. Hancock and Newton (2022) described the need for Pākehā to critically reflect on their "colonising ways of being (paternalistic and racist assumptions, attitudes, styles of communication and behaviours)" and move towards a "ethical-political" relationship which encouraged learning from each other" (Hancock & Newton, 2022, p. 16).

Positionality, privilege and power.

Pākehā need to understand, and critically reflect upon, our positionality, privilege and power and how this impacts upon relationships (Crawford & Langridge, 2022). The work of Pākehā allies to call out racism (Thomas, 2020) should be supported by a conscious positionality that includes understanding of Pākehā culture, respect for Indigenous knowledge and working through our discomfort or fragility with other Pākehā.

Ngata (2020, July 17) said tangata Tiriti (people committed to Te Tiriti) must accept their own positionality, which includes Pākehā recognising our colonial privilege in clear and non-guilty ways while being willing to give up power, for example refusing speaking positions on Indigenous issues. Margaret and Came (2019) identified processes of 'understanding and addressing power' as core to allyship. This requires allies to recentre and amplify the voices of minority and Indigenous people while carefully deciding for oneself when to speak or stay silent, when to act or not (Margaret & Came, 2019). Pākeha allies can also strategically privilege the Indigenous partner by using timelines and budgets to ensure power and resources are equitable (Scott et al., 2020). Perhaps the ultimate privilege that Pākehā health workers have is the choice of whether to engage in anti-racism and decolonisation work (Margaret, 2013; McKegg, 2019).

Following Indigenous leadership.

Berghan et al. (2017) employed the metaphor of the dance to describe how an effective ally follows the lead of Indigenous peoples. 'Respectful relations' between Māori and Pākehā doing decolonisation work requires different roles and "response-abilities" (Hancock & Newton, 2022). During a land occupation Pākehā undertook specific roles with clear mandates from Indigenous leadership, which required following direction even when there was disagreement with a decision (Hancock & Newton, 2022). Thomas (2020, p. 108) emphasised that "Pākehā and other tauiwi should take our cue from Māori in the work of decolonisation – that means Māori set the agenda and are leaders in discussions about decolonisation".

When in relationship with Māori, whilst learning from and taking direction from the Indigenous leaders, Pākehā also engaged with the concept of 'ethical proximity':

> … a kind of closeness that also leaves a space for difference. A proximity in the sense that Māori concern us, Māori matter to Pākehā. But a proximity that allows for distance and difference – in forms of knowledge, in ways of being. (Bell, 2007: para. 70 as quoted in Hancock and Newton, 2022, p. 7).

Huygens (2011) described the importance for decolonisation practice of 'co-intentional relationships,' a term adopted from Freire's (2005) liberation theory that "refers to the oppressed and the coloniser working towards the same end" which for Pākehā can include "institutional reform and re-education about their self-serving myths" (Huygens, 2011, p. 61). Te Huia (2016) outlined an important role for a Pākehā ally is "to support and inform their own Pākehā peers and communities who are in the process of Pākehā decolonization (and) relieve Māori from the emotional resources needed to undertake such tasks" (Te Huia, 2016, p. 14). Ngata (2020, July 17) said there must be respect for the boundaries of tangata whenua including Māori-only safe spaces for discussion, suggesting Pākehā voices be used to speak to Pākehā about what it is to be Pākehā, to be good tangata Tiriti, to allay fears about decolonisation, and conduct work on ourselves, with ourselves. Relationships of accountability between Māori and Pākehā (Came & Tudor, 2016; Crawford & Langridge, 2022; Heke et al., 2022), and checking in "without expecting hand-holding or back-patting" are good practice (Thomas, 2020, p. 108).

Kāwanatanga – Article One

"Pākehā have cultural insider insights into racism and Te Tiriti responsibilities within the kāwanatanga sphere, and need to be responsible for working constructively with their people, in alliance with Māori, to eliminate racism." (Came et al., 2022, p. 107)

Berghan et al. (2017) identified actions under three domains when working with article one: decision-making, Māori representation and kaitiakitanga, and structural mechanisms. Many of the suggested actions focused on advocacy and support for Māori leadership and participation at all levels and actions throughout the health system.

Transforming the system.

The current colonial health system operates from a Eurocentric, monocultural, bio-medical worldview that is individualistic, problem-focused, clinician centred, institutionally racist and culturally unsafe for Māori (Espiner et al., 2021; Graham & Masters-Awatere, 2020; Heke et al., 2022; Hunter & Cook, 2020; Masters-Awatere et al., 2020; Walker et al., 2023; Wilson et al.,

2021). Walker et al. (2022) found Māori felt excluded, devalued, and estranged by a health system that did not include their cultural values and practices.

Came and Humphries (2014) highlighted the contradiction for people in positions of power who see themselves as 'good' people while working for an unethical and racist system. While senior managers can promote 'master narratives' that sustain institutional racism and inequality, managers can also face that challenge by accepting responsibility for revealing and removing institutional racism wherever it exists (Came & Humphries, 2014). Tarena et al. (2022) recommend 'shifting mindsets' from viewing racism as interpersonal to systemic. Advocating for systemic change is a core tool of allied anti-racism praxis: Pākehā who work within a system of privileged dominant 'norms' but do not challenge institutional-level racism are complicit (Margaret & Came, 2019). Transforming the health system must be led by executive management, this includes recognising the impact of colonisation on Māori wellbeing and pledging to uphold equity (Haitana et al., 2022).

Kidd et al. (2022) noted that if all health practitioners were actively anti-racist, this itself could be a systemic response. The meso or organisational actions identified by Kidd et al. (2022) provided a roadmap for allies: organise and evaluate anti-racism professional development; develop anti-racist groups; use tools such as Critical Tiriti Analysis to critique policy; organise human resource processes to ensure Māori are pro-actively prioritised; understand where racism is operating in the system and how it can be disrupted; monitor and report to international human rights bodies; address the effects of historical racism and generational trauma in service and care design; and campaign for the embracing of Indigenous knowledge, evidence, and solutions.

Kidd et al. (2022) emphasise that honourable kāwanatanga means Pākehā have a responsibility to act against racism. Intentionally acting for change (Crawford & Langridge, 2022) can include planning to end racism (Berghan et al., 2017) and measuring, evaluating and monitoring progress towards the plan (Came & Tudor, 2016).

Various systems change models offered overlapping priorities. One literature review developed for the Ministry of Health anti-racism programme of work Ao Mai Te Ra identified 14 levers for system change (Williams, 2022). These levers then contributed to the Whiria te Muka preliminary model on anti-racism systems change (McMeeking et al., 2022). Te Tiriti o Waitangi is not identified as a specific lever however it is integrated into each of the levers identified (Williams & McMeeking, 2022). The summary document for phase one of Ao Mai Te Rā identified

four strategies health organisations can take to address racism and four actions people can take to address systemic racism (Tarena et al., 2022). These are summarised in the table below.

Table 4
Anti-racism Actions for Health Organisations and People

Actions for health organisations	Actions for people
Convince individuals that change is possible, raise knowledge of the negative effects of racism and the advantages of anti-racism.	Be critically conscious, reflect on your power and privilege and commit to act.
Embed anti-racism into organisational strategies, planning, and reporting so that it becomes ingrained and fosters anti-racist culture change.	Champion anti-racism action – raise awareness of how racism affects health and wellbeing and how anti-racism can improve health equity.
Support anti-racist behaviours by training people to recognise and combat systematic racism.	Be a good anti-racism ally, educate yourself, use your power and privilege to make changes.
Develop anti-racism monitoring tools to draw attention to what must change and to gather information establishing what works.	Share power and do things differently, start by naming racism and planning to address it. Work through discomfort and have courage.

Note. Summarised from "Ao mai te rā: the anti-racism kaupapa summary paper - lessons for the Aotearoa New Zealand health system". E. Tarena, A. Anderson, L. Shorter, J. Berentson-Shaw, & M. Salole, 2022. Ministry of Health.

A five stage anti-racism framework for allies outlined by Came and Griffith (2018) included reflexive relational practice, socio-political education, structural power analysis, systems change and monitoring and evaluation. Newcombe and Amundsen (2022) studied Pākehā participants honouring and implementing Te Tiriti within their charitable organisations and identified four themes: 1) individual and organisational self-assessment using purposefully designed tools that operationalise humility, authentic self-reflection, and genuine relationship with Māori; 2) a thorough understanding of Te Tiriti implementation within their organisation cognisant of Māori autonomy and aspirations; 2) a 'role of culture' theme that denoted a non-performative journey including education in te reo; 4) a Māori workers theme encompassing both Māori staffing and meaningful relationships, and involvement of Māori throughout the organisation.

Overcoming Pākehā fragility and paralysis.

Masters-Awatere et al. (2020) described how Pākehā sensitivities were prioritised over Māori patient experiences. Pākehā health practitioners sometimes felt powerless to make anti-racist changes (as opposed to 'work-arounds') with people in powerful positions viewed to have an almost "god-like" omnipotence and immovability, even though "in reality, rules and policies are made by people – and can be changed by people" (Masters-Awatere et al., 2020, p. 10).

Chin et al. (2018) identified the obstructive potential of 'white fragility' and discomfort for which they recommended "free, frank, and fearless discussions about structural racism, colonialism, white privilege, and implicit biases" (Chin et al., 2018, p. 849). Kidd et al. (2020) identified the need for anti-racist Pākehā nurses to move past white fragility and 'Pākehā paralysis'. Crawford and Langridge (2022) emphasise that DiAngelo's (2019) conception of white fragility is "not a state of vulnerability: instead it is a powerful place that silences important challenges and maintains white superiority and power" (Crawford & Langridge, 2022, p. 104). If racism is construed as individual conscious acts, rather than an embedded system of injustice, then Pākehā who (falsely) claim not to be racist can remove ourselves from the problem (Crawford & Langridge, 2022).

Bell (2022) adapted DiAngelo's (2019) concepts to describe the move from settler fragility to developing settler stamina. Bell extends DiAngelo's binary of the 'good' person/ 'bad' racist into a temporal distinction by which a 'bad' colonial past can preserve the fragile settler myth of a 'good' present. This discontinuous view "in which history is not accepted as relevant to the present" (Wetherell and Potter, 1992, p. 185 as quoted in Bell, 2022, p. 5) allows colonial descendants to deny personal responsibility ('it wasn't me') while disavowing the "embedded and structural system of disadvantage, discrimination and privilege in which we are all implicated and positioned" (Bell, 2022, p. 5). Overcoming settler fragility and developing settler stamina requires reflection, development of critical consciousness, learning about colonisation and racism, and sitting with discomfort and acceptance of being complicit in a racist system (Bell, 2022). Ngata (2020, July 17) suggested Pākehā contemplate the difference between our discomfort at decolonisation and the ongoing experience of colonisation for Māori.

Development of critical consciousness.

The development of critical consciousness involves critiquing the 'taken for granted' power structures, critical self-reflection, and shifting the gaze onto the self to challenge one's own culture (Curtis et al., 2019). Silcock (2020), building on the work of O'Sullivan (2016), identified that occupational therapists could improve Māori health outcomes by exercising autonomous

decision-making assisted by the development of critical consciousness. Critical consciousness can generate awareness of power and white privilege operating in a racist health system (Kidd et al., 2020) and foster the confidence and motivation to mobilise around that injustice (Heke et al., 2022).

More broadly, Pākehā are encouraged to reconcile our "collective cultural cognitive dissonance" (McKegg, 2019) and develop a critical consciousness that leads to change (Brewer & Andrews, 2016) and action (Kidd et al., 2022) by revisiting our foundational knowledges about the history of colonisation, colonial privilege and Indigenous experiences of disadvantage (Came & da Silva, 2011; Huygens, 2011; Kidd et al., 2020; Margaret & Came, 2019).

Cultural safety not cultural competency.

Cultural competency practices were broadly critiqued for their capacity to blur Māori health inequity with a generic cultural competency approach (Lee et al., 2021). Although cultural safety does include an element of cultural competency e.g. use of te reo and basic knowledge of tikanga Māori, this is only one part of a broader cultural safety approach (Curtis et al., 2019). Hoskins and Jones (2022) associate cultural competency with an undesirable model of "Indigenous inclusion", an approach in which the 'other' is fitted into a system that is fundamentally unchanged in which, moreover, Māori are divested of their full Indigenous status and included alongside other 'priority' groups. Such competency or inclusion is contrasted with actual Indigenisation, a culturally safe approach which Hoskins and Jones (2022) see as "an invitation for non-Māori to understand their own identities in relation to Māori, to history, to this whenua, and to Te Tiriti o Waitangi as a foundational guide to our work. For Pākehā, it is an invitation to 'be Pākehā', that is, to orient ourselves towards Māori with undemanding attention" (Hoskins & Jones, 2022, p. 7).

Implementing such cultural safety measures was nevertheless seen to face organisational, structural and systemic barriers such as systemic racism and entrenched settler colonialism (Wilkinson et al., 2022). Training must therefore focus on power relations to encourage examination of one's own culture (Lee et al., 2021; Curtis et al., 2019) along with critical consciousness through self-reflection, accountability to patients and communities, and measurement of progress towards health equity (Curtis et al., 2019). Wilson et al. (2022) were concerned with variations in cultural safety training and application, and called for moves beyond the rhetoric to address the interpersonal and structural racism faced by Māori within the system.

There were many calls to return to the concept of cultural safety as outlined by the originator of the term, Irihapeti Ramsden (Came & da Silva, 2011; Curtis et al., 2019; Masters-Awatere et al., 2020; Wilson et al., 2022). Ramsden asserted that cultural safety "must be capable of practical application in terms of Te Tiriti o Waitangi and give effect in political and structural ways to tino rangatiratanga reaffirmed in Te Tiriti. In this sense, cultural safety cannot be separated from constitutional safety" (Ramsden, 1990, p. 58). Masters-Awatere et al. (2020) advocated that cultural safety training should not be designed to be "palatable to Pākehā professionals" and instead return to its "de-colonial roots as an anti-racist reflective practice".

Tino Rangatiratanga – Article Two

"Māori tino rangatiratanga or self-determination, as outlined in Te Tiriti, requires both a departure from the white social contract and direct investment in Māori organisations, kaupapa Māori approaches and mātauranga Māori (Māori knowledges)" (Heke et al., 2022, p. 124)

Tino rangatiratanga competencies for allies outlined by Came, Kidd, Heke, et al. (2021) included understanding the importance of Māori philosophies and te ao Māori while taking guidance from current and historic Māori health literature and Māori health leaders. Challenging racism and advocating for Te Tiriti were identified as core skills (Came, Kidd, Heke, et al., 2021).

Māori health leadership.

Māori leadership is essential to an anti-racist health system and a role of Pākehā allyship is to support this (Haitana et al., 2022; Kidd et al., 2020; Selak et al., 2020; Walker et al., 2023). Selak et al. (2020) advised health professionals and researchers to support the advancement of Māori and Pacific colleagues into roles of leadership and design (Selak et al., 2020). Crawford and Langridge (2022, p. 107) described the role of Pākehā allies to work in 'service' "under Māori and Pasifika leadership while championing mātauranga Māori and Pasifika paradigms". Non-Indigenous health researchers can support Indigenous capacity and research by "stepping aside and handing over leadership" (Scott et al., 2020, p. 144). In their work on Critical Tiriti Analysis (CTA), Came, O'Sullivan, et al. (2020) have been clear that the recognition of tino rangatiratanga requires evidence that significant decisions about the design, delivery and funding of health services is made with Māori leadership.

Kaupapa Māori health.

Kaupapa Māori health interventions can help the government meet their Tiriti obligations and work toward equitable Māori health outcomes (Rolleston et al., 2020). Berghan et al. (2017) advocated for resourcing, promoting, championing, referring to and working in partnership with

Māori health providers. Ingham et al. (2022, p. 10) suggested that "fitting Māori into the current system" could only be avoided by re-indigenising the system, returning it to traditional healing methods rather than "continually trying to decolonise it".

Kaupapa Māori health organisations, funded through the central non-Māori health system, can have their Māori autonomy constrained by 'whitewashing' techniques that include redefining Māori concepts such as tino rangatiratanga, preferencing the English language version of Te Tiriti o Waitangi and other discursive techniques used in contracts to maintain existing power structures (Eggleton et al., 2021)

Ōritetanga – Article Three

"Racial inequities are caused by systemic racism. Everyone getting what they need (advancing equity) means addressing the root cause of inequity – systemic racism" (Tarena et al., 2022, p. 8)

Health equity can only be achieved if the racism within the health system is eradicated. Treating everyone the same, equally, entrenches the powerful and privileged position that Pākehā hold within Aotearoa. While universalist approaches in the health sector (Tarena et al., 2022) have failed to improve health outcomes for rangatahi Māori (Māori youth) (Clark et al., 2022), more successful equity strategies had four characteristics: 1) long term, comprehensive evidence based approaches that combine universalism and specific rangatahi Māori policies; 2) rangatahi and Māori leadership; 3) a political commitment to acknowledge rangatahi Māori rights and concerns; 4) a dedication to anti-racism praxis and Indigenising health care (Clark et al., 2022).

Listen and involve whānau Māori.

Health inequities for Māori can be countered by advancing recommended measures to address issues of power and control such as co-designing health services, listening to the voice of Indigenous people (Gurney et al., 2020; Ingham et al., 2022), and ensuring that the Indigenous voice is not included as a marginal representation (Mako et al., 2022).

While addressing racism and structural barriers such as transport and cost (Espiner et al., 2021; Graham & Masters-Awatere, 2020), recommendations useful for equity-focussed allyship included increased cultural competency with use of te reo (Māori language) and use of Māori tikanga (cultural mores) (Palmer et al., 2019). Practices around whanaungatanga, whānau involvement and manaakitanga (Espiner et al., 2021) may allow allies to mitigate service inadequacies and support whānau wellbeing as they navigate the system (Graham & Masters-Awatere, 2020).

Unpacking discourses of privilege and racism.

Reframing disparities to consider privilege may support self-awareness among the privileged and lead to a commitment to equity (Borell, 2017). Pākehā have societal, institutional, interpersonal and internalised privilege (Borell, 2017) however this privilege can remain invisible due to meritocracy myths and victim-blaming narratives, while disparities themselves are interpreted differently through privilege frameworks and the deficit frameworks that dominate health literature (Borell, 2017; Rolleston et al., 2020). Addressing Pākehā privilege challenges cultural assumptions about 'a fair go' and can support discussion with Māori about self-determination (Borell, 2017).

McCreanor (2020) asserted that Pākehā, as Te Tiriti partners, must work to dismantle these myths and change the discourse. Allies can destabilise the Pākehā-centric norms and colonial racism of the 'standard story' (McCreanor, 2020) by promoting counter-hegemonic discourses and themes, such as 'affirming Māori authority' and 'right relationships between Māori and Pākehā', which can lead to fundamental shifts in organisations (Hotere-Barnes et al., 2015; McCreanor, 2020). Building new anti-racism narratives is identified as a core lever for organisational change (Tarena et al., 2022) and is also a crucial part of Critical Race Theory (Williams & McMeeking, 2022). Even micro changes at the level of everyday talk "can painlessly produce the kinds of tectonic shifts necessary to achieve decolonisation"(McCreanor, 2020, p. 14).

Plan, implement and monitor to address equity.

The development of an equity focused workforce led by Māori (Mako et al., 2022) can be supported by colleagues maintaining a determined and deliberate pro-equity focus (Gurney et al., 2020; Mako et al., 2022). With Indigenous leadership prioritising actions (Gurney et al., 2020), this process requires planning and implementing within regimes of increased accountability and system monitoring that includes equity assessment tools and consistent equity reporting (Chin et al., 2018; Gurney et al., 2020; Mako et al., 2022).

Wairuatanga – Article Four

Embodying the practice of wairuatanga in health is explained by Berghan et al. (2017) as engaging respectfully and proactively with spiritual beliefs and values, while developing specific familiarity with Māori spiritual principles and practices and their importance in te ao Māori.

A values-based approach.

Moana Jackson proposed an 'ethic of restoration' to replace the term decolonisation and described restoration as a process requiring "a change of mind and heart as much as a change of structure" (Jackson, 2020, p. 149). Tarena et al. (2022, p. 20) also identified the need to address racism through opening hearts and minds "to love and care for one another in a way that embraces our shared humanity – mana tangata".

Six values, identified within the various models of constitutional transformation developed by the Matike Mai (Matike Mai Aotearoa, 2016) programme of work, are outlined by Jackson (2020) as interrelated parts of the ethic of restoration. These values are:

1. The value of place – the need to promote good relationships with and ensure the protection of Papatūānuku.
2. The value of tikanga – the core ideals that describe the 'ought to be' of living in Aotearoa and the particular place of Māori within that tikanga.
3. The value of community – the need to facilitate good relationships between all peoples.
4. The value of belonging – the need for everyone to have a sense of belonging.
5. The value of balance – the need to maintain harmony in all relationships, including in the exercise of constitutional authority.
6. The value of conciliation – the need to guarantee a conciliatory and consensual democracy (Jackson, 2020, p. 152).

These values are based on relationships and reflect "the 'politics of love', in which love is seen as both critical and constructive" (Jackson, 2020, p. 153). To be effective anti-racism needs to be informed by values (STIR: Stop Institutional Racism & New Zealand Public Health Association, 2021). Values identified by the Tangata Whenua caucus were:

- Wairua - the impact of racism is felt at a spiritual level and the racism is deeply embedded in non-Māori systems. Sustainable anti-racism requires collective healing.
- Tangata –anti-racist praxis requires people to undertake internal and interpersonal actions to change the power held within systems and structures.
- Mana – mana is the "enduring, indestructible power of the atua (p.11)", recognition of the mana in everyone and the potential for everyone to be anti-racist.
- Reo – the language of anti-racism praxis can build community through shared experience and understanding.
- Tikanga – doing what is correct and proper is intrinsically connected to Māori values. Institutional racism can be disrupted using tikanga in process and policy.

- Mahi pono – disrupting racist systems requires transformational thinking, strategy and action. Sustaining and caring for the workforce is crucial.
- Rangatiratanga – the right to self-determination "nourishes our wairua, strengthens us as tangata, enhances everyone's mana, evolves reo, manifests tikanga and is expressed through mahi pono. Rangatiratanga necessitates an embrace of responsibilities and a commitment to achieve our shared goals in ways that weave all communities together" (p.11).

Understanding self.

Understanding who you are, your whakapapa (genealogy and connections) is required for competency with wairuatanga (Came, Kidd, Heke, et al., 2021). The practice of cultural humility (Came, Kidd, Heke, et al., 2021) for non-Māori is described by Margaret and Came (2019, p. 321) as "an ongoing process of critiquing one's own culture while striving to respectfully understand others' cultures, of recognizing and redressing power imbalances, and of contributing to partnerships that are mutually beneficial and nonpaternalistic". This interrogation of self – understanding values, assumptions, default ways of working and positions of power – is crucial to being able to work alongside others (Margaret & Came, 2019). Berghan et al. (2017) also named the importance of considering yourself as a cultural bearer, reflecting on one's own values and beliefs and how these impacts upon others.

Engaging in te ao Māori (the Māori worldview).

Accurate pronunciation and basic knowledge of te reo Māori, along with understanding Māori tikanga and knowing about the local hapū and iwi and their aspirations are fundamental knowledges and skills for allies (Berghan et al., 2017; Came, Kidd, Heke, et al., 2021; Hoskins & Jones, 2022). Hunter and Cook (2020) described how learning te reo Māori can help tauiwi practitioners (nurses) develop a connection with Māori and a deeper understanding of Māori reality.

Thomas (2020) addressed the political complexities of Pākehā learning tikanga and recommends Pākehā to "be careful, humble and respectful around how we use the gift of te reo Māori" (Thomas, 2020, p. 124 & 125). Taking educational spaces away from Māori learners can mean Pākehā allies exacerbate Māori traumas of colonial assimilation and language dispossession (Thomas, 2020). Ngata (2020, July 17) acknowledged the need for Pākehā to understand and engage in te ao Māori but not to overstep boundaries and end up explaining Māori culture to Māori.

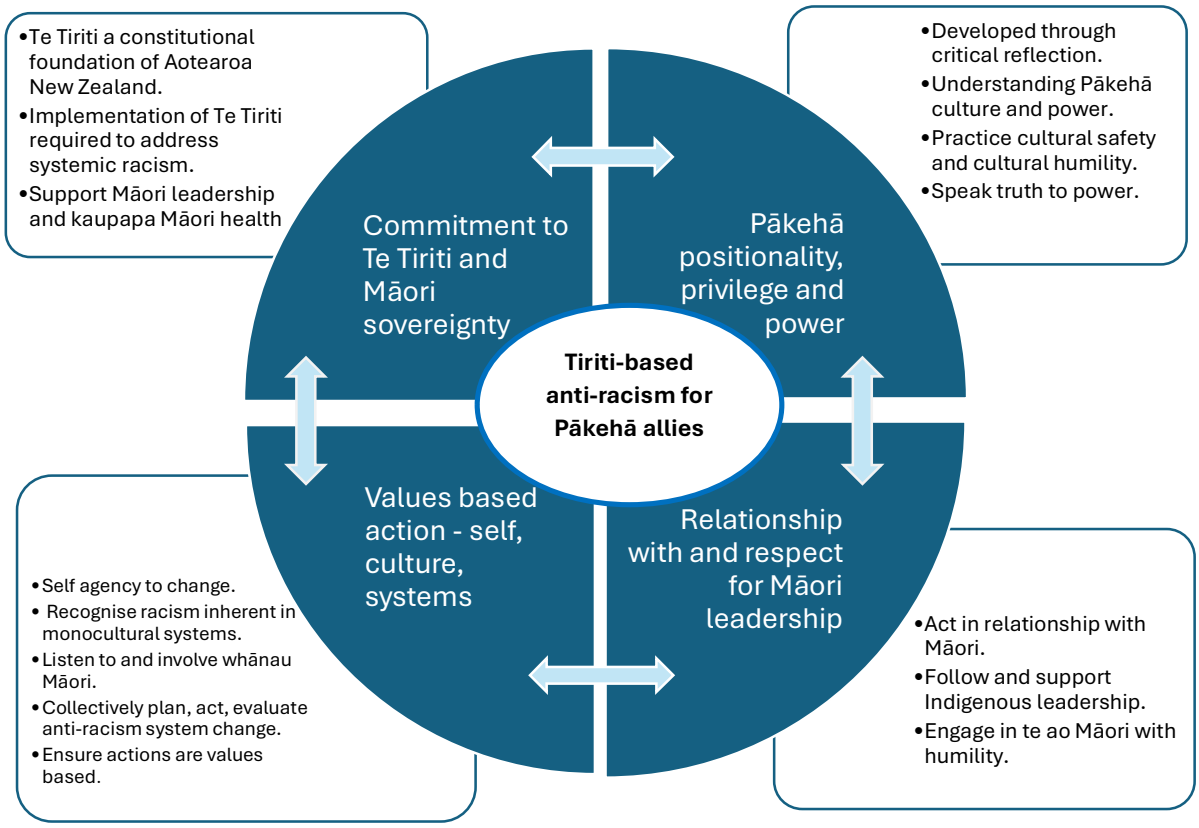
Discussion

This literature review sought to inform Te Tiriti based anti-racism praxis of Pākehā allies within the health sector. The findings are framed within the context of Te Tiriti o Waitangi and reflect that Te Tiriti is viewed as a sacred covenant by Māori (Berghan et al., 2017; Healy et al., 2012), and is fundamental to anti-racism praxis in Aotearoa (STIR: Stop Institutional Racism & New Zealand Public Health Association, 2021) and requires implementation within the health system to eradicate racism (Came et al., 2019; Tarena et al., 2022).

The figure below identifies core concepts from the literature that are key to Te Tiriti based anti-racism praxis. All four cornerstones cross over and all are required for effective praxis.

Figure 7

Four Cornerstones for Tiriti based Anti-racism for Pākehā Allies



A cornerstone of Te Tiriti based anti-racism praxis must include a deep belief in, commitment to and action for, implementation of Te Tiriti o Waitangi. As exemplified in the findings above, each of the five elements of Te Tiriti provide guidance for anti-racism action. The work here builds on others who have articulated how Te Tiriti can be a guide for health promotion practice (Berghan

et al., 2017; Health Promotion Forum, 2002). Te Tiriti based anti-racism praxis has similarities with 'Indigenous specific anti-racism' (Brown, 2023), an approach that centres Indigenous rights and sovereignty. In the context of the health system, and in response to the clear identification of Indigenous specific racism present within the health service of British Columbia (Turpel-Lafond & Johnson, 2021), the First Nations Health Authority has described Indigenous or First Nations specific anti-racism.

The second cornerstone requires Pākehā to have a deep understanding of what it is to be Pākehā in Aotearoa and all the layers of meaning, power, position and privilege that 'being Pākehā' holds. A commitment to, and belief in, Te Tiriti based anti-racism praxis for Pākehā allies requires constant reflection (Crawford & Langridge, 2022), becoming aware of the development of Pākehā identity, power and positionality, central to understanding and unpacking Pākehā privilege and overcoming paralysis, fragility and guilt (Thomas, 2020).

The third cornerstone is the need for Pākehā need to work alongside, and for, Māori to dismantle the racism and decolonise this system. For Pākehā to have genuine relationships with Māori requires positioning ourselves as manuhiri (guests) (Beausoleil, 2022; Martin, 2000), being willing to learn from the 'other' (Hoskins, 2017) and respecting Māori authority (Barber, 2020). This level of relationship requires constant reflection turning the lens on ourselves (Showden et al., 2022). Good allies follow the lead of the Indigenous people (Berghan et al., 2017), this includes developing relationships of accountability (Heke et al., 2022) without the need for constant reassurance (Thomas, 2020).

The final cornerstone is action – on the self, with others, and within systems. Before Pākehā can begin to work towards change within the system we must see it for what it is – a system that upholds institutional racism through the privileging of a Pākehā world view. Thirty-five years ago the landmark report Puao-te-ata-tu, produced by the Ministerial Advisory Committee on a Māori perspective for the Department of Social Welfare (1988) described institutional racism as "(t)he most insidious and destructive form of racism" and defined it as "the outcome of monocultural institutions which simply ignore and freeze out the cultures of those who do not belong to the majority. National structures have evolved which are rooted in the values, systems and viewpoints of one culture only. Participation by minorities is conditional on their subjugating their own values and systems to those of "the system" of the power culture" (p.19). The report also made it clear that people working within the system were not necessarily racist however if people did not work to eliminate the racism then they could be "accused of collaborating with

the system, and therefore of being racist themselves" (p. 78). These messages, delivered so articulately over three decades ago, remain relevant and need to be urgently heeded.

Change within systems must coincide and support the transformation of our society. Moewaka Barnes and McCreanor (2019, p. 26) warn that alongside health system reform the decolonisation and the transformation of Aotearoa society must occur or else "reform will fail in addressing historical trauma and the assumed universality of entrenched health systems, leaving injustice entrenched in the system". Ngata (2022) echoes this realisation that transformation cannot occur unless the power and control currently held by the hegemonic colonial settler state is relinquished and Indigenous sovereignty is restored. Indeed, work within systems that partially address self-determination while attempting to reduce harm caused by systems can be viewed as a distraction from the achievement of Māori sovereignty (Ngata, 2022). Recent developments such as the Māori Health Authority and treaty settlements, will not redress the "parental injustice" of loss of Māori political authority until there is "Māori political authority over Māori futures. Only when we, Māori hold the ultimate authority over our lands, our waters, our families, our futures. Only then are we free on our own land" (Ngata, 2022).

Allies must navigate the complexity of acting within existing systems to mitigate their impact, affecting change within structures or policies, whilst also trying to envision alternative and decolonised systems grounded in relationality (Jones et al., 2022). Jones et al. (2022) suggest that this decolonial orientation requires:

> each person [to] actively look for positive relational tipping points in everything they do, and seek to shift systems towards the vision of the world they cannot live without. Essentially this endeavour is about identifying strategic places to disrupt business-as-usual and initiate a virtuous cycle of normalising and strengthening relational, pro-equity, anti-racist, decolonial, pro Indigenous-sovereignty approaches that can pave the way to system transformation (p. 838).

Navigating the enormity of the task of transforming society and systems requires holding on to values from this place. Te Tiriti based anti-racism action is guided by values that care for all people and lead to collective healing (Jackson, 2020; STIR: Stop Institutional Racism & New Zealand Public Health Association, 2021).

The deliberate relational citational approach taken in this review reflects a fundamental allyship practice of 'being in relation'. This requires reading, understanding, giving attention to, and heeding the work of Māori. This approach follows that of other Pākehā researchers who seek to

honour Te Tiriti and adopt a decolonising research approach. Newcombe and Amundsen (2022) intentionally researched Pākehā whilst engaging with Indigenous scholarship to provide a "critical and self-reflective lens"(p. 8). The work of Indigenous authors is described as a "touchstone" for Pākehā research, that "recognises the pre-eminence of Indigenous knowledge, and that the work of Pākehā allies needs to be measured against what Māori have identified as important" (Newcombe, 2019, p. 9/10).

Within an international context, the deliberate relational citational approach aligns with the cite Black Women movement (C. A. Smith et al., 2021, p. 5) which "charges scholars in all disciplines to reimagine hegemonic citational politics by critically and actively reflecting on how gender, race, nationality, and class shape the possibilities of knowledge production". Citational practice is also central to feminist research ethics (Xin Liu, 2021) *who* contributes to knowledge production is a feminist and anti-racist position. Mott and Cockayne (2017, p. 956), two white researchers from America and Canada, argued for a "conscientious engagement with the politics of citation". The feminist and anti-racist citational practice is deliberate in engaging with "those authors and voices we wish to carry forward" (2017, p. 954). Who is cited and who is not is a political act that can contribute to the maintenance of the status quo or help to disrupt. The approach taken here, originally inspired by the work of Burgess et al. (2021), provides a method for scholars seeking a critical citational practice that reflects the contextual and geographical nature of racism and settler colonisation.

A limitation of this review is the lack of engagement with literature from other colonial settler nations on the work of allies doing anti-racism within their respective health systems. Working in allyship is specific to whom one is working in solidarity with and although international literature is not irrelevant to Aotearoa it is secondary considering the importance of context: place, people, history and current events. Looking to other colonial settler nations for solutions – particularly those in the global north – cannot replace theory and wisdom developed from the people working within and for this country.

Conclusion

This paper is focused on reviewing literature to inform Te Tiriti based anti-racism praxis of Pākehā allies in the Aotearoa health sector. We are facing a unique time in the health sector in Aotearoa with the current structural reforms of the health system and the commitment by the Ministry of Health to an anti-racism programme. This review provides guidance, under the framework of Te Tiriti, to Pākehā allies wishing to take action to address racism and the resultant health inequities.

The table below provides a summary of the literature under each of the five parts of Te Tiriti.

Table 5
Core Components to Inform Tiriti-based Anti-racism Praxis of Pākehā Allies

He kupu whakataki - preamble	
Whanaungatanga	Importance of allyship action in relation with Māori and following leadership of Māori. Respect for difference; connect and learn from the 'other' but not in an extractive manner. Overcome Pākehā individuality and work collectively. Critical reflection supports action based in relationship.
Positionality, privilege and power	Understand our positionality as Pākehā and the power and privilege inherent within. Amplify voices of those experiencing racism. Understand and address power, speak out against racism. Share power and resources within relationships.
Following Indigenous leadership	Roles for colonised and coloniser; co-intentional relationships; accountability mechanisms with Māori.
Kāwanatanga – article one	
Transforming the system	To change the system first need to recognise the system is Eurocentric, individualistic and inherently racist; people with power in system need to act on institutional racism; organise collectively; map and plan to dismantle the racism. Reflexive relational practice and conscientisation; analysis of power who makes and influences decisions in the system; monitoring and evaluating change.
Overcoming Pākehā fragility and paralysis	Requirement to view racism as systemic not just interpersonal; active anti-racism required to not be complicit; understanding history of colonisation; allow yourself to sit with discomfort and critically reflect.
Development of critical consciousness	Gaining critical consciousness requires an understanding of history; analysis of Pākehā power and Pākehā privilege and how it operates; shifting the gaze from 'others' to self.
Cultural safety not cultural competency	Development of critical consciousness key to cultural safety; requires questioning power and structures within

	health system; health service users define what cultural safety is; measure and monitor progress towards equity.
Tino rangatiratanga – article two	
Māori health leadership	Support Māori health leadership at all levels of the health system. Decisions about design, delivery and funding of health services is made with Māori leadership. Work in 'service' of Māori leadership. Step aside from leadership roles when required.
Kaupapa Māori health	Advocate for, promote, refer to and work in partnership with Kaupapa Māori health providers. Support the implementation of Māori knowledge throughout the health sector.
Ōritetanga – article three	
Listen and involve whānau Māori	Ensure policy and decision-making includes the voice of Māori. Ensure Māori whānau are included in healthcare and are enabled to support whānau to navigate the system. Identify and rectify barriers to access.
Plan, implement, monitor to address equity	Focus on equity through planning, implementing and monitoring actions and ensure adequate funding. Māori led equity focused workforce.
Unpacking discourses of privilege and racism	Frame inequities and disparities as consequences of colonisation and racism; take a structural analysis approach to naming and considering how privilege works to uphold racism. Identify how the 'standard story' of racism operates and provide a new discourse / narrative based on Te Tiriti 'right relationships' and 'affirming Māori sovereignty'.
Wairuatanga – article four	
A values-based approach Understanding self	Work from a values-based position with open hearts. Understand your history and culture, practice cultural humility.

Engaging in Te ao Māori	Accurate pronunciation of te reo Māori, understanding of tikanga Māori are important knowledge and skills for allies. Be humble and discerning with how and when te reo is used.

The above is not intended to be a checklist or tick box for doing Tiriti based anti-racism within the health system, nor should it be construed as separate parts to a whole as several components are connected and / or repeated, for example understanding self and Pākehā positionality. This summary, and overall goal of the paper, however, is to provide guidance for Pākehā reflecting on their role in working for change. This action must be premised by an analysis of power, critical reflection and always in relationship, remaining humble and working for change without expectation of recognition or praise.

This review may also be useful for other tangata Tiriti who seek a Tiriti based future for our health system and Aotearoa. Allies working within other colonial settler states may also find guidance for their own context from the findings. This review may also contribute to the beginning articulation of 'Indigenous specific anti-racism' (Brown, 2023).

The methodology of the literature review contributes to the development of deliberate citational practice and offers a novel perspective from Aotearoa and may be of interest to other activist scholars seeking decolonising ways of working within academia.

Finally, it is hoped this review is useful for the many people across Aotearoa and the world who are working to end racism and uphold Indigenous rights in the pursuit of justice. Now more than ever our work is needed.

Chapter Four: Looking Beyond Our Shores - A Review of the International Literature

Introduction

The deliberate relational citational praxis outlined in the previous chapter privileged the scholarship of Māori and allies from Aotearoa. This approach adopted a relational and decolonising approach to citations (Burgess et al., 2021; Tynan & Bishop, 2023) and recognised the historical, socio-political, and geographical dimensions of racism and anti-racism (Grosfoguel, 2016). This chapter reviews the international literature relevant to the study of how Pākehā allies disrupt anti-Māori racism within the health system and discusses how this relates to or adds to the previous literature review. This brief review of the international literature focuses on scholarship from colonial settler nations, recognising the distinction of settler colonialism (Veracini, 2011a). Settler colonialism relies on the elimination of Indigenous peoples (cultural genocide) or the assimilation of Indigenous peoples into the white settler culture (Veracini, 2011a). Both these strategies were utilised in the colonisation of Aotearoa, and certainly, particularly with recent events, assimilation is an active agenda. Monoculturalism remains a distinct feature of institutional racism in Aotearoa. In Aotearoa, Pākehā, many of whom are the descendants of the white colonial settler population, are in the majority and Māori are in the minority. In Aotearoa the British were the colonisers. This is also the case for Australia, the United States and Canada, where there are many commonalities in the colonisation experience for Indigenous peoples. Although there is a vast and varied literature on colonisation and decolonisation beyond these settler-colonial nations, particularly from the Global South, this review mainly sources literature from these countries due to their shared and ongoing experiences of settler colonialism.

There are many areas of literature connected to the study of how Pākehā allies disrupt anti-Māori racism within the health system. The following review explores literature that explicitly discussed:

1. The role of non-Indigenous, white, settler allies addressing anti-Indigenous racism and Indigenous health inequities *within health systems*.
2. The role of non-Indigenous, white, settler allies working with Indigenous peoples against racism, towards decolonisation.

3. Addressing anti-Indigenous racism, Indigenous health inequities and/or colonisation within health systems/institutions.

Method

As described in the previous chapter, a literature search of the CINAHL and SCOPUS databases using six varied search terms identified 123 articles for review. Of these 28 were kept for further consideration within this international review. The focus was on literature from 2010 onwards. Another search of the ESBCO database identified 40 articles, many of which had already been identified. Search terms used were: health or healthcare or health systems or public health or health promotion or health education AND allyship or ally or allies or solidarity or action on behalf of disadvantaged groups or accomplice AND racism or anti-racism or antiracism or systemic racism or decolonization or settler colonizer or settler colonialism. Preference was given to articles that identified Indigenous authorship, or that explicitly mentioned addressing anti-Indigenous racism, and/or Indigenous health. Reviews of reference lists were also undertaken to identify suitable articles. In total, 32 articles were reviewed across the three broad areas of literature described above, 16 of which included an Indigenous author.

Table 6
International Literature Reviewed

Non-Indigenous, white, settler allies addressing anti-Indigenous racism and Indigenous health inequities within health systems			
Citation	**Country**	**Description**	**Authors**
Hall et al. (2023)	Australia	Paper outlining cultural safety as conceptual antithesis to racism	Aboriginal and Torres Strait Islander
Jongbloed et al. (2023)	Canada	Paper outlining a 'net' model of oppression applied to health	Indigenous and non-Indigenous
Leung and Min (2020)	Canada	Paper sharing experience as allies decolonising pharmacy training	Non-Indigenous
McGibbon (2018)	Canada	Paper outlining how white settlers can be active participants in decolonising healthcare	Non-Indigenous
McGuire-Adams (2021)	Canada	Paper giving directions to anti-racist allies working in health system	Indigenous
Nixon (2019)	Canada	Paper outlining the coin model of white privilege and application in health system	Non-Indigenous
Parter et al. (2023)	Australia	Case study of implementation of cultural determinants of health into clinical practice	Aboriginal and Torres Strait Islander

Rix et al. (2024)	Australia	Paper outlining decolonising approach to cultural safety training focus on white nurse accomplices	Indigenous and non-Indigenous
Weitzel et al. (2020)	United States	Paper describing role of nurses as allies against racism and discrimination	Indigenous and non-Indigenous
Wilson et al. (2016)	Australia	Paper reporting qualitative study exploring non-Indigenous healthcare professionals experience working in Aboriginal health	Non-Indigenous (primary author)

Non-Indigenous, white, settler allies working with Indigenous people against racism, towards decolonisation

Citation	Country	Description	Authors
Barker (2010)	Canada	Book chapter on alliances between Indigenous and settlers	Non-Indigenous
Barker and Pickerill (2012)	Canada Australia	Paper describing relationships between Indigenous and non-Indigenous environmental activists	Non-Indigenous
Boudreau Morris (2017)	Canada	Paper describing decolonising solidarity based on self-reflexive relationships	Indigenous
Davis et al. (2022)	Canada	Paper based on three case studies of long-term Indigenous–settler alliances exploring roles and contributions of settlers towards decolonisation	Non-Indigenous
Davis and Shpuniarsky (2010)	Canada	Book chapter based on research exploring Indigenous and non-Indigenous alliances	Indigenous and non-Indigenous
Kluttz et al. (2020)	Canada	Paper exploring learnings as white settler-colonialists researching allyship	Non-Indigenous
Land (2015)	Australia	Book, based on PhD, exploring Indigenous and non-Indigenous relationships on decolonising	Non-Indigenous
McGloin (2016)	Australia	Paper exploring non-Indigenous educator role teaching Indigenous studies	Non-Indigenous
Steinman (2020)	United States	Paper describing everyday settler acts unsettling colonial relations	Non-Indigenous

Addressing anti-Indigenous racism, Indigenous health inequities and / or colonisation within health systems or institutions

Citation	Country	Description	Authors
Ahmed (2016)	Britain	Paper exploring concept of non-performativity of institutions regarding anti-racism	Non-Indigenous
Aquino (2020)	Australia	Book chapter on everyday anti-racism, including in institutions	Non-Indigenous
Browne et al. (2022)	Canada	Paper discussing anti-Indigenous racism in Canadian health systems	Indigenous and non-Indigenous
Czyzewski (2011)	Canada	Paper outlining settler colonialism as health determinant	Non-Indigenous
Elias et al. (2024)	Australia	Paper arguing for implementation of anti-racism as a core value within institutions	Unknown / not stated

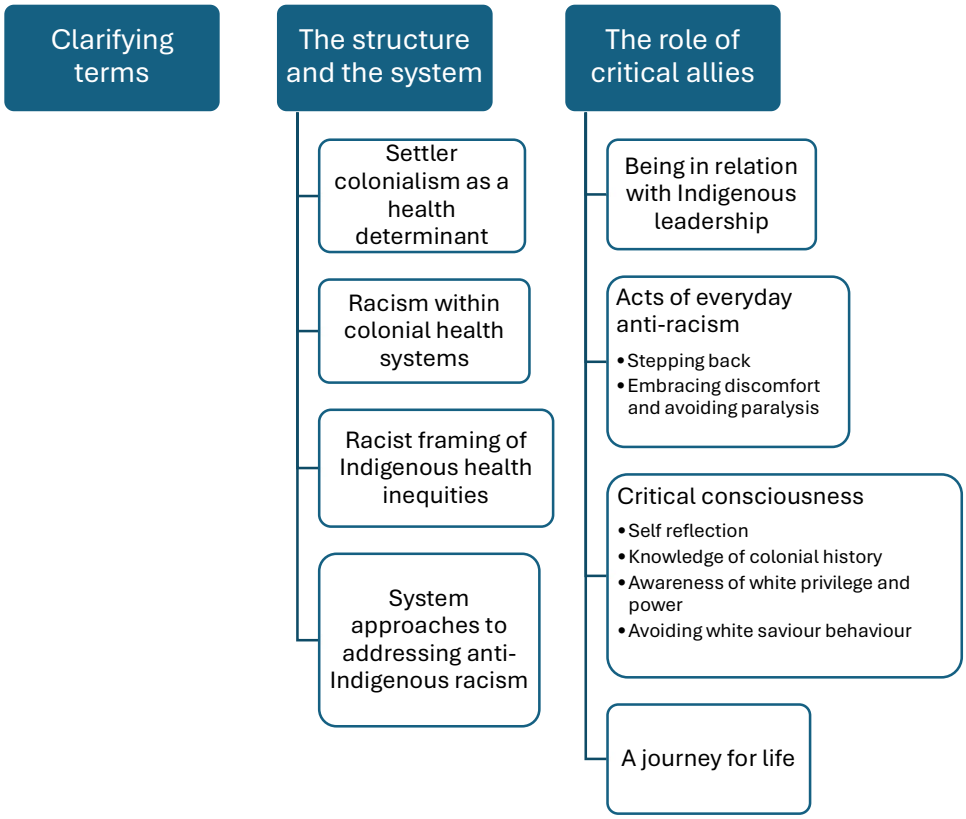
Hassen et al. (2021)	Canada	Paper reviewing literature on anti-racism interventions in healthcare	Non-Indigenous
Jones et al. (2019)	International	International consensus statement on medical education for Indigenous health	Indigenous and non-Indigenous
Paradies (2018)	Australia	Paper exploring colonisation, racism and Indigenous health	Indigenous
Ray et al. (2022)	Canada	Paper exploring systems thinking to address Indigenous health inequity	Indigenous and non-Indigenous
Shannon et al. (2022)	International	Paper exploring intersectional insights into racism and health	Indigenous and non-Indigenous
Sherwood (2013)	Australia	Paper exploring impact of colonisation on Aboriginal health	Indigenous
Turpel-Lafond and Johnson (2021)	Canada	Paper describing Indigenous specific racism within Canadian health system	Indigenous
Wispelwey et al. (2023)	International	Paper describing settler colonial health determinants	Indigenous and non-Indigenous

A general inductive approach was used to analyse the literature (Thomas, 2006). Each selected paper was read initially, with parts of text highlighted and notes taken. The notes were then reviewed to establish if there were any initial similarities. At this point it was determined that there were two broad groupings, 1: literature regarding structures and systems, and 2: literature that explored the role of allies. Within each of these groupings, several key ideas were identified; these were considered initial codes. Each paper was then re-read and selected text coded – either with an existing code or a new code created. At this point, a third theme was identified regarding the various terms used to describe allies and allyship. The two initial groupings were selected as the two main themes, each with subthemes. These three themes: clarifying terms, the structure and the system, and the role of allies, are described fully below.

Findings

The first theme is ‘clarifying terms’, which outlines the varied terminology in use to describe the work of non-Indigenous people working alongside Indigenous peoples addressing racism and colonialism. The second theme, ‘the structure and the system’, has four subthemes: significance of settler colonialism as a health determinant, how racism manifests within colonial health systems, the racist framing of Indigenous health inequity, and system approaches to addressing anti-Indigenous racism. The third theme is ‘the role of allies’, which also has four subthemes: the significance of being in relationship and working with Indigenous leadership, the importance of everyday anti-racism action, the role of critical consciousness, and the role of an ally as being a journey for life. An overview of these themes and subthemes is provided in the figure below.

Figure 8
Themes Identified Within the Literature



Clarifying Terms

'Ally' is defined not as a fixed status or identity but as a "constant relational negotiation" alongside those whom allies seek to be allied with (Davis et al., 2022, p. 621). For McGloin (2016) and Nixon (2019), the addition of the adjective 'critical', e.g., critical ally, critical allyship and critical alliances acknowledges the required engagement with a critical consciousness about the dominance of whiteness and how this is privileged within institutions. Nixon (2019, p. 9) said the "'critical' in critical allyship draws explicit attention to systems of power to emphasize that change at the interpersonal level is important but should not eclipse the goal of structural change." Rix et al. (2024, p. 1), eschewed identity claims, and instead proposed critical allyship as a constant ongoing practice, preferring the term 'accomplice' rather than "mere performative allies". Parter et al. (2023, p. 9) used both 'ally' and 'accomplice' but differentiated the terms to define allies as having a limited analysis about institutional racism,

whereas accomplices were “those who are genuinely committed to Indigenous Peoples’ empowerment, self-determination, and sovereignty.”

Decolonising solidarity is a term proposed by Boudreau Morris (2017) and Kluttz et al. (2020). Kluttz et al. (2020, p. 52) asked “who is an ally and who gets to decide? If you are an ally, are you always an ally? For how long? In what contexts?”. They concluded that being an ally is not a self-identity, nor a permanent designation, and actions in some contexts could be construed as allied but not in another (Kluttz et al., 2020). Decolonising solidarity was explained as “messy: it is not fixed or settled or easy, but requires continuous rethinking, and acknowledgement and self-reflection on positionality, power, privilege, guilt and legacies of oppression” (Kluttz et al., 2020, p. 52).

Steinman (2020) proposed ‘unsettling’, building upon the substantial body of scholarship regarding unsettling the settlers. The predominant use of the term ‘unsettling’ focuses on “the cognitive and emotional process of grappling with Indigenous sovereignty, one’s miseducation and ignorance, guilt, one’s own identity and relationship to place, and related uncomfortable topics” (Steinman, 2020, p. 562).

Rather than use the generic terms or decide at this stage about what term is most appropriate, this findings section employs the term used in the cited literature.

The Structure and the System

Three interrelated systems – settler colonialism, white supremacy and Indigenous-specific racism – were described by Jongbloed et al. (2023) as a net that structurally embedded oppression for Indigenous peoples. This net is “composed of hundreds of thousands of ‘colonial knots’ that entangle Indigenous Peoples and prevent them from exerting sovereignty and self-determination,” whilst impacting gravely on Indigenous health and wellbeing (Jongbloed et al., 2023, p. 229).

Settler colonialism as a health determinant.

> Health is created and upheld by factors within and outside of the health system: it is a political choice, shaped by interlocking social and structural determinants, which are influenced by historical and geopolitical events, which in turn shape institutional cultures and individual and community behaviours. (Shannon et al., 2022, p. 2134)

Although racism and anti-racism have common characteristics throughout the world, both phenomena vary across countries and are culturally localised (Elias et al., 2024). The racism directed at Indigenous peoples has its antecedents within the ongoing process of settler

colonialism (Czyzewski, 2011; Elias et al., 2024; Shannon et al., 2022; Wispelwey et al., 2023). Colonialism, and the inherent racism towards Indigenous peoples, is the controlling power that dominates the historic, political, social, and economic contexts determining Indigenous health (Czyzewski, 2011). Including history and coloniality in the structural and social determinants of health ensures this is considered when addressing health inequities (Czyzewski, 2011; Shannon et al., 2022).

Colonisation and the resulting racism affects the lives of Indigenous peoples worldwide. Racism impacts health outcomes for Indigenous peoples, leading to shorter life expectancy compared to non-Indigenous peoples, chronic and acute psychological distress, physical illness over a range of conditions, poor oral health, increased substance use and underutilisation of health services (Paradies, 2018).

Racism within colonial health systems.

Settler colonialism, and a distinctly non-Indigenous worldview, structures the health systems imposed upon Indigenous peoples (Sherwood, 2013; Wispelwey et al., 2023), and impacts how healthcare is funded, delivered and accessed (Czyzewski, 2011; Hassen et al., 2021). Racism and colonialism are enmeshed and embedded within health systems (McGuire-Adams, 2021; Ray et al., 2022). McGibbon (2018) identified several ways in which the Canadian health system sustained colonisation: the delivery of health services that are individually focused; the exclusion of Indigenous ways of healing; racism at point-of-care; and the failure to prioritise cultural safety, to embed cultural safety in health training and to integrate cultural safety into professional codes of ethics and health practitioner licences. In addition, the system creates "a veneer of complicity in the fight for racial equality; then, we just as deftly craft a countermove that undoes or obfuscates progress" (McGibbon, 2018, p. 20). As an example, they described how Canadian Government documents, supposedly focused on health equity, omitted the words 'Indigenous', 'racism' or 'poverty'. Hassen et al. (2021) noted organisations want to appear to do the right thing through ticking boxes. Even if the words are in institutional documents, they are often not committed to or acted upon – the writing of the words becomes the commitment (Ahmed, 2016). "Non-performative" is the term Ahmed (2016) used to describe a commitment to action made by institutions that was not followed through on.

Racist framing of Indigenous health inequity.

The myth of Indigenous biological inferiority is still used to explain Indigenous health inequities (Hassen et al., 2021; Sherwood, 2013; Wispelwey et al., 2023). If Indigenous health inequities are reported or discussed without context and without attribution to racism, unwelcoming health services, and the legacy of colonialism, then racist beliefs about Indigenous people as

"non-compliant", and "less capable" are reinforced (Turpel-Lafond & Johnson, 2021). Ray et al. (2022, p. 2) described these beliefs as founded on the persistent "settler colonial logic of Indigenous self-demise". The focus of the "medical gaze" on the health of individuals either as due to genetics or lifestyle "is based in Western, Eurocentric biomedical ways of knowing" (McGloin, 2016, p. 37). Sherwood (2013) argued for a decolonising gaze to disrupt the colonising construction blaming Indigenous people as the cause of their own demise. Shedding 'colonial amnesia' and instead taking the history of colonisation into consideration when working with Indigenous peoples was recommended as good practice for all health professionals working with Indigenous peoples (Sherwood, 2013).

The discomfort of talking about racism within health, and the inability of white settlers to see racism, contributes to holding it in place and results in inaction (Turpel-Lafond & Johnson, 2021). At a system level it means there is no integrated strategy to address Indigenous-specific racism, no monitoring framework, nor the urgency required to create culturally safe access to health care (Turpel-Lafond & Johnson, 2021). At the interpersonal level incidents of racism go unreported (Turpel-Lafond & Johnson, 2021). A "speak up" culture in health requires "the knowledge and language to identify racism when we see it, the systems to report and address it, and the strategies and tools to counteract it" (Turpel-Lafond & Johnson, 2021, p. 15). To act upon the racism in the health system, allies need to see the racism or have what Turpel-Lafond and Johnson (2021) described as an anti-racist mindset. A role of allies is to "make visible their cultural and epistemic domination (hegemony) in health care" (McGibbon, 2018, p. 41). Decolonising the health system has to start with the recognition that the system is a colonising system that requires rebuilding (Leung & Min, 2020).

System approaches to addressing anti-Indigenous racism.

Wispelwey et al. (2023) argued for the incorporation of settler-colonial theory into public health approaches to address racism and health inequities. Settler-colonial theory explains why and how "White supremacy and structural racism are embedded within settler policies, institutions, laws, academia, and societal practices" (Wispelwey et al., 2023, p. 4). This shifts the focus from Indigenous "biology and culture to settler sociopolitical formations and their attendant violence" (Wispelwey et al., 2023, p. 4). System approaches that address health inequities through governance, policy, institutions and people are required (Ray et al., 2022). Applying complexity theory and systems thinking

> encourages health care providers and policy makers to turn the gaze onto the failures of the health system. It focuses on the changes health systems can make to colonial

> practices and structures, rather than on how Indigenous peoples can fit in and navigate their way through this hostile terrain. (Ray et al., 2022, p. 2)

Paradies (2018, p. 1) outlined five key areas for combating systemic racism within institutions: (a) institutional accountability; (b) diversity in human resources; (c) community partnership; (d) anti-racism and cultural competence training; and (e) research and evaluation. These align well with the findings from a review of anti-racism interventions in colonial health systems by Hassen et al. (2021). Of the 37 peer-reviewed articles they analysed, 12 focused on addressing racism for Indigenous populations. The review identified foundational principles for anti-racism interventions in healthcare. These included: having clearly defined problems, goals and objectives that reflect the pervasiveness of racism throughout the system; including explicit anti-racism language and shared understandings rather than ambiguous or euphemistic language; leadership commitment that is strong, consistent and visible including executive leadership and governance; dedicated funding and resources for implementation and evaluation, including supporting Indigenous community participation; expertise in racism including lived experience of racism to provide input and oversight in interventions; ongoing meaningful community and patient partnerships; and a long-term commitment to relationships (Hassen et al., 2021).

The review noted the importance of multi-level, multi-strategic interventions which embedded anti-racist policies and procedures, with mandatory requirements, accompanied by a monitoring and accountability framework (Hassen et al., 2021). The review found there was an over-emphasis on individual-level training and recommended a focus within health systems on "policies and practices that seek to dismantle pervasive institutional and systemic racism" (Hassen et al., 2021, p. 11).

Similarly, Elias et al. (2024, p. 17) argued that within organisations, in white majority societies, where whiteness is the norm, the "onus of anti-racist moral responsibility is placed on white people as the beneficiaries of racism as a system of white privilege". They argued for inculcating anti-racism as a core value within organisations to elevate the pivotal role of addressing racism in governance, policy and practice (Elias et al., 2024). Systemic racism is inbuilt into health systems through professional training and education, with the conditioning and learning of white (and male) superiority individually, ideologically, and institutionally (Shannon et al., 2022). This system conveys who matters and who is worthy of respectful treatment (Shannon et al., 2022). Adopting anti-racism as a core value requires fundamental changes in the organisational culture, distribution of power and decision-making (Elias et al., 2024).

Racism manifests within structures and systems and it is these sites of racism that must be dismantled. The next section describes the role of allies in addressing anti-Indigenous racism within health systems and gleans concepts from the literature regarding ally work towards decolonisation within colonial settler nations.

The Role of Allies

Land (2015, p. 215) said that because we "are part of the system, we are the system, we are colonialism," to be seen as reliable allies we have be able to critique the system, work to change the system and "try to convince ourselves and others that the system – which does its most violent work on Indigenous people – is also not in our (enlightened) self-interest." Understanding that the structures that oppress Indigenous peoples also oppress non-Indigenous people can lead to decolonising action (Land, 2015). Davis et al. (2022, p. 635) said that, over time, allies developed an understanding of settler colonialism as an "intentional inter-connected system of oppression and violence" based on the "dehumanization of Indigenous peoples".

Significance of Indigenous leadership.

It is stated, and taken for granted, almost entirely uncritically, that a requirement of allies is to respect and follow Indigenous leadership. This is particularly evident within activist/social-movement Canadian scholarship describing the role of allies. For example, Davis et al. (2022, p. 628) said an important role for allies was "respecting Indigenous leadership and ensuring that one's actions/messages are approved by and consistent with the goals of the Indigenous community/nation in question." Further to this, allyship was "learning to centre and celebrate Indigenous leadership while relinquishing control – over agenda, decision-making, roles, even organizational structures" and accepting that allyship involved "taking direction from someone else"(Davis et al., 2022, p. 634).

Writing from the United States, Steinman (2020) identified that, within Canadian scholarship, 'unsettling' is tied to norms of following Indigenous leadership and building relationships with Indigenous Nations and communities. He asked, in the absence of Indigenous guidance "how can settlers and non-Native allies exercise such responsibility?"(Steinman, 2020, p. 564). Steinman (2020) described a concept of 'quotidian unsettling' (everyday anti-racism actions) that people in hegemonic positions, particularly within institutions, can embrace regardless of whether they consider themselves an ally or accomplice.

Land (2015) discussed the advice to follow leadership from Indigenous people and the potential issues that arise from this stance. This approach can expect work from already over-burdened Indigenous leadership and it can be paralysing for non-Indigenous people if opportunities for

allied action are missed by waiting for direction (Land, 2015). An uncritical acceptance and deference to Indigenous views absolves allies of responsibility and agency (Land, 2015). When Indigenous nations, organisations and/or leaders have differing goals and agendas or when there is fragmentation within Indigenous communities, the 'murkiness' of following Indigenous leadership is apparent (Steinman, 2020). It is not up to Indigenous leaders and scholars to provide guidance to settlers/non-Indigenous people who are seeking to act as allies in support of Indigenous struggles. Instead, allies, at an individual and collective level, need to work out the 'how' of allyship themselves (Barker, 2010). Land (2015) and Steinman (2020) also concluded that allyship is context-dependent and there will be times when non-Indigenous people require humility and self-effacement, and others when they need to exercise independent judgement and "talk straight and be honest" (Land, 2015, p. 200).

Further to this, Steinman (2020) proposed the approach of "discerning openness" to work out what to do in the face of incongruent Indigenous leadership. In summary, the advice was as follows:

> We can express our intent (reaching out), draw upon our mind (critical awareness), clear our hearts and egos (thick skin and letting go), and ally ourselves with the individuals and actions that most reflect the guidance provided by those components, and which, in the end, 'feel right' (discernment). (Steinman, 2020, p. 571)

Being in relation

Boudreau Morris (2017, p. 464) argued that decolonising solidarity is a relational practice that firstly nurtures a practice of discomfort and questioning/listening to oneself, which then forms a basis for "engag[ing] in specific, contextualised, and contingent conversation with and listening to others". A starting point can be to read and learn from the work of Indigenous scholars (Kluttz et al., 2020; McGuire-Adams, 2021).

Barker (2010) suggested working with Indigenous peoples towards the pursuit of Indigenous defined goals through a process of radical experimentation. This process requires constant self-reflection and consideration of questions such as: "who are we, what do we want our society to look like, and how do we wish to relate to the Indigenous peoples whose lands we live upon?" (Barker, 2010, p. 328). The answers to these questions do not lie within existing structures; rather, they are informed by principles, of which the most important is respect, including respect within relationships between Indigenous peoples and colonial settlers (Barker, 2010).

The potential for colonial, paternalistic, power-over relationships to be reproduced within Indigenous and non-Indigenous relationships was discussed by Davis and Shpuniarsky (2010).

Taking time to build relationships of respect and trust is key, with mistrust of non-Indigenous people a constant presence shaping relations (Davis & Shpuniarsky, 2010).

Everyday anti-racism acts.

Aquino (2020, p. 222) discussed the 'doing' of 'every-day' anti-racism within organisations and noted the false "institutional/individual binary" and instead emphasised that "institutions comprise people and are not independent of them, and that structural racisms are perpetuated or challenged via human action". Wilson et al. (2016) explored the experiences of non-Indigenous health professionals working at the interface in Aboriginal health. They highlighted that factors at the individual level cannot be separated from the organisational context. The practice of critical allyship requires transforming institutions (Nixon, 2019).

McGibbon (2018) described decolonising health care as an embodied process of everyday commitments to action, thinking, feeling and understanding. This relates to the 'quotidian unsettling' described by Steinman (2020) as everyday actions that non-Indigenous people can take to support decolonisation within institutions. The pervasiveness of settler colonialism requires acknowledging "we are in it, all the time, and we can act to undermine it where we are" (Steinman, 2020, p. 561). This was echoed by Jongbloed et al. (2023) who said white supremacy was an everyday issue that required everyday attention. There was a role for everyone to untie 'colonial knots' in the net that structures oppression for Indigenous people (Jongbloed et al., 2023).

Suggestions for action within the health system were to name and challenge interpersonal racism and microaggressions, have conversations with non-Indigenous people that challenge hegemonic behaviour, invite Indigenous peoples to critique and challenge your behaviour, work through feelings of fragility and doubt with non-Indigenous folk, consider "where, when and how they may unknowingly reproduce whiteness and white supremacy" (McGuire-Adams, 2021, p. 8). Doing work to organise and educate other white people is important, valuable work. Suggestions for action included "find yourself a racist" to educate and talk with, and facilitate reading groups, discussion groups, or workshops (Land, 2015, p. 175). Taking action does not require perfection or to be 'decolonised'; "flawed and uncertain settlers can likely act to unsettle their contexts even as they continue to grow in understanding and commitment" (Steinman, 2020, p. 565).

Everyday actions to make space can be done even when Indigenous people are not present, and done without the need to take credit, or to be seen, identified or acknowledged as an ally (Steinman, 2020). This point was echoed by Land (2015), who said it is important to be

responsible for challenging racism whenever it occurs, whether Indigenous people are present or not. Systems of oppression continue to operate if people do nothing "to disrupt the status quo and in so doing collude with racism and injustice" (Weitzel et al., 2020, p. 110).

Stepping back

Effective allies and accomplices within healthcare settings are described as knowing "their place", knowing when to "step up" to call out racism, "when to 'walk alongside' Indigenous patients and colleagues … and when to 'step back' (e.g., enabling Indigenous clients and colleague's leadership, truth telling, self-determination, and governance)" Parter et al. (2023, pp. 9-10). McGibbon (2018, p. 42) identified the "heightened responsibility" of people with power in the administration of hierarchical health systems to "create specific spaces" for Indigenous voices; if allies do not speak up, "silence means assent". The role of nurses in advocating and amplifying the voices of those in the margins was noted by Weitzel et al. (2020). Davis et al. (2022, p. 634) advised allies to

> step back: to listen iteratively, with humility, and on Indigenous terms [and to] step up: to name and confront settler entitlement and assertions of power – their own and those of others – and to use whatever resources, influence, or creativity they have to amplify Indigenous perspectives and to create spaces where Indigenous peoples can speak for themselves.

For Nixon (2019), stepping back required giving up power, particularly considering what resources under one's control can be handed over.

Embracing discomfort and avoiding paralysis

Before considering what to do, Barker (2010) advised, allies need to be situated in a place of profound discomfort arising from their realisation of the cause and effect of colonialism and their complicity within it. The choice then becomes to either remain openly colonial or to act and work towards decolonisation (Barker, 2010). Feeling uncomfortable is more likely to result in motivation to act rather than hearing a rational argument (Land, 2015).

Moving out of white-only spaces and engaging with Indigenous peoples and 'non-white spaces' is a strategy for anti-racism if it helps white people to see and experience another reality and way of being (Land, 2015). Land (2015, p. 219) quoted Regan (2005, p. 6) who said her "deepest learning has always come from those times when I was in unfamiliar territory – culturally, intellectually and emotionally." Land (2015, p. 219) noted "the productive potential of discomfort" when paying "embodied attention to boundaries." Boudreau Morris (2017, p. 466) said a barrier to solidarity is not difference but "the lack of engagement with difference";

decolonising solidarity requires the "cultivation of a relationship with difference based on discomfort and contingency." This work is challenging emotionally but settlers

> must keep in mind that such work is only done from a position of privilege, because settlers remain in control of whether to avoid and control or to become vulnerable to unpleasant emotions. Indigeneity in the context of settler colonialism, on the other hand, is bound up with intergenerational emotional labour and identity struggles. (Boudreau Morris, 2017, pp. 468-469)

Kluttz et al. (2020, p. 63) said that

> fear, discomfort and shame tied to acknowledging privilege and complicity in colonisation are powerful teachers, but they must be felt rather than thought about, which is only possible through speaking, interacting and putting one's body in spaces that politicises it.

Nixon (2019) acknowledged that feelings of discomfort and guilt, arising from recognition of unearned privilege, can immobilise people. Nixon quoted Audre Lorde who said, "Guilt is not a response to anger; it is a response to one's own actions or lack of action" (p. 7). Therefore, a solution is to "reframe guilt as responsibility deriving from complicity" and then act to change the systems of oppression (Nixon, 2019, p. 7). Land (2015) also described how non-Indigenous anxieties about doing or saying something wrong can be paralysing. This reflects "a position of privilege in that white people don't act or say anything because this leaves them vulnerable to criticism" (Land, 2015, p. 196). Kluttz et al. (2020, p. 63) described the practice of decolonising solidarity meant "learning to be uncomfortable, but not to be immobilised". Doing the work ourselves, with ourselves, rather than asking Indigenous peoples for direction, avoids re-centring whiteness (Kluttz et al., 2020). McGloin (2016, p. 842) highlighted the risk of white allies burdening Indigenous colleagues with their "discomfort or complicity in oppression" and "difficulty coping with our dis-ease and the constant requirement of self-reflexivity". It is not the role of Indigenous people to challenge or change white consciousness (McGloin, 2016). This is our work to do. It is also not the role or responsibility of Indigenous peoples to teach settler people: "it remains the responsibility of the Settler to learn; decolonisation is an act of becoming" (Barker & Pickerill, 2012, p. 31). Critical allyship is not an identity but a constant evolving practice (Nixon, 2019).

Critical consciousness.

Critical consciousness requires recognising and analysing how power and oppression is operating within systems. It requires deep thinking about self – culture, bias and privilege – and

is an essential part of being culturally safe. Importantly, it requires taking action to address oppression.

Self-reflection

The importance of allies undertaking critical self-reflection alongside public political action is identified by Land (2015). Both these concepts require development and inform each other. Critical self-reflection is about "knowing ourselves, understanding ourselves, interrogating where our focus should be, and developing cognizance of the workings of race and privilege" (Land, 2015, p. 200). This must be accompanied by political action that addresses structural privilege (Land, 2015). The action is essential because

> it is possible to not be racist (in the individual sense of not perpetrating overtly racist acts) and yet at the same time fail to be antiracist (in the political sense of resisting a racist system). … Because white people benefit from living in a white supremacist society, there is an added obligation for us to struggle against the injustice of that system. (Jensen, 2005, p. 80, as cited in Land, 2015, p. 162)

Critical self-reflection

> entails active and ongoing mindfulness of one's thoughts, actions and behaviours towards Indigenous people. … It is uncomfortable and difficult to critically look at oneself to accept the vulnerability of our emotions, to be humble enough to let go of ego and to allow oneself to be imperfect. (McGuire-Adams, 2021, p. 7)

Recognising that making mistakes, when we reflect upon them, help us to grow, develop and do things differently is an important part of allyship (Davis et al., 2022; McGibbon, 2018). Barker and Pickerill (2012, p. 29) advised allies not to seek perfect activism as "humbling mistakes are too valuable to miss." Davis et al. (2022) also identified the role of humility in admitting mistakes and then instigating change.

Knowledge of colonial history

Conscientisation for allies requires learning the truth about the colonial history and the racist oppression of Indigenous peoples (McGibbon, 2018; McGloin, 2016). This connects "brutal colonial histories" and the contemporary experience of health inequities for Indigenous peoples (Rix et al., 2024; Sherwood, 2013). Land (2015) emphasised finding out about local history to facilitate engagement with local struggles. Location-telling is one part of the decolonising framework proposed by Boudreau Morris (2017). Building relationships of solidarity requires a process of self-interrogation "grounded on the land one occupies", asking questions "Who am I?

What are my relationships with my communities? What are my relationships with the land I live on?" (Boudreau Morris, 2017, p. 464). Sherwood (2013) connected the clinical procedure of taking a client's detailed history with the requirement to also consider the impact of colonisation on health and advocated for health professionals to take colonial, political, social and economic histories when working with Aboriginal and Torres Strait Islander peoples.

Awareness of privilege and power

Land (2015) wrote about reconstructing whiteness rather than abolishing it. This would mean accepting being white and how it shapes our lives, and also challenging the systems which create white privilege and maintain white supremacy (Land, 2015). To become a decolonising settler requires an explicit acknowledgement of the positions of power and privilege that settlers hold, and with that acceptance an accountability and responsibility to act (Barker, 2010). The recognition or seeing of privilege is central to practicing critical allyship (Nixon, 2019). As all institutions privilege whiteness, being a critical ally requires maintaining a critical consciousness about the dominance this structures, and how to work to erode this power (McGloin, 2016).

Avoiding white saviour behaviour

Without a conscious appreciation about how privilege and power manifests, a desire to 'help', which may come from a position of empathy to alleviate suffering, can reinforce "power relations that position white folks as the 'helpers' and Others as in need of (our) help" (McGloin, 2016, p. 846). Critical self-reflection helps to avoid becoming a white saviour or "enthusiastic saviourism" (Leung & Min, 2020). Critical allyship for health care providers, Nixon (2019, p. 9) argued, required stopping "being a white saviour" and instead adopting a "cultural safety approach to understand how power is operating." Critical consciousness, as described by Hall et al. (2023, p. 5), is a "deep part of emancipatory praxis" where critical reflection occurs and then people undertake transformative action on systems to address inequity. For Hall et al. (2023), the practical application of cultural safety is 'critical consciousness' and 'transformative reflection' that inform 'transformative action'. Steinman (2020, p. 567) contended it is "difficult and dangerous" to attempt to unsettle settler institutions without settlers "simultaneously experiencing disruptions to and critical evaluations of their settler selves and cognitions." Action without this conscious reflection can lead to "performances of radical wokeness while actually re-centering settlers through actions and claims that are distinctly unbounded and immodest" (Steinman, 2020, p. 567).

A journey for life.

Critical allies are always in a state of learning and unlearning and it is a conscious journey for life which requires a lifelong practice of building relationships with Indigenous peoples (Leung & Min, 2020; McGloin, 2016; Rix et al., 2024). Accepting "the endlessness of struggle is central to effecting an ethical stance as an ally: colonial histories are enduring for colonised people and if we are to be allies, these histories must be enduring for us also" (McGloin, 2016, p. 846). Long-term struggles need long-term allies (Land, 2015) and persistence and stamina are required (Jongbloed et al., 2023; McGuire-Adams, 2021). The option to act or not act is a privilege of whiteness, and being consistent requires constant awareness of this privilege to inform action against colonising structures (Kluttz et al., 2020). Jongbloed et al. (2023, p. 232) emphasised the requirement for "hands, hearts and minds" to inform everyday Indigenous-specific anti-racist action.

Discussion

There are multiple terms in use to describe white people who work alongside Indigenous peoples to address anti-Indigenous racism, achieve Indigenous health equity and decolonise the settler-colonial health system. This review canvassed some of those terms. The most utilitarian for the purposes of this study are 'critical ally' and 'critical allyship' due to the emphasis on critical. The term 'critical' ensures a focus is given to privilege and power and their manifestation within systems (Nixon, 2019). 'Critical' maintains a focus on addressing structural oppression (McGloin, 2016) and, importantly, 'critical' emphasises the importance of critical consciousness and critical reflection to the practice of being an ally. There was little critique of the term 'ally' within the previous literature review chapter, although the work of Jen Margaret (2013) has always been clear that being an ally is not an identity, a point affirmed in the international literature.

The literature on the role of allies addressing anti-Indigenous racism and colonialism within health systems is sparse, with empirical studies even rarer. Much of the literature explored here consisted of ethnographic insider viewpoints and expert commentary, based on experience working with, or as, a critical ally. Broadening the scope to include literature exploring allyship with Indigenous peoples, outside the context of health systems, provided additional insights particularly regarding the significance of relationship, being in relation with Indigenous and non-Indigenous people. There was also instruction within the literature to follow Indigenous leadership; this theme, along with the importance of relationship, were among themes common across both reviews.

Some of the literature reviewed here was based on research in activist movements such as environmental or land occupations. This may not be directly applicable to institutional settings given the more anarchic nature of activist social movements and the potential volatility that requires much greater clarity on daily strategic actions. In these settings, Indigenous peoples face the main brunt of state aggression and repercussions such as imprisonment and, as such, must determine risk. It is clear the role of critical allies is to support Indigenous-led action to maintain the integrity of the campaign goals and safety for all involved.

Both reviews noted the significance of relationship between allies and Indigenous peoples, and both engaged with navigating the complexities of these relationships considering how power and white privilege play out in colonised societies. The work of Steinman (2020) was particularly instructive for people working in systems where, using his description of 'ubiquitous unsettling', there is a role for undertaking everyday actions to challenge racism where and when we see it. His discerning openness approach of feeling our way through situations with critical awareness and analysis is a useful guide to avoiding inaction and paralysis.

Both reviews found that to disrupt racism firstly requires addressing colonialism as a health determinant across systems, and recognising the Eurocentric, individual-focused colonial health system and the racism inherent within it. Disrupting racism through systems change processes required leadership, participation and monitoring by Indigenous peoples. Both reviews discussed unpacking the colonial logics of the racist victim-blaming framing of Indigenous health inequities. Seeing the racism inherent within our systems is a challenge for white people within colonised nations such as Aotearoa, Canada and Australia where whiteness is the norm and Indigeneity is the other or the exception. This has resulted in most of the work to undo anti-Indigenous racism being shouldered by Indigenous peoples, despite racism being a white problem.

Taking action was a theme across both reviews. In the previous review this was described as values-based action at the levels of individual, culture and system. This review described action as everyday anti-racism with particular focus on speaking up and stepping back. Both reviews described the importance of embracing emotion, particularly discomfort, identifying and working through these to avoid paralysis, and ensure that action occurs. Everyday, ubiquitous racism, which is the status quo for Indigenous peoples within colonial settler nations, must be undone by everyday acts of anti-racism. As the majority population, white people must play a role in this dismantling (Elias et al., 2024). Key to this, however, is the requirement to be able to see the racism and then overcome barriers to action.

Although recognising emotional responses and embracing discomfort was raised in the previous chapter, more emphasis on noting and working through embodied responses was described within the international literature. Engaging with our emotions enables deep reflective relational critical allyship.

Both reviews described the importance of critical consciousness, the ability to reflect upon power and privilege, how these are manifest and how to use this knowledge, particularly within roles of influence in the health system to disrupt racism. Learning about colonial history, particularly local knowledge about the land one lives on, is a crucial link in developing critical consciousness. This resonated throughout both reviews. Conscientisation enables non-Indigenous people to firstly see the racism, and their resulting white privilege, and then to act. The realisation that, if we continue to do nothing, we are complicit and the vow to 'first do no harm' cannot be upheld if we stay silent or inactive. Practicing critical allyship enables movement from complicity to responsibility (Nixon, 2019). Avoiding white saviour behaviour, which was explicitly discussed in the international literature, was not discussed in the previous review. A potential trap for many working in health as a helping profession is the propensity to become a 'white saviour'. Adopting a cultural safety approach with its emphasis on identifying and critically reflecting on power and where it is operating was identified as mediating the 'white saviour' tendency.

Cultural safety has long recognised the centrality of conscientisation and critical reflection. The concept of cultural safety, first articulated by Māori nursing leader and educator Irihapeti Ramsden (1990), has influenced approaches to addressing racism and health equity within health systems around the globe (Hall et al., 2023). Cultural safety interrogates how power is operating within health systems and actively seeks to reduce power imbalances (Rix et al., 2024).

Within the previous literature review, an element identified was for Pākehā to overcome individuality and work collectively to address racism. This was not a theme within this review and is perhaps a lesson for others working internationally to consider how our Western individual-centric approach requires active dismantling in pursuit of decolonisation.

The international literature review found a particular subtheme in the literature, which was not described in the local literature, regarding the importance of considering being a critical ally as a journey for life. The lesson here is that there is no knowledge saturation point, no peak where allies can say we've arrived. A constant interrogation is required and an acceptance that we may never know enough but we must act. Through action comes more learning and development.

There was limited discussion about Treaty rights within the international literature although there was engagement with rights of Indigenous peoples, and health as a human right. As outlined in the previous review, Te Tiriti provides guidance at a structural, system and relational level to critical allies. Te Tiriti is a gift to all who reside in Aotearoa.

Conclusion

The literature review in the previous chapter followed a deliberate citational practice of privileging literature from Aotearoa, in particular that of Māori scholars. The purpose of that review was to examine literature that could inform anti-racism praxis for Pākehā allies in the context of the Aotearoa health system. The review in this chapter has focused on international literature and prioritised writing by Indigenous scholars from colonial settler nations with a white majority population, exploring the role of allies (accomplices, settlers) in disrupting anti-Indigenous racism within health systems. Due to the scarcity of material addressing this specific topic (the role of allies within health systems), the review broadened the scope to consider literature regarding the role of allies working in relationship with Indigenous people, and literature exploring anti-Indigenous racism, colonialism and health. A limitation of this review was the limited scope of focus on anti-Indigenous racism; undoubtedly, there are other significant studies that focus on anti-black racism that were not included due to the review scope.

There is direction in the literature as to what action needs to be taken to address racism and disrupt the Eurocentric, individualistic, illness-focused culture of colonial health systems. The current system works, albeit minimally, for the people it was designed by and for – the white majority population. The right for Indigenous peoples to determine their health is a human right. The health system is just one system among many systems that require change. Structural transformations honouring self-determination for Indigenous peoples are required throughout colonial settler nations.

To make significant and sustainable change for Indigenous health outcomes, system responses are required. This review emphasised the need for multi-level, multi-strategy system responses that address Indigenous-specific health determinants. However, whatever action is undertaken must be done by the people within the system (Aquino, 2020) with active leadership and participation by Indigenous peoples (Hassen et al., 2021). Additionally, change must be substantive and evidenced rather than non-performative or based in rhetoric. The health system will be culturally safe for Indigenous peoples only when they report it as such (Hall et al., 2023).

The role of critical allies is clearly described. At the core of an effective praxis is the development of critical consciousness which requires self-reflection and awareness of colonial history, engaging with our emotional responses, cognisance of privilege and power, and avoidance of white saviour behaviour. Everyday anti-racism action requires stepping back to make space and speaking out. Critical allies need to feel comfortable within the uncomfortable – disruption, after all, requires making waves. Finally, the role of a critical ally is a journey over time, progressed whilst in relation with Indigenous peoples.

Chapter Five: Considering Te Tiriti o Waitangi as a Methodology for Transformative Research for Non-Indigenous Scholars in Aotearoa New Zealand

This chapter is the second of two papers submitted for publication. It is a unique and innovative contribution to applying Te Tiriti o Waitangi as a methodology. As with Chapter Three, there have been some slight changes to the text that was submitted for publication, but it is essentially the same. Table and figure numbers have been amended to remain in sequence within the thesis.

This paper was co-authored with my supervisors and members of the critical research whānau.

Abstract

In Aotearoa New Zealand all research has obligations to Te Tiriti o Waitangi (Te Tiriti), a foundational document of the colonial settler nation. This paper provides a brief overview of Te Tiriti and the relevance to health research. The study, exploring Te Tiriti based anti-racism praxis of Pākehā (white settler) allies during health system reform in Aotearoa, is described including how the transformative paradigm and kaupapa Māori, critical race and feminist theories, along with activist scholarship informed the methodology. Then the application of Te Tiriti to the study is provided along with a series of questions for researcher's consideration.

Finally, the paper considers how Te Tiriti methodology can be a useful frame for non-Indigenous researchers seeking ethical and just research practices. Although specific to the Aotearoa New Zealand health context, this paper is relevant to international, particularly colonial settler researchers seeking decolonising methodology aligned with Indigenous rights and justice.

Key Words

Te Tiriti, health research, methodology, decolonisation, transformative paradigm

Introduction

Aotearoa New Zealand is an island nation of about 5 million people located in the south Pacific Ocean. Māori, the Indigenous peoples, enjoyed good health and lived in relative harmony with each other and the environment prior to first contact with explorers, sealers, whalers and ultimately colonial settlers in the late 1700s and early 1800s. In 1835, the rangatira (leaders) of many predominately northern hapū (sub-tribes) developed He Wakaputanga o te Rangatiratanga o Nū Tīreni, a collective declaration of sovereignty as a strategic response to increasing contact with visitors to Aotearoa and Māori international trade and exploration. This

declaration was recognised by the British Crown and internationally (Mutu, 2019). Five years later Te Tiriti o Waitangi, recognised as the founding document of the colonial state of New Zealand, was negotiated between Māori rangatira and representatives from the Queen of England.

There is Te Tiriti o Waitangi (the authoritative Māori text) and the Treaty of Waitangi (a draft of the treaty in English). The Māori text guaranteed and re-affirmed Māori sovereignty (O'Sullivan, 2019), whereas the English version is largely viewed as a treaty of cession by the colonial settler government and the majority white settler population. The Māori text of Te Tiriti is authoritative because of the number of signatories on the Māori text, over 500 rangatira signed, whereas less than 40 signed the English version; the much larger Māori population at the time of signing (about 100,000 Māori compared with about 2000 non-Māori), and in international legal doctrine the rule of contra proferentem which "provides that, in situations of conflict about treaty interpretation, the treaty is interpreted against those who proposed or drafted the treaty. In this instance, the Māori text is recognised" (Berghan et al., 2017). Most significantly, the Waitangi Tribunal (2014), a standing commission of inquiry set up by the Crown in 1975 to investigate breaches of Te Tiriti, found sovereignty was never ceded.

There are a range of national documents aimed at providing guidance to health researchers. According to the Health Research Council (2019) all health research is of interest to Māori, has the potential to improve Māori health, and potential to cause harm (National Ethics Advisory Committee, 2019). Four domains are outlined in the Health Research Council guidelines: relationships, significance, research team and research characteristics. For each of these domains a series of questions are posed for researchers to consider. An internationally relevant document is the CONSIDER statement which aims to strengthen research and improve Indigenous health outcomes by providing a checklist for reporting health research involving Indigenous peoples (Huria et al., 2019).

Following the approach set out in the New Zealand Health Research Strategy (Ministry of Business Innovation and Employment & Ministry of Health, 2017), guidelines from the Health Research Council (2019) and the National Ethics Advisory Committee (2019) advised researchers to consider the application of the principles of the Treaty of Waitangi[8], identified as partnership, participation and protection. These principles, often referred to as the 'three P's'

[8] When Treaty or Treaty of Waitangi is used in the text it refers to the English version and is used consistent with the original authors usage. Te Tiriti or te Tiriti o Waitangi is used when specifically referring to the Māori text.

(Hayward, 2023) were originally developed by the New Zealand Royal Commission on Social Policy (1988) and have, until recently, dominated health discourse about Te Tiriti since the late 1980s.

The landmark Waitangi Tribunal (2019) Hauora report criticised the 'outdated' health sector use of the 'three P's' noting for example how partnership was defined as 'working together'; this was criticised as a reductionist view of the Treaty, "influencing decisions or participating in making them is not the same as making decisions"(Waitangi Tribunal, 2019, p. 80) . The Tribunal recommended the use of five principles: 1. self-determination and autonomy; 2. equitable health outcomes; 3. active protection; 4. options; 5. partnership (Waitangi Tribunal, 2019). In a reasonably short period these principles have influenced, and been written into, the Pae Ora (Healthy Futures) Act (2022). The Ministry of Health (2020b), Māori health action plan, Whakamaua, also considered these five principles alongside the articles of Te Tiriti o Waitangi as expressions of mana (power).

There has been limited scholarship in Aotearoa exploring the application of the Treaty of Waitangi (English version) and even less considering Te Tiriti o Waitangi and health research. Examples include Cram et al. (2006), who described a collaborative research project with Māori and Pākehā researchers that applied Te Tiriti o Waitangi to the research relationship. Framing Māori and Pākehā as 'interested parties' to the treaty (rather than partners) both with rights and responsibilities, enabled reflection on roles, checked assumptions and provided clarity on accountability (Cram et al., 2006).

Wyeth et al. (2010, p. 305) described engagement with the Treaty of Waitangi for a study on injury outcomes. Of note the article describes the Treaty of Waitangi as a "treaty of cession" and provides full details of the English version but relatively dismissively describes the three articles of the "Māori version" as kāwanatanga (governorship), rangatiratanga (chieftainship) and ōritetanga (equality) (Wyeth et al., 2010, p. 305). The authors acknowledged this study was "not a perfect model for addressing the principles of the Treaty" in health research (Wyeth et al., 2010, p. 313) but did believe a consideration of the Treaty enhanced the study's acceptability and accountability to Māori.

A framework, based on Treaty of Waitangi principles, to achieve health equity in Aotearoa through developing responsive to Māori in health research was outlined by Reid et al. (2017). Four main areas for health researchers to consider were described.

Table 7
Achieving Māori Health Equity Health Research Framework

Element	Description
Relevance to Māori	• Context specific, respectful discussion with Māori based on good faith quality relationships. • Ensuring dissemination of research results maintain relationships and enable further action. • Genuine respectful mutual relationships with clarity on outcomes, processes and resource sharing. • Develop Māori health research workforce • Role clarity of Māori and non-Māori when engaging with kaupapa Māori theory and research.
Māori as participants	Researchers need to understand, and consider the strengths and limitations of, concepts such as ethnicity, ancestry and descent.
Promoting Māori voice	Use processes such as equal explanatory power to ensure Māori are not subsumed within studies of the majority population. Have a critical view of data analysis that avoids deficit theorising and instead focuses on system or structural factors.
Human tissue and data	Ensuring best practice on the collection and care of human tissue and data sovereignty.

Note. Summarised from "Achieving health equity in Aotearoa: strengthening responsiveness to Māori in health research". P. Reid, S.J. Paine, E. Curtis, R. Jones, A. Anderson, E. Willing, & M. Harwood, 2017, *New Zealand Medical Journal, 130* (1465), 96-103.

Hikaka et al. (2021) applied the five Treaty principles described in the Hauora report (Waitangi Tribunal, 2019) to the research and design of a health intervention and argued the application of these principles contributed to the development of a culturally safe, pro-equity intervention.

A significant recent development, Critical Tiriti Analysis (CTA) is a pro-equity, anti-racist policy review tool which has been developed to retrospectively (Came, O'Sullivan, et al., 2020) and prospectively (Came et al., 2023) evaluate and consider colonial health policy through the application of the five elements of Te Tiriti. Both approaches offer a range of questions for policy analysts to consider regarding Tiriti relevancy. In earlier work, Berghan et al. (2017) and the

Health Promotion Forum (2002) applied the articles of Te Tiriti o Waitangi to health promotion practice.

Māori have been consistent and clear that Te Tiriti o Waitangi is the only "valid or relevant" version (Healy et al., 2012; Mutu, 2011). Durie (1998b) said Māori are uncomfortable with Crown defined Treaty principles and instead give greater credence to the actual text. Mutu (2011) is clear the Māori text of Te Tiriti is the official document and, along with Durie (1998b), also emphasises the preamble of Te Tiriti. The practice of defining principles derived from Te Tiriti "diminishes the standing and influence of the original text" (Came et al., 2023). Titewhai Harawira, a prominent Māori rights activist, strongly rejected the use of Treaty principles,

> everyone knows that the promise and agreements forged with He Wakaputanga and Te Tiriti o Waitangi have been broken. Yet instead of figuring out how to honour these covenants in a principled way, new principles have been invented to change what the agreement was in the first place, weakening the words of our tupuna while trampling upon the visions of what they were trying to achieve. (Healy et al., 2012, p. ix)

As awareness grows and understanding evolves, there is guidance available to health researchers considering the importance of Te Tiriti and the Treaty to health research. However, there is considerable divergence in the literature about which treaty is being referred to, the Māori text i.e. Te Tiriti or the English version, the Treaty, and whether principles and their various interpretations are under discussion. Reference to the English language draft of the Treaty of Waitangi rather than the authoritative Māori text, Te Tiriti o Waitangi, significantly weakens the position on Māori sovereignty, potentially reducing the impact for Māori health equity.

Discussing principles rather than Te Tiriti articles obfuscates and creates confusion about a simple document. This paper considers and describes how to apply the five elements of the Māori text, Te Tiriti o Waitangi, to health research in Aotearoa. Particularly for non-Indigenous researchers, clarity about how Te Tiriti can be genuinely and respectfully expressed in research that is distinctly different from research by Māori for Māori, requires further elucidation.

Study Description

In 2021, amidst the global COVID-19 pandemic, the New Zealand health system began the most significant period of structural reform in over 20 years. The 2022 had an explicit aim to improve Māori health equity. To succeed this ambitious agenda must address the institutional racism entrenched within the health sector (Waitangi Tribunal, 2019) which requires action from Pākehā allies within the system committed to Tiriti implementation (Came & Griffith, 2018;

Came, Warbrick, et al., 2020). The study under discussion, to which the Tiriti methodology was applied, explored Te Tiriti based anti-racism praxis of Pākehā allies during health system reform. Semi-structured interviews were completed with seven Pākehā allies working within the health system. Considering the focus on Te Tiriti application, a core question asked during the study design was: how best to conduct Tiriti compliant research?

Critical Research Whānau

Being in relationship with, and taking leadership and guidance from those you seek to be in alliance with, are well established principles of allyship (Berghan et al., 2017; Crawford & Langridge, 2022; Hoskins, 2017) and mirror the intent of Te Tiriti o Waitangi which offered limited authority to the newcomers within the context of absolute Māori authority over Aotearoa (Healy et al., 2012). In reflection of this, a critical research whānau (extended family) was established made up of four Māori and two Pākehā. Each member had a long-standing and trusting relationship with the lead researcher and were invited to contribute based on their commitment to Te Tiriti, anti-racism, pursuit of health equity and their respective knowledge, experience and relationships within the health sector. The critical research whānau provided political, cultural, strategic and practical advice to the lead researcher during the study formation, implementation, analysis, and dissemination. This included endorsing each research participant as an 'ally': people, working in the health system, and trusted by the critical research whānau, to act in accordance with Te Tiriti and anti-racism praxis.

Researcher Standpoint

The lead researcher for this study identifies as a Pākehā activist scholar who has worked extensively as a health promoter within the primary health care sector, alongside and for Māori, in the pursuit of health equity. Identifying as Pākehā within Aotearoa for her is a political statement acknowledging Pākehā have a distinct culture embued with power resulting from the brutal and ongoing colonisation process that privileged our ancestors and continues to privilege our worldview and institutions. This critical realisation of our power and positioning requires action to de-colonise (Margaret, 2017; McCreanor, 2020; Nairn, 2009). As Mikaere (2004, p. 45) said,

> When you think about it, there is nowhere else in the world that one can be Pākehā. Whether the term remains forever linked to the shameful role of the oppressor or whether it can become a positive source of identity and pride is up to Pākehā themselves. All that is required from them is a leap of faith.

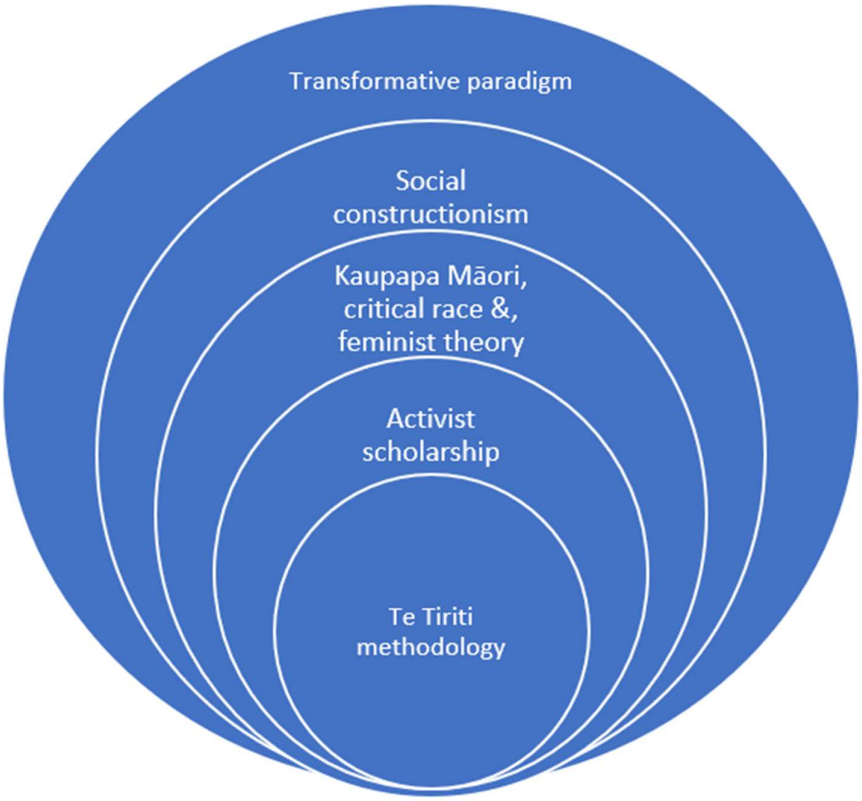
This inquiry arose from the frustration at the intractability of the institutional racism inherent within the health system and the pursuit of knowledge to understand how best to work for change. This paper has been written largely by the lead researcher with contributions from the critical research whānau and supervisory team.

Study Design

All scholarly research is informed by a research paradigm, which then informs the methodology and methods (Held, 2019). Paradigms are a way of viewing the world and are made up of axiological, ontological, epistemological and methodological assumptions (Held, 2019). Methodology is the convergence of assumptions about the nature of and reality of knowledge (ontology and epistemology), values and ethics (axiology) and theoretical framework and literature (Chilesa & Kawulich, 2012).

The figure below provides an overview of how Te Tiriti methodology is located within the transformative paradigm, informed by various theories and principles of activist scholarship.

Figure 9
Overview of study design



Transformative Research Paradigm

The transformative research paradigm is founded on the basis that researchers are ethically responsible to explore issues of social justice and human rights and to work towards change (Cram & Mertens, 2016). Transformative or critical research is characterised by, (1) interactive, dialogic, reciprocal methods; (2) making connections between power and history; (3) respect for the experiences of people's everyday lives; (4) being aware of the great liberator / white saviour concept of research and working with, rather than to or for, oppressed groups (Lather, 2004). Cultural respect, social justice, human rights and the reduction of inequities are the axiological values underpinning the transformative paradigm (Cram & Mertens, 2016). As the overriding goal of the transformative paradigm is to question systems of power and seek change, methodological choices are pragmatic and prioritise how best they will achieve the goals of social justice (Cram & Mertens, 2016).

The ontological and epistemological philosophy of the transformative research paradigm is based in social constructionism with attention given to whose realities and knowledge is produced and privileged (Mertens, 2007). Three tenets of social constructionism are, 1: knowledge has a cultural and historical specificity; 2: discourse constructs reality and has a productive power which influences our actions and a disciplinary power which encourages conforming behaviour; and 3: some people have power and authority over others; this power is not fixed and is wielded at individual and societal levels (Burr & Dick, 2017).

The transformative paradigm informed the study by ensuring the colonial history and the current socio-political context of anti-racism scholarship and health system reform was considered. Recognition of the hegemonic power of the dominant Pākehā culture was mitigated through the involvement of a critical research whānau which provided direction over research design, participant selection and dissemination. The implications of a social constructionist approach to this research include understanding the findings generated from the research should be "held lightly and tentatively" (Crotty, 1998, p. 64), that they will be historically and culturally located, contextually relevant (Moon & Blackman, 2014), with learnings applicable to a distinct group of people at a particular time.

Constructionism also provides an orientation to the research that invites a humility about assumptions and ways of life, encourages curiosity, exploration of perspective and values, and promotes a respect and tolerance for difference (Gergen, 2015). Possibly one of the most significant implications of a social constructionist epistemology is the realisation that "everything we take to be real, rational or good – everything we hold dear – finds its origins in our

processes of relating" (Gergen, 2015, p. 13). Relationships are contextual – time and place – care and respect for relationships with the critical research whānau and participants, indeed all involved in the research process, is primary.

Theoretical Considerations

Four key theories have informed this study. The first is kaupapa Māori theory, a framework for research by, for and with Māori, based on Māori ways of knowing and being (Smith, 2015). Critical race theory, feminist theory and activist scholarship also informed the study.

Kaupapa Māori theory aligns with the transformative paradigm in that both have an emancipation agenda, seek to challenge dominant systems of power (Bishop, 1994; Pihama, 2010) and have research outcomes that benefit Māori by challenging ideologies and changing systems (Walker et al., 2006). Smith (2012) describes kaupapa Māori research as localised critical theory due to its emancipatory objectives. Kaupapa Māori methodology rejects deficit framing of Māori health inequities and "purposely acknowledges and challenges the power dynamics that have created and maintain the unequal position of Māori within society" (Reid et al., 2022, p. 2).

Many authors state researchers must be Māori in order to do kaupapa Māori research (Smith, 2012) however others suggest non-Māori can engage in kaupapa Māori research as long as Māori retain control over the research (Bishop, 1994; Hoskins & Jones, 2017; Walker et al., 2006). Whilst discussing kaupapa Māori services and programmes, Rolleston et al. (2020) said by definition only Māori can deliver kaupapa Māori however non-Māori organisations can incorporate a Māori philosophical lens to ensure their services are responsive to Māori. There is significant, and increasing, engagement by non-Māori researchers considering how kaupapa Māori theory can inform the way in which their research is conducted (Barnes, 2013; Came, 2012; Eggleton, 2020; Fabish, 2014; Gibbs, 2001; Hancock, 2018; Jones, 2012). This study is not kaupapa Māori research as the lead researcher is Pākehā, however kaupapa Māori theory and core principles such as whanaungatanga have contributed greatly to the study design through the inclusion of a critical research whānau as a supervisory and organising function. The critical research whānau involvement shifts the research from an individual endeavour to the collective, aligning closer with a te ao Māori worldview. This aligns with the social constructionism approach towards relationships being context and place specific, based on humility and respect (Bishop, 1994; Smith, 2012).

Critical race theory aligns with social constructionism in the belief "races are categories that society invents, manipulates, or retires when convenient" (Delgado & Stefancic, 2017, p. 7). If racism can be

constructed, then it can also be deconstructed. A feature of critical race theory is 'centering in the margins' seeking out minority voices (Ford & Airhihenbuwa, 2010). The participants in this study, as Pākehā allies, may be viewed as holding views from the 'margins'; a perspective counter to the dominant white narrative within the existing health system. Huygens (2007) identified the value of generating theory about social change through inquiring of how people working towards change theorise about their work. She advises seeking out counter-hegemonic discourses as these will "carry both idealistic ethics for a changed world, and, most importantly, theory for achieving such change" (p. 264).

Although this study is not focused on an analysis of gender, feminist research does not have to essentialize gender or be solely about gender differences, to count as feminist research (Brinton Lykes & Crosby, 2014). Indeed hooks (2014, p. 27) recognises race and class oppression as "feminist issues with as much relevance as sexism". Collins (2016) says we should assume race, class, and gender oppression are always present albeit one may be more visible than others. This intersectionality analysis relies on understanding race, class, and gender, rather than being viewed as separate and mutually exclusive, actually build upon and work together; and that these intersecting power relations have an impact on all facets of the social world (Hill Collins & Bilge, 2020). Doing feminist research in Aotearoa requires engaging in decolonising efforts (Weatherall, 2020) and ensuring "voicing and redressing colonial violence is at the forefront of feminist work" (Murphy, 2017, p. 4). The investigation into lived experience, in this study the Tiriti based anti-racism praxis of Pākehā allies in the health system, and the learnings, the action orientation, are central to feminist theory (Bailey & Fonow, 2015). Feminist standpoint theory, aligns with social constructionism, by asserting knowledge is situated and localised (Cohen et al., 2022). In an essay proposing research as praxis, feminist researcher Lather (1986) proposed the concept of catalytic validity, that is to what degree does the research process contribute to participant reflection, self-understanding and ultimately 'conscientisation'. One way of doing this is through developing reciprocity between the researcher and participants – research with, not on. Within this study reciprocity was intended by conducting sequential, interactive, dialogic interviews, where the interviewer disclosed her position, values, experience and politics; and checking in with participants on the meaning of the findings, significance and dissemination. Researcher reflexivity, a core element of this study, is also core to feminist theory (Bailey & Fonow, 2015) and a requirement of the feminist philosophy the ethics of care, proposed by Brannelly and Boulton (2017) as a framework for decolonising research. Ethics of care requires researchers to examine their positionality, power

and privilege, to be concerned with issues of equality and justice and act in solidarity with Māori (Brannelly & Boulton, 2017).

Activist scholarship acknowledges knowledge production is political and that research can be a tool for social and political change, indeed the purpose of research should be to inform action (Came et al., 2015; Choudry, 2020; Kluttz et al., 2020). Came et al. (2015) proposed seven principles of activist scholarship in the context of Aotearoa. The table below describes these principles and how this is reflected in the study.

Table 8
Application of Activist Scholarship Principles

Principles of Activist Scholarship	Application in my research
Inclusive social justice (both people and planet).	Pursuit of anti-racist, Tiriti based future.
Working with activists to challenge existing power relations.	Lead researcher is a member of STIR (Stop Institutional Racism) a group committed to ending institutional racism in the health sector (Came et al., 2017) and a member of Network Waitangi Whangārei (2022).
Scholarship and action informed by intergenerational knowledge.	Relationship and mentorship with local Pākehā Treaty workers, critical research whānau, STIR and Re-imagining anti-racism for the health sector kaitiaki rōpū (Came et al., 2022); recognition of history of anti-racism efforts within Aotearoa and pro-equity responses within health.
Political struggle and critique and/or building radical communities.	By describing the praxis of Pākehā allies within the health system the study aimed to inform and strengthen other Pākehā activists working to end racism in the health system.
Gathering credible evidence and powerful stories to inform activism.	Telling the stories of Pākehā allies working in the health system for change.
Rejecting objectivity and embrace (ethical and political) complexity.	The research agenda is working towards transformative change.
Robust research process and concrete social change outcomes.	This study aimed to provide findings and recommendations to further strengthen anti-racism praxis within the health system.

Note. Summarised from "Enhancing activist scholarship in New Zealand and beyond" H. Came, J. MacDonald, & M. Humphries, 2015, *Contention, 3(1),* 37-54.

Findings: Te Tiriti o Waitangi Methodology

The following section provides an outline of each of the five Tiriti elements. For each element the relevance to health research is explored, followed by how the element was applied as a methodological approach in the study, and a list of questions for researcher consideration are provided.

Preamble – Whanaungatanga, Relationships of Mutual Respect

The preamble introduced why a treaty was required and provided the context for the articles that followed. Te Tiriti sought a relationship between two sovereign nations England and the hapū of Nū Tīreni (the term used for Aotearoa New Zealand in 1840) and recognised the rangatiratanga (paramount authority) of the chiefs of the hapū (Mutu, 2011). The main reason for Te Tiriti described within the preamble was to enable the kāwana (governor) to control the lawless Pākehā through the granting of kāwanatanga (governance) over settlers (Mutu, 2011). The preamble speaks to the importance of relationships between Māori as tangata whenua and all others who settle in Aotearoa.

Central to the preamble is the relationship with tangata whenua and intentional action towards peace and justice. The preamble encourages researchers to consider how prepared they are to engage in health research that is mutually beneficial to all parties. Relationships based on trust and respect, that are collaborative, accountable, reciprocal, long-standing and exist beyond the research timeframe are essential (Cram et al., 2006; Health Research Council, 2019; Huria et al., 2019; Reid et al., 2017). Pākehā researcher reflexivity was a core consideration for Pākehā who engage with kaupapa Māori research (Barnes, 2013). This reflexivity requires answering "questions about how collective relationships are held and negotiated. This includes being reflective and upfront about one's personal values and intentions over time, and how to 'be' with/in complex and often political cultural spaces"(Barnes, 2013, p. 25). Jones (2020, p. 190) said to fully inhabit a Pākehā identity required being "permanently oriented to Māori" and "if Pākehā thinking has a reflexive openness to Māori, then it is quite different to European thinking. It is peculiarly located here, with Māori".

Preamble application to study.

The preamble is clearly reflected in this study through the explicit focus on how to support Tiriti implementation within the health sector.

In addition to the relationship with the critical research whānau, whanaungatanga was incorporated into the methodology through relationships of accountability with several other groups. These included Pākehā Tiriti educators, STIR and the kaitiaki rōpū (caretaking group) of

an aligned study – re-imagining anti-racism theory for the health sector (Came et al., 2022). For each of these groups the lead researcher provided updates on the research throughout the duration of the study including dissemination.

The decision to interview each participant three times, with the first interview designed specifically to foster relationship and connection between the researcher and participants, also reflected whanaungatanga. Respectful relationships were further developed through seeking participant reflection and relevance on the initial findings, and the lead researcher consciously committed to ongoing connection with participants beyond the study completion.

Preamble questions.

How will this research respect existing Māori authority, strengthen relationships and contribute to Māori health priorities? (Came et al., 2023; Health Research Council, 2019).

How will Māori contribute to the research proposal including dissemination? How will Māori benefit from this research? (Reid et al., 2017)

How is Te Tiriti reflected in and central to this research?

Recognition of Māori sovereignty requires knowing who are the hapū and iwi (tribes) in the local area, who do you need to talk to about this study? Who are you in relationship with, regarding this research?

How can the relationships that have been formed throughout the study process be sustained now and into the future? (Barnes, 2013).

Article One – Kāwanatanga, Governance

Article one re-affirmed what had been raised in the preamble and grants the Crown kāwanatanga (governance) over the settlers here and those yet to come (Mutu, 2011). The responsibility to govern includes its duty to do so in the best interests of Māori as well as those of other citizens (Came et al., 2023). This requires genuine Māori involvement in all decision-making processes and safeguarding Māori interests (Came et al., 2023). Berghan et al. (2017) identified actions under three domains when working with article one: decision-making by Māori, Māori representation and role in kaitiakitanga, and considering structural mechanisms – embedding Te Tiriti. Cram et al. (2006), in their application of Te Tiriti to research, stated non-Indigenous researchers, seeking to do research that serves an Indigenous research agenda, need to negotiate, and have accountability to Indigenous people, including when the research is with non-Indigenous communities.

Article one application to study.

The study explored how Pākehā allies consider and implement Te Tiriti within the health system. This focus on the structures that facilitate or impede Te Tiriti elevates the gaze to consider the overall processes of how systems are governed, policies developed, and processes implemented.

The critical research whānau had an overall governance role over the research. As an example of how this impacted the study development phase, the critical research whānau strongly advised participants be limited to those who identify as Pākehā, rather than all 'Tangata Tiriti' (non-Māori committed to Te Tiriti) as this would ensure the lead researcher was 'staying in her lane', doing the work with her people – Pākehā – those who hold power and can use it for change within the system. This is supported by Cram et al. (2006, p. 60) who said the role for Pākehā researchers is to turn our gaze towards ourselves and our communities to where the "underlying causes of Indigenous marginalization can be found and challenged".

Collective agreement about role clarity and accountability from the researcher to the critical research whānau is important. The table below provides a summary of the role of the critical research whānau, and the accountability of the researcher in relation to various components of the study.

Table 9
Critical Research Whānau Role and Researcher Accountability

Study method	Critical research whānau role	Researcher accountability and actions
Invitation to participate	Agree to participate and what group role will consist of.	Discussion about what the general idea of study is, how they might be involved and whether they would be interested. Role of research whānau mutually agreed.
Initial research proposal	Provide comment and suggestions.	Provide proposal to group in timely manner to enable review and critique. Change the proposal as required by research whānau.
Participant selection	Suggest and identify potential participants. Endorse (or not) participants as 'allies'.	Provide list of potential participants for review and invite additions. Only seek participation from people endorsed as allies.
Interview questions and process	Provide comment on draft and suggest additional questions.	Provide draft interview questions for review. Change interview schedule based on feedback.

Post-interview debrief and reflection	Provide listening ear, wisdom, advice, reflections.	Provide updates and present reflections on interviews and seek thoughts and reflections.
Data analysis	Provide reflections on initial theme development. Provide advice on political and cultural significance of findings.	Present initial analysis and seek reflections on significance of findings (particularly within the current climate), possible dissemination avenues.
Literature review paper	Contribute as available to.	Discuss idea of deliberate citational praxis for literature review. Amend and refine approach for literature review based on feedback. Provide drafts for review. Edit as suggested. Acknowledge input as contributing authors.
Methodology paper	Contribute as available to.	Provide drafts for review. Edit as suggested. Acknowledge input as contributing authors.
Writing up of study	Contribute as available to.	Provide drafts for review. Edit as suggested. Acknowledge input as contributing authors.
Findings dissemination	Provide advice on where findings might be best disseminated.	Ask for thoughts on where and how findings are best disseminated. Action as required.
Identifying next steps	Discuss and provide advice on potential next steps.	Consider and develop action plan.

Article one questions.

How are Māori leading and contributing to the study development, and to establishing the priorities of the research; do Māori say these arrangements are satisfactory? (Came et al., 2023)

How are our processes, actions and decision-making shaped by Māori worldviews/perspectives? (Came et al., 2023)

How does this research contribute to the implementation of Te Tiriti within the system or structure?

Article Two – Tino Rangatiratanga, Paramount Authority

Article two affirmed the hapū of New Zealand had tino rangatiratanga, translated as "paramount and ultimate power and authority over their lands, their villages and all their treasured possessions" (Mutu, 2011). The essence of tino rangatiratanga is "the right for Māori to make decisions for Māori" (Matike Mai Aotearoa, 2016, p. 8). The recognition of tino rangatiratanga

requires evidence that significant decisions about the design, delivery and funding of health research is made with Māori leadership (Came, O'Sullivan, et al. 2020). Core tino rangatiratanga competencies for allies outlined by Came, Kidd, Heke, et al. (2021) included having a basic understanding of the importance of Māori philosophies and te ao Māori, being familiar with, and taking guidance from, current and historic Māori health literature and Māori health leaders. Challenging racism and advocating for Te Tiriti were also identified as core skills. Berghan et al. (2017) also identified addressing institutional racism as central to upholding tino rangatiratanga.

Article two application to study.

In this study the lead researcher, as a member of Tiriti education and anti-racism groups, is deeply committed to advocating and acting for Te Tiriti within the health system and the broader Aotearoa society. The study aimed to contribute towards the upholding of tino rangatiratanga and a Tiriti honouring anti-racist health system.

The literature supports the process of participants (who are seen as allies) being endorsed by those whom they are in solidarity with (Land, 2012; Ostrove & Brown, 2018; Pease, 2010). The social justice validity point of critical race theory also endorses this method (Parker & Lynn, 2002). McGuire-Adams (2021, p. 8) stated "the designation (of the label ally) must come from Indigenous leaders". Kluttz et al. (2020, p. 52), in their study exploring what was required to be 'good allies', understood "activists and organisers cannot self-identify as allies; instead, this designation must come from Indigenous communities, and not just any Indigenous community, but leaders within a specific context at a specific time." In this study participants were purposefully selected through conversation with the critical research whānau to identify who they consider to be Pākehā allies – people committed to enacting Tiriti based anti-racism within the health system. This included the power to veto potential participants. This veto, an exercise of rangatiratanga, was exercised on one occasion.

The deliberate relational citational practice employed for the study literature review, inspired by Burgess et al. (2021), reflected feminist (Xin Liu, 2021) and decolonial theory (Tynan & Bishop, 2023) by being purposeful about who was cited and why. This was an intentional tool to incorporate another method of ensuring the research considered and incorporated Māori voice and reflected the geographical, historical, and socio-political components of racism and anti-racism. This innovative literature review method also sought to counter the racism inherent within academia which marginalises Indigenous scholars voices (Kidman, 2020). This component of the methodology also reflects whanaungatanga – who we cite and our relationship with their scholarship matters.

Article two questions.

Is this research more appropriate to be carried out in whole, or in part, by Māori researchers as an expression of rangatiratanga? If not do Māori people say matters of tikanga (Māori processes and protocol) or specific Māori interest need to be considered and how are Māori experts contributing to this research? (Came et al., 2023).

How does this research respect tino rangatiratanga? Does this research undermine tino rangatiratanga in any fashion?

How does the research ensure the integrity of the te ao Māori worldview is upheld?

How does the research address institutional racism?

Article Three – Ōritetanga, Equity

Article three, acknowledged Māori granting kāwanatanga to the Crown in article one and in reciprocation ensured the Crown would "care for all the Māori people of New Zealand and will allow them all the same customs as the people of England" (Mutu, 2011). The cataclysmic impact of colonisation "loss of culture, loss of land, loss of voice, loss of population, loss of dignity, loss of health, and wellbeing" (Durie, 2004, p. 1138) has resulted in entrenched inequities for Māori. Addressing health inequities is a core responsibility of health researchers (Health Research Council, 2019) and health research incorporating Māori methods is important to address Māori health equity (Rolleston et al., 2016). The kaupapa Māori research principle of social justice ensures research outcomes benefit Māori and challenges ideologies and systems that disadvantage Māori (Walker et al., 2006). As Rolleston et al. (2020, p. 130) said so articulately:

> the system should no longer privilege a Western medical model of health for a population plagued by problems that Western medicine has thus far failed to solve. Interventions therefore that are inclusive of Māori worldviews and values, grown from within Māori communities, where Māori are partners, will have more of an effect on the disparity gap than any intervention grown from colonial soil.

Reid et al. (2017) also highlighted the importance of promoting Māori voice in health research focused on Māori health equity. If health research reveals differences between Māori and non-Māori, they warn of a tendency to 'victim-blame' through deficit theorising and instead advised consideration of structures and systems that maintain health inequities (Reid et al., 2017).

Article three application to study.

This study, clearly located within the transformation paradigm, acknowledges the cause of health inequities lies within systems, and through identifying how Pākehā work towards change, seeks to contribute to the development of an equitable, Tiriti based health system.

Article three questions.

How will this research consider the responsibilities, rights and capacities of Māori citizens and ensure equity of outcomes as Māori people define them? (Came, et al. 2023).

How does this topic advance health equity for Māori? (Health Research Council, 2019)

Does the research take a strengths-based approach in relation to Māori or does the study perpetuate a deficit focus (thinking particularly about data and how data is presented and discussed)? (Kukutai et al., 2023; Reid et al., 2017)

Oral declaration – Wairuatanga, Religious Freedom and Customary Law Protection

On the morning of the signing of Te Tiriti it was agreed it would contain a commitment to protect religious freedom and te ritenga Māori (Māori custom) (Healy et al., 2012). This agreement is significant for Māori and is regarded as an additional guarantee that Māori custom, authority and law would be protected (Durie, 1996; Healy et al., 2012). The fourth oral article is also represented as the protection of wairuatanga (spiritual practices and wellbeing) (Came et al., 2023). Wairuatanga is "an essential expression of rangatiratanga" (Came, O'Sullivan, et al., 2020, p. 439) and crucial to a Māori world view of wellbeing (Berghan et al., 2017).

The oral declaration invites researchers to respect Māori cultural worldviews. Cultural safety requires an understanding of your own cultural worldview and the power and privilege your cultural position wields (Curtis et al., 2019). This requires reflection on positionality of who is carrying out the study and their intentions. Engaging in culturally respectful research requires researchers to critically examine their own values, assumptions, and beliefs to comprehend the cultural lens they bring to their research (Mertens, 2017).

Reflexivity informs positionality and requires the researcher to be explicit about how their views frame the study and influence the design, recruitment, data collection, interpretation, and data analysis (Brannelly & Boulton, 2017; Holmes, 2020; Olukotun et al., 2021). Unless Pākehā researchers examine their worldview and privileged cultural position they will be limited in their ability to do Tiriti based research (Silcock & Hocking, 2021), they may also perpetuate racism and actively do harm. In Aotearoa this requires Pākehā researchers know about the multiple and

ongoing breaches of Te Tiriti and understand how our violent colonial history results in power and privilege residing within the Pākehā monocultural society. Increasingly Pākehā are engaging with the idea that to live a just life in Aotearoa requires honouring Te Tiriti (Black, 2010). Audre Lorde (1985) urged us to "tackle what is most difficult for us all, self-scrutiny of our complacencies, the idea that since each of us believes she is on the side of right, she need not examine her position" (Collins, 2016, p. 13).

The importance of health researchers having at least a basic understanding of tikanga Māori and te reo Māori (the Māori language) is also a consideration under the oral declaration. It is a requirement of health researchers to value tikanga Māori when doing research in Aotearoa (Health Research Council, 2019). This knowledge will foster connection with Māori (Hunter & Cook, 2020), however care and humility with how and why te reo Māori is used is advised (Thomas, 2020).

Oral declaration application to study.

Researcher standpoint or positionality for this study was clearly articulated. A research journal was kept by the lead researcher to 'examine her position'. Regular conversations with the critical research whānau and other groups of accountability such as STIR and Network Waitangi Whangārei, also encouraged critical reflection on the study progress, and helped the lead researcher to recognise and navigate the nuanced realities of the project.

Oral declaration questions.

Are you the right person to be doing this study? In what ways does your cultural position help or hinder this study? (National Ethics Advisory Committee, 2019).

What is the researcher positionality? What is the dominant researcher worldview? How does this inform and impact upon the research?

What power and privilege are held by the researchers? How does this manifest within the research?

How will this study support the right of Māori to live as Māori and according to Māori values and customs? (Came et al., 2023).

How does the research incorporate Māori ethical considerations and processes? (Health Research Council, 2019).

How is wairuatanga and tikanga upheld throughout the research?

Discussion

In 2016, Matike Mai Aotearoa, the Independent Working Group on Constitutional Transformation, published a visionary, hope filled, values based report, outlining an inclusive future for Aotearoa based on He Wakaputanga, Te Tiriti and the United Nations Declaration on the Rights of Indigenous People (Matike Mai Aotearoa, 2016). In June 2022 Aotearoa celebrated a new public holiday, the rising of the star cluster Matariki which signals the Māori new year, the first ever public holiday that recognised te ao Māori (the Māori world). A month later, te Aka Whai Ora, the Māori Health Authority, a landmark development for Māori health (Baker, 2022, July 4), was launched, an outcome, in part, of the Waitangi Tribunal (2019) Hauora report and the Health and Disability System Review (2020). These developments follow a growing number of legal judgements establishing Te Tiriti as constitutionally significant (Kukutai et al., 2021).

These actions, among many others, have arisen from the concerted efforts of both Māori and non-Māori activists to move towards a Tiriti honouring future for Aotearoa. Amongst this backdrop of transformation there is a specific and valuable role for health researchers to consider and apply Te Tiriti o Waitangi. Speaking more generally about the science policy interface, Kukutai et al. (2021, p. 29) advised,

> though obvious, it is important to note that the rights and responsibilities guaranteed by Te Tiriti are not only for Māori but also for tauiwi (non-Māori). In this light, the onus is on tauiwi working at the science policy interface to upskill themselves on what it takes to be a good Te Tiriti partner, and to examine their own practices and accountabilities in the system. Continuing to ignore repeated instances of advice from Māori is untenable.

Guidance on how Te Tiriti can inform health research has evolved quickly in the last few years. A first step to be a good Tiriti partner requires understanding and engaging directly with the Māori text of Te Tiriti and the guidance it provides. Additionally, considering the contribution of institutional racism to the production and maintenance of health inequity, Pākehā health researchers have a role within their sphere of influence to actively consider and work towards disrupting racism. If they fail to do so they remain complicit with the system. Came et al. (2019) posited implementing Te Tiriti may address institutional racism. This Tiriti methodology may also be employed to address institutional racism and improve health equity by requiring researchers to explicitly name and address the impact of racism, Pākehā privilege and power, ensure their research respects Māori sovereign rights and aligns with Māori health research priorities.

Although this Tiriti methodology is informed in part by kaupapa Māori theory it does not, and cannot, fully adopt the epistemological and ontological world view of mātauranga Māori, when employed by Pākehā. Brannelly and Boulton (2017, p. 345) caution that despite reflection, questioning and challenge, "epistemological differences may not be overcome." It is important for Pākehā researchers to be clear about what paradigm they are operating within because the relationship between methodology and paradigm is "reciprocal interdependence"; methodology is informed by and in return determines the research paradigm (Held, 2019). It is crucial Pākehā undertake self-reflective activities, ideally in conversation with others, that illuminate their cultural worldview and epistemic privilege, so they are enabled to understand, critique and consider how this influences the research approach.

In a discussion on how to generate 'non-stupid optimism', as a response to Pākehā paralysis, and a suggested Pākehā research praxis, Hotere-Barnes (2015) identified five capabilities required for Pākehā working with Māori within a research context to overcome paralysis of action: 1) value cultural identity, the richness of diversity and challenges, whilst remaining cognisant of the power-dynamics between Māori and Pākehā; 2) recognise the politics and use of te reo (Māori language) and tikanga Māori (customs) 3) be comfortable with complexity – "power, privilege, and paralysis" are not overcome via a checklist but rather by sitting with discomfort, critically reflecting, being flexible, open to learn and change; 4) sustain the self – personally and professionally, and finally 5) commit to evolving and long-term relationships (Hotere-Barnes, 2015, p. 49). This Tiriti methodology also provides clarity and guidance for Pākehā to engage respectfully, with caution and humility in relationship with Māori, and enables Pākehā to move on from fragility and paralysis (Tolich, 2002) to find our place and role in working towards a just and equitable future for Aotearoa.

The relationship with a critical research whānau is a central concept of the Tiriti methodology presented here, adopted from kaupapa Māori theory (Smith, 2012), activist scholarship, particularly learning intergenerationally from our elders (Came et al., 2015) and also reflected in feminist and critical race theory. The involvement of a critical research whānau shifts the research from an individual endeavour to the collective, supports the incorporation of a Māori world view through the privileging of Māori voice and activates both kāwanatanga and tino rangatiratanga. The power of the researcher is purposely diminished as unilateral decision-making is ceded but the quality and justice of the research is enhanced when key decisions about the research are made by, and with, a collective and more experienced view.

The importance of sound relationships based on trust and honesty is essential if a critical research whānau is to work. Researchers need to be able to approach the collective with issues of concern, trust and most importantly, act on the guidance provided. Researchers also need to be conscious of the 'asks' and potential to be burdensome to community leaders who are likely already to be over-committed and over-worked with responsibilities to their work, communities and / or whānau, hapū and iwi (tribes). As outlined above clear roles and accountabilities for the researcher and the critical research whānau, need to be discussed and collectively agreed. Researchers are cautioned to only adopt this structure if committed to the implications – otherwise it can be tokenistic, not fully realise the benefit of having expert guidance and at its worst perpetuate injustice.

For Pākehā researchers who have limited relationships with Māori then forming a critical research whānau will be difficult and the application of this methodology is not recommended. Other methods of ensuring Māori interests are served in the research agenda should be explored. Māori health priorities are well established (Curtis et al., 2022) as are the mechanisms by which institutional racism creates and maintains health inequities: differential access to health determinants; differential access to health care and differential treatment within the health system (Jones, 2002). Focusing the researcher gaze on these parts of the system is suggested. Importantly researchers need to avoid victim blaming and deficit theorising (Reid et al., 2017). Consideration of how to work 'in service' of a Māori health agenda is also recommended (Crawford & Langridge, 2022). Experienced health researchers also have obligations to develop and support Māori health researchers (Barrett et al., 2023).

This paper is context specific to the study location within the transformative paradigm and qualitative research. Readers are encouraged to consider how Te Tiriti may specifically relate to their study paradigm and approach. This paper does not consider how Te Tiriti as a methodology could be applied to more quantitative research approaches. However the literature on Māori data sovereignty which directly engages with Te Tiriti o Waitangi provides instruction here (Kukutai et al., 2023). In the study in which this Tiriti methodology was applied, the lead researcher and the participants all identified as Pākehā; Tauiwi (non-Māori) researchers working with Māori participants will have additional considerations to further consider cultural safety (Curtis et al., 2019). This paper focuses on Pākehā health researchers however the guidance provided here could be considered by Tauiwi health researchers within Aotearoa as they too have Tiriti obligations. White settlers from other colonial settler nations could consider how this methodology, and particularly the questions under each of the respective Tiriti elements, could be configured for their locale. These questions might be usefully read alongside Conrad (2023)

who provided an insightful and reflective account of her research practice partnership with an advisory group of First Nation Coast Salish leaders. She concluded transforming white settler dominant and trained research required embedding structures of Indigenous sovereignty throughout the research to create mechanisms of accountability and answerability (Conrad, 2023).

Conclusion

All research in Aotearoa has obligations to Te Tiriti and to contribute to the advancement of Māori. Over the last twenty years there has been increasing focus throughout Aotearoa society to consider how Te Tiriti o Waitangi can be honoured, this is mirrored in guidance provided to health researchers. Largely because of the Waitangi Tribunal (2019), Hauora report, the last few years have seen significant change towards how Te Tiriti is viewed and applied within the health system, ultimately resulting in substantial structural reform of the health system.

Te Tiriti provides a place for all that settle here (Matike Mai Aotearoa, 2016). Te Tiriti can also guide research methodology particularly for Pākehā and Tauiwi who are motivated by social justice and envisage a Tiriti based future for Aotearoa. By engaging directly with the Māori text and critically reflecting on their role, responsibilities and accountabilities, health researchers can design health research to address institutional racism and improve health equity. This focus on decolonising action must be paramount within the research agenda.

This paper contributes to the evolution of Pākehā cultural research praxis and builds on the growing scholarship by other Pākehā that have engaged with how kaupapa Māori theory can inform their approaches. This approach gives prominence to Māori voice and honours the Indigenous wisdom and matauranga located uniquely here. This paper is a humble offering for others to consider how it might inform and strengthen their research approach.

Chapter Six: Methods

Introduction

The study was informed by a Tiriti-based methodology located within the transformative research paradigm, informed by kaupapa Māori, critical race and feminist theory, and activist scholarship. This methodology affirms the place of Te Tiriti o Waitangi within health research in Aotearoa that seeks transformative change. The five elements of Te Tiriti provided guidance for the methodology under the domains of whanaungatanga, seeking relationships of mutual respect within the research; kāwanatanga, overall governance and oversight of the study; tino rangatiratanga, paramount Māori authority; ōritetanga, equity; and wairuatanga, respect and care. This chapter describes the methods used within this methodology. It begins with a fuller description of how participants were selected. Then, following the example of Came (2013), I provide more detail on the ethical considerations, using Te Ara Tika as a guide (Hudson et al., 2010). A description of the interview process is provided before an explanation of the steps I carried out for data analysis using a slightly expanded reflexive thematic analysis approach (Braun & Clarke, 2022a). The dissemination strategy that was developed collaboratively with the critical research whānau, STIR and Network Waitangi Whangārei is presented before providing a review of my self-reflexivity. This final section considers my purpose, process and relationships throughout the research, making explicit my influence on the study.

Participants

Participants were purposefully selected through conversation with the critical research whānau to identify who they considered to be Pākehā (white people of European descent) and an ally – someone committed to enacting Te Tiriti within the health system. This process of participant selection has been utilised in other studies such as Davis et al. (2022). Participants were also people working in the health sector and involved in some way with the change agenda. I compiled a long list of 52 potential participants, all considered to be Pākehā critical allies, from various suggestions provided by my supervisors, STIR members, critical research whānau and Māori health sector colleagues. The long list was then reviewed by the critical research whānau, and a consensus reached on eight people; four men and four women. Six of the participants were from the field of public health, five were medical doctors (all with public health training), some were working in senior positions within either the Ministry of Health or DHBs, and others worked for Māori health providers, or in primary health care. Importantly, although it was not deliberately intended, all participants were health sector leaders in some way.

I was unable to contact one of the selected participants, despite multiple attempts and, considering they were a GP working during the midst of COVID (February 2022), decided not to persist. Another participant had been recommended to me, so I asked the critical research whānau to consider them. Although all the first interviews had been completed with the other participants, we collectively decided to invite the additional prospective participant to join the study and, if they consented, to combine interviews one and two together. They did consent and this interview was held in mid-2022 at about the same time as the second interviews with other participants.

One participant completed the first interview and second interview but was unable to be contacted for the third interview. Their data was removed from the data set. The seven remaining participants were three men, and four women, all aged between mid-40s and late 60s, all had public health training and/or experience, and years of contribution to the health system in Aotearoa.

Ethical Considerations

This section provides an overview of how ethical considerations were applied within this study. In the research proposal for this study, Te Ara Tika, a Māori ethical framework comprising four tikanga-based principles – whakapapa (relationships), tika (research design), manaakitanga (cultural and social responsibility), and mana (justice and equity) (Hudson et al., 2010) – was applied to make explicit how ethics was incorporated into the research design. Many components of this ethical framework have been described in the previous chapter but more detail is provided here to support ethical review.

Ethical approval was granted by the Auckland University of Technology Ethics Committee, AUTEC Reference number 21/393 (see Appendix A).

Whakapapa – Quality of Relationships

Whakapapa, within ethical decision-making, refers to the calibre of relationships and the procedures that have been put in place to support these relationships (Hudson et al., 2010). My relationship with the critical research whānau and their role in this study has already been described in detail in the previous chapter. The ethical issues discussed here focus on my relationships with the participants and include informed consent and benefits to them.

For me this was a matter of prime importance, and one revisited not only at the beginning but throughout the entire study duration. Is this research of benefit? Will it be of benefit to the participants? This study, as a work of activist scholarship and critical inquiry, must attempt to

confront injustice (Kincheloe & McLaren, 2011). Will this study contribute (even in some small way) to attaining Tiriti justice in Aotearoa?

I hoped that participants would benefit from their participation in the research through taking time to consider and reflect, and potentially gain insight and learning that would strengthen their Tiriti-based anti-racism praxis. This was based on a process Lather (1986) described as catalytic validity – that is, the research process contributes to participant reflection, self-understanding and, ultimately, 'conscientisation'. The researcher must consider the degree to which this is achieved. At the end of the third interview, I asked participants about their reflections on being involved in the research process. Their responses indicated that there was benefit to their participation. One said they "loved it", another "it's made me think. I've always thought after every interview." This statement was echoed by several others: one participant said, "It's helped me reflect a bit on things," and another appreciated the opportunity to spend time considering these issues. Another said they found the questions helped them to think more strategically, and said they reflected upon the questions for several days after the interview. Participating in the interview was "really positive for me, actually, just to be part of it. I feel honoured to be part of it actually." Several participants were really interested in what others had to say and were keen to come together with the other participants to discuss the initial themes. Participants consented to being involved in the online group meeting with the knowledge that participating would reveal their identities to other participants.

Another benefit to participants was the potential for 'mana-enhancement' with the recognition given to them by the critical research whānau for their knowledge and experience as anti-racism allies. Being selected for participation in the study was a compliment and acknowledgement of the respect others have for them. All participants were pleased to have been described as an ally, one saying "they loved being thought of as an ally, that was a big thing for me."

The benefit of this study to the wider community was the intention to contribute to the further development of Tiriti-based anti-racism praxis. This is discussed in-depth in the discussion and conclusion chapters to follow.

Regarding informed consent, participants were approached to participate in the study initially by email or phone. If the first contact was email and, if the response was positive, this was followed up with a phone call. Then the participant information sheet and consent form were emailed for review. Before we began the first interview, I was particularly careful to talk about the various options participants could choose regarding being identified (or not) in the study.

The following options were described in the participant information sheet (Appendix B) and the consent form (Appendix C).

- I consent to being identified in the research by name.
- I consent to being identified in the research by name and role / health profession.
- I consent to being identified in the research by name, role / health profession and organisation.
- I consent to a biography (reviewed and approved by me) being included in the research thesis.
- I DO NOT consent to being identified in the research.

Consent forms were returned either before the first interview via email or were completed in person at the first interview. One participant consented to being identified in the research, one did not consent to being identified and everyone else did not indicate a choice, explaining that they would like to consider this and decide at the study's end. At the end of interview three, I discussed with the participant who had agreed to be identified whether they were still ok with this choice. After talking it through they decided not to be identified as they thought people might consider any quote attributed to them differently if they knew who the quote was from.

Tika – Research Design

Tika refers to what is good and right in any given scenario (Hudson et al., 2010). Regarding research, tika is concerned with the quality of the research design, which affects whether the intended objectives, participant and community benefits, and positive, revolutionary change are achieved (Hudson et al., 2010). Three levels of 'tika' research design are outlined by Hudson et al. (2010). The minimum standard is described as mainstream research that may or may not be a) relevant to Māori or b) involve Māori as research participants. At this level Māori have limited involvement; however, if Māori are participants, consideration must be given to facilitating and supporting Māori engagement. The second level, described as good practice, is Māori-centred. Māori-centred research ensures Māori have significant participation throughout the research – including design, research development, analysis and dissemination. The third level, best practice, is kaupapa Māori research. Research that is designed, conducted by and benefits Māori, is kaupapa Māori research (Hudson et al., 2010). Some core questions for researchers to consider here include: Is the study relevant to Māori? Who is the researcher accountable to? Who is supporting the research, researchers and research participants?

This study is not mainstream, considering the involvement of the critical research whānau in study design and governance, and the intended benefit to Māori through disrupting racism. The

study is also not kaupapa Māori as I am not Māori. However, the study could be considered Māori-centred. Nonetheless, considering the Tiriti methodology outlined in the previous chapter, I am not sure whether I would now use the Te Ara Tika typology to characterise this study; instead, I would refer to it as Tiriti-based.

Manaakitanga – Upholding Mana, Cultural and Social Responsibility

Manaakitanga is concerned with respectful relations between people, and within a research context it is about acknowledging the responsibility to care for people and to protect privacy and confidentiality (Hudson et al., 2010). This study met the minimum standards of manaakitanga by working through issues of consent (as discussed above in the section on whakapapa).

One of the ways I was purposeful in upholding the mana of participants was to ensure careful and accurate representation of our discussions, by taking care with the selection of quotes to be used and how the quotes were presented in the research. After writing up the findings chapter, I sent a copy to all the participants with their quotes highlighted. I asked them to review and to approve they were happy for those quotes to be included in this study, and in any future publications. Most were happy with the quotes as written, two asked for a small edit, one to ensure confidentiality related to a workplace and another for ease of reading. I had already edited the quotes to remove superfluous words such as 'you know', 'um', and 'yeah' that were peppered through the dialogue, not only to help with ease of reading but also to facilitate comprehension. I had also offered to send participants a copy of the edited transcripts of the interviews, but they all declined.

For many participants it was not possible to meet in person. For those interviews held online, I was especially conscious about establishing rapport and helping participants to be at ease. As an example, for one interview with the participant I knew least-well, I started by establishing connections with people we both knew, and talking about my knowledge and respect for their previous work. The first interview had been designed to start with a focus on their family background and values which, hopefully, were comfortable topics.

For the interviews in which I was able to meet participants in person, we arranged to meet in places familiar and comfortable for them, in several instances this was their home or workplace. I brought along food which we shared together. These practices were intentional, to develop connection and relationship, and enhance participant comfort.

Mana – Justice and Equity

In the Te Ara Tika framework, the ethical review process enables the research to go from being tapu (restricted) through to noa (unrestricted) (Hudson et al., 2010). The starting point in this process is to kia tūpato (be careful) in considering the risks and benefits of the research (Hudson et al., 2010). The principle of mana asks researchers to consider the quality of their relationships within the research through a lens of power. Rights, roles and responsibilities are considered alongside risks, benefits and outcomes.

The sections above consider the informed consent of participants at an individual level. There were three other levels of collective collaboration in this study: with the critical research whānau, Network Waitangi Whangārei, and STIR. Being a member of both Network Waitangi and STIR provided another level of accountability back to a collective that was additional to the role of the critical research whānau. My relationships with, responsibility to and accountability to these people and groups will endure beyond the duration of the study.

I was attentive to issues of power and these were considered when considering potential participants, conducting interviews (questions asked, place of interview). For example, as I was a Northland DHB member at the start of the study, I chose not to include participants who worked directly for the DHB to eliminate potential conflicts of interest and to avoid any power imbalances between the researcher and the potential participant.

Interviews

Three interviews, each between one and one-and-a-half hours long, were held with each participant over a period of about 18 months. The first interview, held in December 2021, focused on values and family background, thoughts on allyship, their journey and development as a Pākehā ally, and initial thoughts about the health reforms. At the second interview, held in mid-2022, a summary of the initial analysis of the first interview was discussed and reflections sought. This interview also covered anti-racism praxis and progress of the health reforms. The third interview was held a year later, in mid-2023, and again explored a recap of findings from the previous interviews, along with further thoughts on the health reforms and anti-racism praxis. The interviews were recorded, and extensive notes taken. I transcribed the interviews soon after each interview. Participants were given the option to review their transcripts, but all declined. The initial plan was to hold four interviews but after discussing this with the critical research whānau, I decided that a fourth interview would not be required because the topics identified for discussion had been well canvassed.

After the National/ACT/New Zealand First Government was elected in November 2023, and the immediate announcement within the government's 100-day plan to abolish Te Aka Whai Ora, I contemplated inviting participants to another interview to explore their reaction and any immediate impact observed within the system. However, after discussion with the critical research whānau and my academic supervisors, it was decided to 'draw a line' under data gathering.

Although there was an interview schedule for each interview, not all questions were asked of each participant, either because they had already been answered within a response to another question or because I felt that the conversation in the interview had gone another direction and the question was now out of place or irrelevant. Some questions were asked in slightly different ways from how they were worded in the schedule; I found this happened as I progressed through the interviews, as I developed a comfort with framing or introducing the question. I was deliberate in being reflective of, responsive to, and acting upon, what occurred during the interview. As one of my critical research whānau reminded me, when doing work on anti-racism praxis – which is relational work – then you need to be relational in the interview. It is ok to respond to what is happening in the interview; indeed, you have a responsibility to do so. For example, in the third interview, held in mid-2023, one year on from the reform implementation, some participants were in the midst of restructure and facing real uncertainty about their future within the reformed health system. The interview provided an opportunity for people to share what was occurring for them, to reflect and deeply consider the issues. I am aware of not wanting to over-exaggerate claims of benefit to participants, but I do think in these instances an external listening ear was a valuable contribution.

Reflexive Thematic Analysis

Reflexive thematic analysis (TA) (Braun & Clarke, 2022a) was chosen due to the alignment with the social constructionist, critical inquiry methodology of this study. A theoretical "knowingness" is crucial to quality TA (Braun & Clarke, 2013, 2019) and reflexive TA acknowledges the core role of the researcher in the knowledge production process. The subjective role of the researcher as the storyteller and interpreter of data is seen as valid and a resource (Braun et al., 2019). To make this point explicitly, "The researcher makes active, interpretative choices in generating codes and in constructing themes" (Clarke & Braun, 2014, p. 1948). Another distinctive element of reflexive TA is how themes are conceptualised. Within reflexive TA, themes do not "passively emerge from the data"; rather, they are generated from the data as "patterns of shared meaning underpinned or united by a core concept" (Braun &

Clarke, 2019, p. 593). To be explicit about my role in making active, interpretative choices with the data, my process of reflexive TA is described in detail here. This process is a slightly expanded version of the six-phase process proposed by Braun et al. (2019).

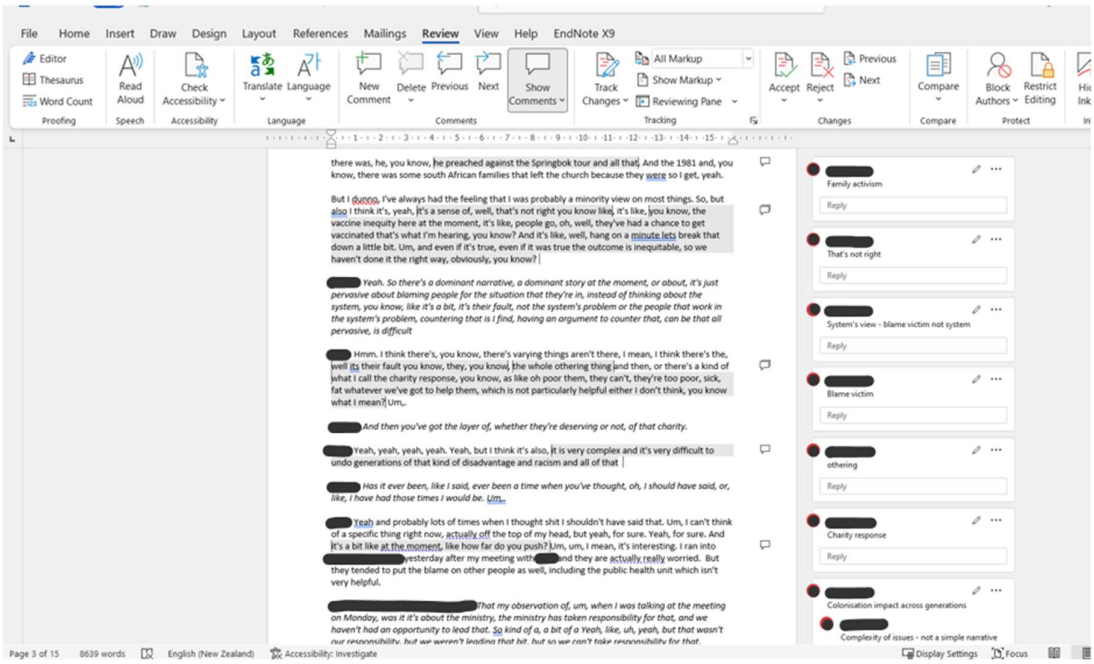
Familiarisation with the Data

After the completion of each set of interviews, I transcribed the audio files. The first set of interviews were transcribed with the assistance of the MS Word 'Dictate' function. The second and third set of interviews were transcribed with an online transcription service. Although the use of technology to transcribe helped, this was still a time-consuming process but it did greatly facilitate getting familiar with the data. After the transcription of each interview was completed, I re-read each interview, and then the set of interviews together.

Coding

Coding was conducted by using the 'Review'/'Insert Comment' function on MS Word (see Figure 10, below). I then installed a 'Copy Comments to Excel' macro in Word that enabled the export of each comment (code) to an MS Excel spreadsheet. The codes from each interview were then combined into one Excel sheet (see Figure 11) so all the codes from each interview were available to see on one spreadsheet.

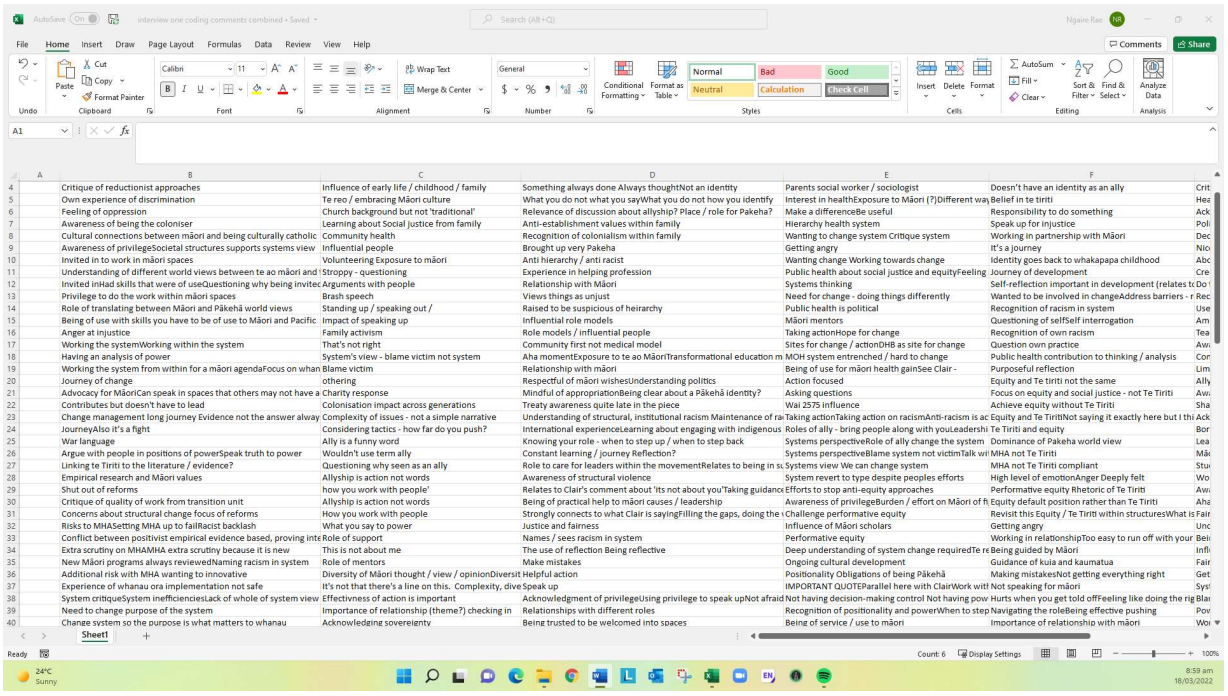
Figure 10
Example of Coding Using Review Comment Function



Coding was a mixture of inductive and deductive processes, with a weighting towards the inductive end of the coding continuum as a starting point (Braun & Clarke, 2022a) because the research was focused on understanding and describing the experiences of Pākehā critical allies. As I was coding, however, I became aware that I was interpreting or layering my understanding and knowledge of anti-racism theory and praxis on the data, hence an element of deductive coding was present. However, the coding was not theory-driven in the sense of checking or interpreting the data against a pre-determined set of ideas, a framework or a code book. The coding was also a mixture of semantic and latent codes. Some codes were semantic in that they captured the idea(s) stated by participants, while other codes were latent in that they reflected a conceptual idea (Braun & Clarke, 2022a). Again, recognising this as a continuum, the coding swayed more to the semantic end.

As each interview was coded, some codes were repeated, new codes created, and some were slight variations on existing codes. On reflection, it may have been easier to build themes if I had kept and used the same consistent codes throughout. But this may not have captured the nuances in the data, nor my responses to the data as they were occurring. Figure 11, below, shows the list of codes for the first set of interviews exported from Word into Excel. This enabled the review of all codes across each interview in one place.

Figure 11
List of Codes Exported from Word into Excel



Constructing Themes

Candidate themes from interview one were generated by reading through the codes and noting groupings. The spreadsheet was also interrogated using the 'Find' function to search for codes with common words, e.g., ally, action, Tiriti, equity. As groups of codes were identified, they were written on to variously coloured 'notes' and stuck on a Miro board. The colours represented a collection of codes or the 'building blocks' of a theme. Each of these blocks were then put into frames and could be moved to connect with other blocks. The use of the Miro board helped to visually 'build' the themes. Each code or group of codes became a building block. Those building blocks gathered together helped to construct a subtheme. These 'subthemes' could then also be grouped together to form an 'overarching' theme. Figure 12, below, shows how this looked on the Miro board.

These framed groups of code were chosen as candidate themes, i.e., potential themes but not fixed or determined yet. Three broad or overarching themes (health system reform; positionality; anti-racism praxis) and eleven subthemes were generated from the first interview. For each of these candidate themes, a description of the main ideas and concept was developed.

Figure 12
Miro Board of Framed Codes from Interview One

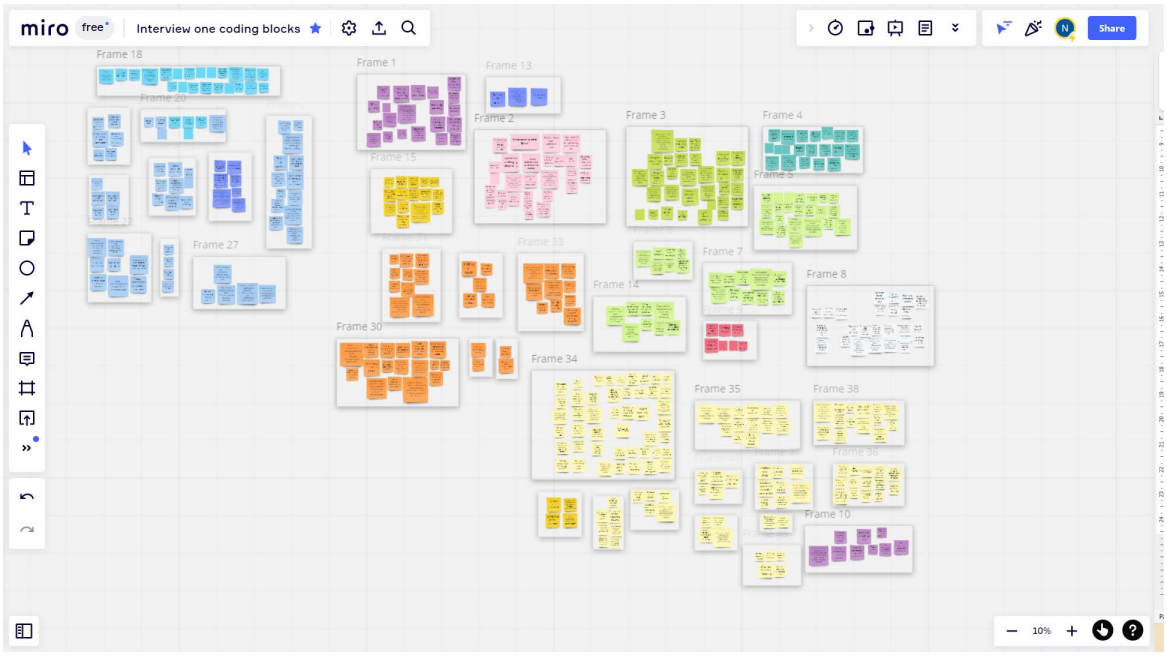


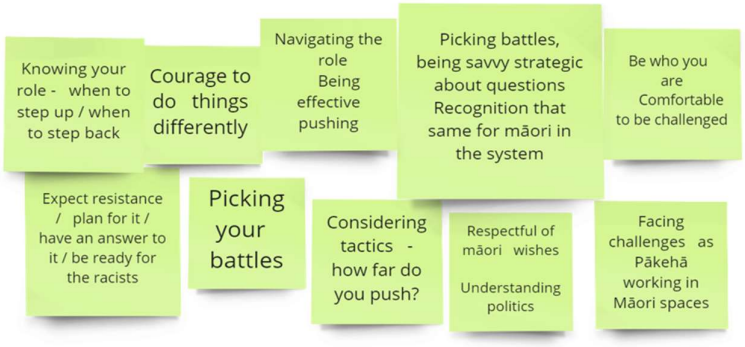
Figure 13, below, shows the initial candidate theme 'navigating the role / picking battles' that was within the overarching candidate theme of anti-racism praxis.

Figure 13

Candidate Theme Description and Identified Building Block Codes

Navigating the role / picking battles

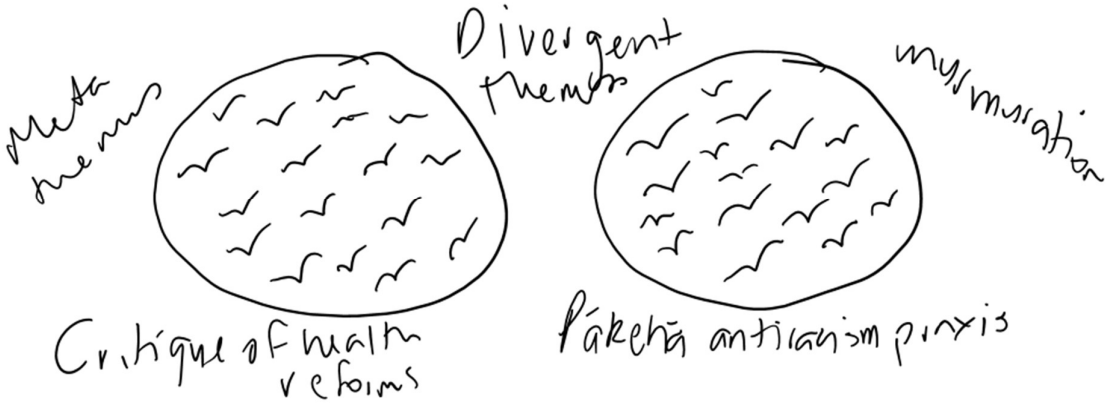
Discussion about being strategic or considering when to raise issues, when to step up, speak out or step back. Knowing which fight to pick, what do you let go and what do you hold the line on, being courageous, but also being tactical. Always respectful of Māori agenda and understanding politics but also knowing to expect racism and resistance and to have an answer for it.



It was about this stage that I was starting to think that there was little or no connection between the theme about 'system change' and the other three themes. I started to think I had two different topics and was struggling to see how they connected. I envisaged the topics like a murmuration of starlings, but two flocks: one topic (flock) as a critique of the health reforms, and the second as Pākehā anti-racism praxis. Figure 14 shows how I drew it in my research journal:

Figure 14

Depiction of Initial Conception of Topics/Themes



For interviews two and three the same coding process was undertaken; however, the method for theme generation was slightly different. As some candidate themes had already been

generated, and the content of the second and third interviews built upon and elaborated on the first rather than being a totally new topic, the coding from the second and third interviews built upon the blocks of code from the first interview.

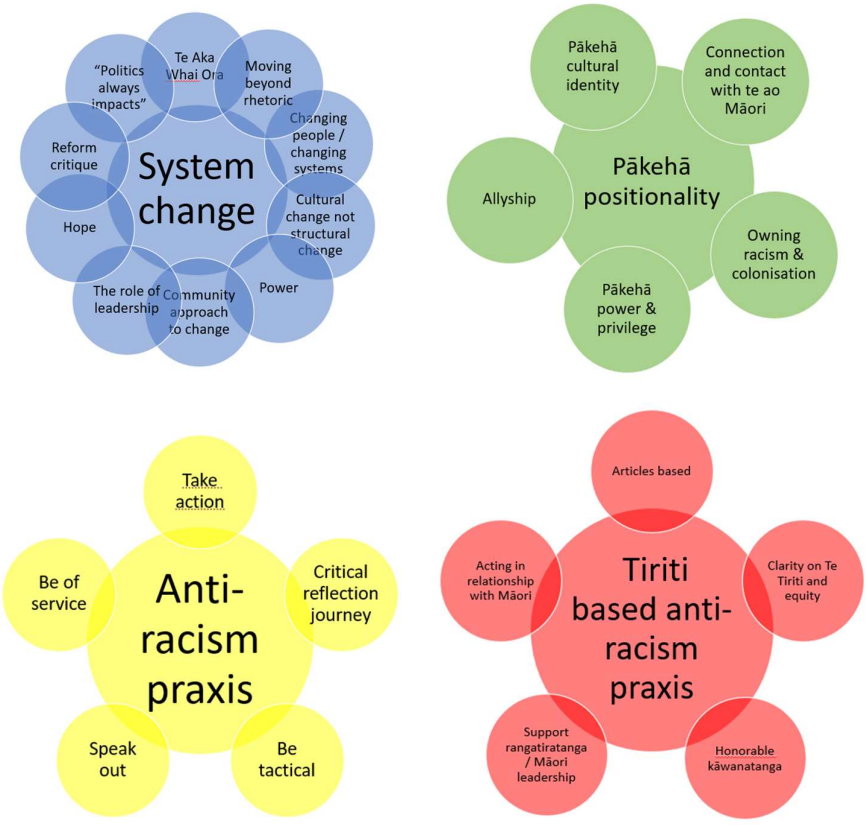
I also noticed that, in some interviews, the way I paraphrased back to participants was how I eventually coded the text. For example, in response to an explanation from one of the participants about how to use the system to achieve one's goal, I responded:

> *N: it's working the system is what I'm hearing a lot of like or working within the system or...?*

I later coded part of that text 'working the system'.

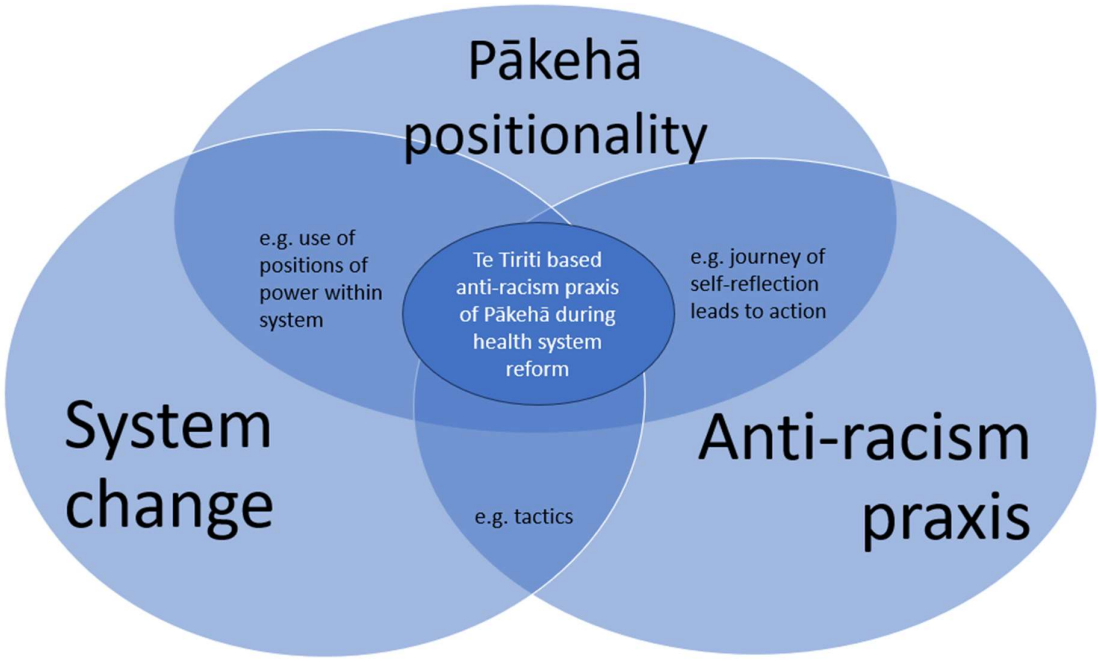
During this phase several more subthemes were developed, increasing from 11 to 20 within four overarching themes: system change; Pākehā positionality; anti-racism praxis; and Tiriti-based anti-racism praxis. I found it helpful to map the themes visually and this was represented in the diagrams in Figure 15.

Figure 15
Themes and the Subthemes



Although themes necessarily have to be distinct (Braun & Clarke, 2020), I started to actively look for convergence among the themes, rather than divergence, to provide a cohesive story within the data. For example, Pākehā positionality requires understanding how to use the position of power within the system, although a component of Pākehā positionality connected with the system change theme. An important connection was self-reflection, which informed anti-racism praxis and contributed to Pākehā positionality. I conceived of this as a Venn diagram (Figure 16).

Figure 16
Venn Diagram Connecting Themes



Critical Research Whānau and Participant Theme Development, Review and Reflection

There were two ways the critical research whānau and participants contributed to the theme development and provided review and reflection. Firstly, some of the candidate themes were shared with participants in interview two and their reflections sought. I focused mainly on the anti-racism praxis analysis as my thinking on this was more developed, reflecting my engagement and interest with this area. This generated some great insights as we thought through and discussed the initial findings together. For example, with one participant, it facilitated a discussion about the difference between 'being of service' and 'being a white saviour' and the role of ego. With another, we discussed how Pākehā positionality was a

recognition of the myth of meritocracy. In interview three, the thread of conversation from the previous two interviews was picked up but a formal re-presentation of the candidate themes was not a focus of the interview as no new 'themes' had come from interview two. In addition, throughout the study, conversations were ongoing with the critical research whānau and my supervisors about theme development.

The second process used was a more formal presentation of the candidate themes, via an online meeting, firstly to the critical research whānau and a week later to the participants. The decision to present the candidate themes rather than a more refined version of themes was deliberate, with the intention being to involve both the research whānau and the participants in the further development and articulation of themes. Presenting the initial findings for 'participant reflections' was a shift from what was described in the research proposal. I had originally thought of holding meetings with participants to 'validate' the findings; this was intended as a quality measure, to check that they were coherent and accurate. However, during the study, as I learnt more about reflexive TA, I discovered 'member reflections' as an alternative to member checking (Tracy, 2010). The intention of member reflections is not to check whether the analysis is correct, or to have them validated; rather, the goal is to seek further reflections, insights and comments from participants (Tracy, 2010). This shift ensures the methodological coherence of reflexive TA. Member checking is assumed to control for the "potentially distorting effects of researcher influence" to establish 'a truth' and is aligned with realist or positivist research quality practices (Braun & Clarke, 2022b, p. 4). Member reflections are grounded in qualitative methodology which makes clear the role of researcher subjectivity – a hallmark of this analytic method.

The discussion with the critical research whānau involved questioning and clarifying the understanding of the themes, particularly the hierarchy of the overarching themes. For example, the critical research whānau suggested the theme 'system change' could be viewed as context for the other themes, and the Pākehā positionality theme could be foundational for anti-racism praxis.

The discussions with participants centred more on what resonated with them and what elements of a theme could be emphasised, as well as clarification on language. For example, the participants did not want to be characterised as exceptional in their anti-racism praxis; rather, they expressed that doing the work of anti-racism was something everyone in the system should be doing. Both the critical research whānau and the participants, reflecting their overall orientation and experience in working for health equity and anti-racism, were interested in

discussing how the findings would be used and encouraged careful thought be given to dissemination and knowledge transmission.

On reflection, this process was valuable for me as I gained insights into how to think conceptually about the data, and what parts of the findings to highlight or unpack more. I felt that the presentations were rushed as I tried to communicate all the over-arching themes and the multiple subthemes. It may have been better to wait until I had done more work on consolidating the subthemes. This may have provided participants and critical research whānau with more time to discuss a tighter, more formed analysis.

Revising and Defining Themes

In the final phase of refining, defining and naming theme development, a definition of each theme was written, and a final name given to the themes. It was in this process that I realised that my characterisation of 'overarching themes' and subthemes differed from that advised by Braun and Clarke (2022a). What I did have was four themes and within them several well-defined subthemes. Also, during this process, I realised that my delineation of 'anti-racism praxis' and 'Tiriti-based anti-racism praxis' as two themes was unnecessary: the subthemes identified were all part of 'Tiriti-based anti-racism praxis'. In this final phase, some subthemes were discarded, and several less well-developed or 'thin' themes (Braun & Clarke, 2022a) were combined with others. Chapter Seven, the findings chapter that follows, describes the final three themes and the 14 subthemes contained with them.

Writing up the Research

When writing up the findings, the themes were refined yet again in a constant cycle of theme description, review and refine. This process helped to make connections, particularly between subthemes and their contribution to the main theme. However, no substantive changes were made.

Dissemination

A draft strategy for research dissemination was written and sent to the critical research whānau and discussed with STIR and Network Waitangi Whangārei. The first iteration was adapted from Came (2012). Table 10, below, was collectively agreed upon.

Table 10
Dissemination Strategy

Who	Focus	How
Pākehā working within health system	Training and upskilling Consciousness raising Collaboration	Research summary Journal articles Workshop offering Webinars Blogs Poster
Te Ao Māori - Māori media - Te Pāti Māori - E-tangata - Te Rau Ora	Support rangatiratanga Honour Te Tiriti	Media release Articles Blog
Public health community - Public Health Association - Health Promotion Forum - International Union of Health Promotion and Education - Health Coalition Aotearoa	Consciousness raising Sharing evidence	Conference presentations Workshops
Health system / sector - Ministry of Health - Te Whatu Ora - Te Kete Hauora - Ao Mai Te Ra Kaupapa - NGOs - Māori Health Providers	Supporting systems change Sharing evidence Seeking collaboration	Presentation as part of 'Re-imagining anti-racism theory for the health sector' study results launch Webinars Blogs Workshops Research summary Journal articles
Academic community - Anti-racism - Public health - Political science - Social policy - Health inequities	Contributing to evidence	Journal articles - Literature review - Methodology - Findings x 2 Conference presentations
Activist community: - STIR - Pākehā Tiriti workers - Unions: NZNO; NZEI; PSA; CTU	Training and development Consciousness raising	Workshops Webinars Blog – STIR & Network Waitangi Whangārei
Pākehā community - Churches	Informed public	Press release Media interviews

Self-reflexivity

Reflexivity and being clear about one's positionality is a critical part of ethical qualitative research (Holmes, 2020; Strega, 2005) and feminist research (Collins, 2016; Lather, 2004). Being explicit about how I framed the study and my influence on the design, recruitment, data collection, interpretation, and data analysis is essential (Holmes, 2020; Olukotun et al., 2021). Tracy (2010) named this 'sincerity', one of eight criteria to be used to assess the quality of qualitative research. The two parts of this criterion are: self-reflexivity about how researcher biases and values informed the research, and transparency about researcher decisions regarding methods and challenges. The term 'sincerity' is used because "it relates to being earnest and vulnerable" (Tracy, 2010, p. 842). Also, as already discussed, *reflexive* TA requires that the researcher makes explicit their subjectivity and their reflexive engagement with the data during the analysis process (Braun & Clarke, 2020). This section provides a further account of my reflections during the research. The intention in providing this account is to be honest about the research process, to provide an authentic account of what I learnt through doing (or not doing), to be sincere, and to further locate myself within the research. This enables an assessment of the quality of the research.

To aid self-reflexivity, throughout the study I kept a research journal. Looking through the journal, there were gaps of time with few entries, and periods where I journalled every day. Although there are gaps, and I would recommend to other researchers to actively develop a daily journalling habit, the journal provides a record of my journey through the study. Two themes are visible relating to questions and ponderings that I would constantly revisit. Firstly, regarding purpose: Am I clear about my focus? Am I making a difference? Secondly about process: How am I doing (and being) in the research? How does being an 'activist scholar' contribute to this research? These reflections, the learnings, and any subsequent changes made, are described below.

Purpose

At a broader study level, there has been a language shift from how I first described the study in the research proposal to how I describe the study now. When I was writing about Tiriti-based anti-racism, I was thinking specifically about racism against Māori. But this is not explicitly stated. These are the research questions from the original research proposal:

1. What are the experiences of Pākehā allies advocating and acting for honourable kāwanatanga, Te Tiriti implementation and anti-racism during the 2021 Aotearoa health system reform?

2. How does the complexity of navigating health system change impact on equity and anti-racism efforts?
3. How can their experiences inform further anti-racism responses and provide guidance to other Pākehā working to decolonise the health system, achieve health equity and end racism?

I attended the Healing our Spirit Worldwide conference in September, 2023. There were presentations on Indigenous-specific racism and Indigenous anti-racism (Brown, 2023). I had not come across the term 'Indigenous anti-racism', but it triggered my thinking about the importance of being clear about this distinction. Indigenous-specific racism is entrenched in the history of settler colonialism and identifies the stereotyping, bias and prejudice experienced by Indigenous peoples (Turpel-Lafond & Johnson, 2021). I realised I had been using the term 'Tiriti-based anti-racism' as an ambiguous way of describing action addressing racism directed at Māori, but I had not named this directly. My intention has always been to explore how Pākehā, as the descendants of colonisers, implement Te Tiriti and disrupt Māori-specific racism in the colonial health system. I had not been explicit about what was obvious to me, once it had become visible, I needed to clearly define the scope of the research.

Accordingly, in the thesis introduction I made important edits to research questions one and three to ensure this focus was clear. I also removed the reference to honourable kāwanatanga as I considered this expanded the research scope beyond the study capacity.

Question one became: What are the experiences of Pākehā allies advocating and acting for Tiriti implementation, improving Māori health and *addressing anti-Māori racism* during health system reforms?

Question three became: How can their experiences inform further responses to *anti-Māori racism* and provide guidance to other Pākehā working to decolonise the health system, achieve health equity and end racism?

At a personal level, I often wondered whether this study would 'make a difference'. Is this study a useful contribution to a Tiriti-based future? The following is an entry from my research journal, from March 2022:

> *Have been listening to several of the Tiriti-based futures webinars and starting to feel quite overwhelmed by the enormity of what is required to be done – in all areas not just health. And of course, I've known this and have had these feelings before, but also questioning whether my research is going to contribute anything useful. Although lots of*

> *different speakers said it, I finally really heard it when walking the dogs and listening to Carmen Parahi speaking about how she sees her mahi as building on all the work that has been done before and also a contribution to the work that will continue. She quoted Sir James Henare, we have come too far not to continue. … And I was thinking yes this is true. This idea of it being a journey is also what nearly all the participants say.*

However, this resolution did not stick for long and the self-doubt returned. There are several other entries in my journal considering this question of impact and 'making a difference'.

When I am being generous with myself, I consider this an example of being conscientious, wanting to do my best, and wanting to honour the contributions of participants, the critical research whānau, supervisors and all others who have supported this research. Ultimately, I want to make a difference, so things change. The intention of this study was to learn how to be more effective within the health system in addressing racism, implementing Te Tiriti and, ultimately, improving Māori health inequities. The urgency of this injustice has not lessened in the last few years; indeed, the last few months have seen it escalate.

Although I was aware of the concept of 'being a white saviour', it was not until undertaking the review on the international literature that I really started to question whether this may apply to me. How much of this concern about making a difference was about my ego? About wanting to help? Were there elements of this a) in my previous work and b) in this study? I think there were and are. Of course I want to help – the anger and frustration at the wrongness of the system is real. But it would be dishonest to not recognise that some part of this 'helping' is also serving me – my ego, my importance, my positioning. Not to mention the material gain of a PhD. What is most revealing to me, now, is not that there were elements of being a 'saviour' present, but that it took me so long to recognise this. Why did I think I was immune to the dominant ideology? Did I think my decolonisation journey was complete? That as the 'researcher' I was somehow outside of this? I recognise my own racism, and privilege, but somehow this component had remained elusive. I realised that I, along with my participants, and other critical allies, are on a journey of decolonisation. Just like everyone else, I require constant critical reflection.

I was aware, from early in the study, about the potential of this study to reinforce white privilege. Others working in this area have described the potential for studies looking at anti-racism from a 'white' perspective to reinscribe white privilege (Foste, 2020; Land, 2015). As Clare Land (2015, p. 25) asked, does this study do enough to overcome "the creation of yet more stories from a colonizer perspective which remains unnamed?" I contemplated this in my research journal:

I think I've talked about this already but question around privileging the voices of the privileged already?

Maintaining a focus on privilege, and latterly white saviourism, has ensured a consideration of how the findings, discussion and the conclusion are framed. As I present later, there are essential components of this work – together they are all required for effective Tiriti-based anti-racism. Taking a systems view, naming the power, privilege and positioning of Pākehā in the health system, and critical reflection, are essential components.

Process

I have struggled with how to write about this issue or even whether I should include this, as I wanted to ensure that this discussion was ethical and kept the mana of all people involved in this process intact. I decided to include this reflection, with a focus on my responses, as I think it reveals some interesting dilemmas within qualitative research about how to deal with anomalies. One of the participants was unable to be contacted for the third interview despite several attempts. A complicating factor was that although they had participated in two interviews, clearly consenting to do so, I had not received a signed consent form. Ethically, I had to remove their data. There were several instances during the interviews with this person that I had a sense of unease and a worry about how to incorporate the data when it 'felt' so different from the other participants. I did not know this person, they were recommended by one of the critical research whānau, but were unknown to others. I felt like I had struggled to 'connect' with them during the interview. After the first interview I wrote in my journal "What is it about my sense of discomfort? Need to really sit and think on this". After the second interview it felt to me that the interview had not gone well, I had not stuck to the interview guide, I was not sure what to ask as none of the questions seemed relevant. I questioned my process, "Have I got the right approach? Do I have to review all the questions?" Finally, I asked myself, "What is going on here?" At the time I debriefed the interview with a couple of people from my critical research whānau, they advised to listen to the interview and look for where it sits within the bigger picture.

I procrastinated, carried on with all the other interviews, and left the interview that seemed out of place un-listened to, uncoded. When I could not get hold of this participant for the third and final interview, although I was disappointed, I admit I also felt relieved. Now I could get on with analysing the data from all the other participants that appeared coherent, and I would not have to work out 'what was going on' with this potential anomalous data. Now, as I write this up, I feel

some regret. I will never know how this participant's data could have further informed the research, potentially finding 'edges' and substance missing from the other discussions.

Being an activist scholar

This study is shaped by being a work of activist scholarship. Writing from their position as anti-racist scholar-activists in Britain, Joseph-Salisbury and Connelly (2021) argued how the concept of 'working in service' is essential to anti-racism activist scholars. Three elements to working in service are accountability, being useful, and accessibility and reach (Joseph-Salisbury & Connelly, 2021).

I have various layers of accountability – my critical research whānau, and the groups that I am a member of, STIR and Network Waitangi Whangārei. When I took the plunge and left my job to do my PhD study full-time, I also fully engaged with the movement, regularly running introductory Tiriti workshops with Network Waitangi Whangārei, doing anti-racism workshops with STIR colleagues, attending protests, supporting action on Waitangi Day, continuing to be the secretary of STIR, and co-ordinating a day of post-graduate student presentations on anti-racism and decolonisation as part of the *Te Tiriti-based Futures* online event (Barnes et al., 2024). My involvement with the Tiriti and anti-racism movement in Aotearoa keeps me accountable, useful and connected. Through talking, thinking and working with fellow activists, I apply my knowledge and generate further considerations.

Having multiple accountability relationships, and receiving conflicting viewpoints, was a concern I had to work through. For example, when finalising the model Whiti Mai te Rā, I presented this to STIR and the critical research whānau, I received various and conflicting advice on how the concepts should be depicted. When considering what action to take, I found myself thinking back to the words of one of the participants and their advice on dealing with diverse perspectives within relationships of accountability, and the importance of *"making sure that the people that matter for the thing that I'm doing … are comfortable with what's being done or we fix that" (Jill, 3)*. Ultimately, I decided to contact the critical research whānau again and discuss the critique with them, to get their input. The response was significant and led to some crucial breakthroughs in the model development. See Chapter Eight and Appendix D for more detailed discussion of this.

Figure 17
Pākehā for Tiriti Justice

Note. Photos of author during Tiriti justice protests. Own work.

The collective aspect of meeting with the critical research whānau as a group was hard to achieve. Due to geography, timeframes, people's availability, and COVID restrictions, we could not meet physically, and group online discussions were not the best way for people to participate. To overcome this, I met individually with people or had discussions over the phone. Pākehā culture is focused on individual responsibility, and this is reinforced within academia. Being accountable to a collective is not a common experience among Pākehā and my orientation was to ensure I involved the critical research whānau at all the core junctures of the research; however, it is possible that I could have involved them more. I wonder whether the tension I felt of 'not wanting to burden' the critical research whānau may have reflected my dominant cultural pattern to be self-reliant and independent and also retain control.

Whenever I did connect with any of the critical research whānau, the benefits to the research process were numerous. In addition to what has already been described in the methodology chapter, their contribution shaped this thesis in many significant ways: thinking through the relational citational praxis, Te Tiriti as a methodology, and the naming and depiction of the model Whiti Mai te Rā presented in Chapter Eight.

Conclusion

This chapter has provided an overview of the methods used throughout the study, building on the previous methodology chapter. The intention of providing a detailed account was twofold. Firstly, it was intended to provide a level of detail, particularly on the process of doing reflexive TA, that can guide other emerging researchers. Detailed accounts of how data analysis is undertaken are rare within published journal articles due to restricted word counts (Braun & Clarke, 2022a). Secondly, I wanted to enable the evaluation of the quality of the research by providing a transparent account of ethics and self-critical assessment. I hope this honest appraisal provides the clarity needed to enable a sound understanding of the processes used to produce the findings presented in the next chapter.

Chapter Seven: Findings

Introduction

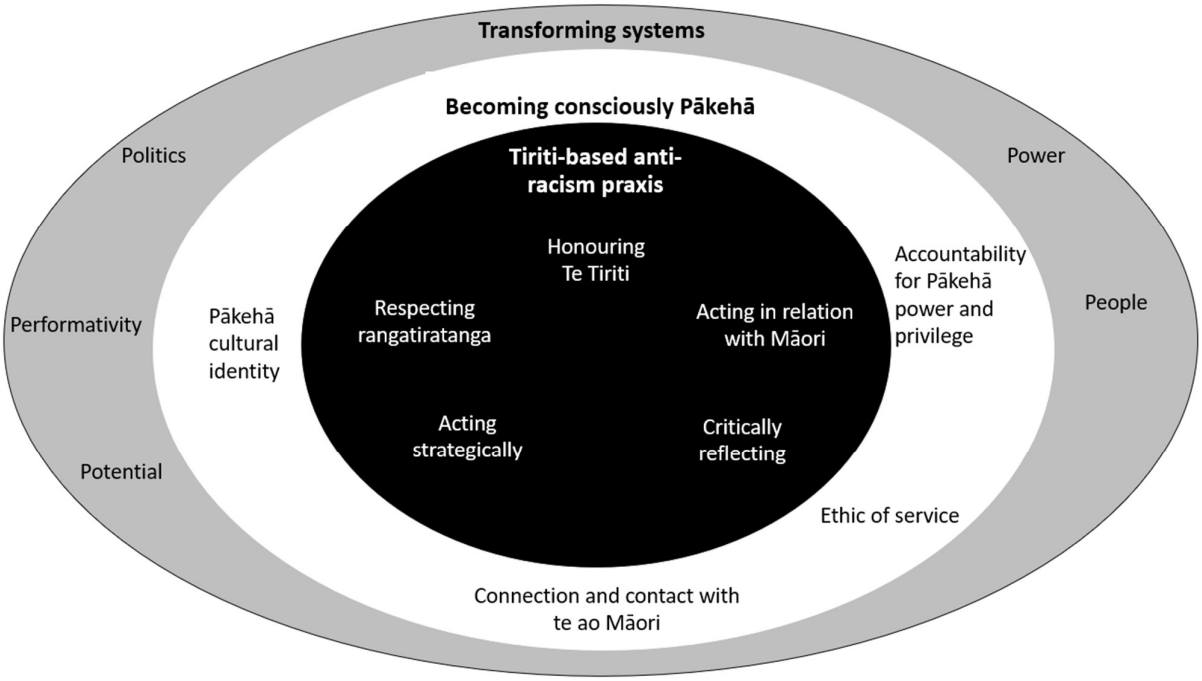
In mid-2022 the health system was restructured, 20 DHBs were disestablished, and their functions merged into a central agency, Te Whatu Ora (Health New Zealand). Te Aka Whai Ora (Māori Health Authority) was created, and a new Public Health Agency was established within Manatū Hauora (Ministry of Health) which retained its role as health system steward. These reforms were influenced by the recommendations from the Waitangi Tribunal (2019) kaupapa inquiry into primary health care, and the *Health and Disability System Review* (2020).

This study involved semi-structured interviews with seven participants held over three time periods during the health reforms, late 2021, mid-2022 and mid-2023. All participants were Pākehā working in the health system, identified and endorsed as allies by the critical research whānau advising this study. Interviews were analysed using an expanded reflexive TA framework (Braun & Clarke, 2022a) as previously outlined in Chapter Six.

Three themes were developed. The first is 'transforming systems', with the subthemes politics always impacts, power, performativity, people changing systems, and potential. The second theme is 'becoming consciously Pākehā' which includes four subthemes of Pākehā cultural identity, connection and contact with te ao Māori, accountability for Pākehā power and privilege, and ethic of service. The third theme is 'Tiriti-based anti-racism praxis', with subthemes of honouring Te Tiriti, respecting rangatiratanga, acting in relation with Māori, acting strategically and critically reflecting. Figure 18, below, shows the three themes and the subthemes within each.

This chapter highlights the voices of participants and quotes from the interviews are used liberally. After each of the quotes a pseudonym for the participant is given, after the name a number is written which corresponds to the first, second or third interview. For example (Jill, 3) explains that the quote is taken from the third interview with Jill. All the quotes used in this finding chapter have been reviewed by participants and approved for use. For ease of reading and comprehension, the quotes have been edited for grammar and fill-in words removed, e.g., 'you know'. The use of an ellipsis … indicates a section of text has been removed and a word enclosed in square brackets [ ] indicates this word has been added to the text; these edits have been done to aid comprehension and/or improve readability.

Figure 18
Themes and Subthemes



Transforming Systems

The first theme relates to the influences on health system change, the context in which the research into experiences of Pākehā Tiriti-based critical allyship was undertaken.

Politics Always Impacts

> *Politics always impacts and the higher up you are, the more impact it is. (Jill, 3)*

This subtheme describes how health system reform and health policy is ultimately a political choice by the government of the day. Questions about whether government is representative of all people in Aotearoa and whose interests are served by government are reflected in the following remark, when Robyn noted, *"At the end of the day, it is still a political decision by non-Māori about what this reform looks like" (Robyn, 2)*.

The following quote, from an interview in mid-2022, with the prospect of an election in 2023 looming, reveals the tension felt by those working in the system as they balance how much to advocate for a strong equity and Māori health focus whilst also considering the political fragility of Te Aka Whai Ora. This was within the context of a growing backlash by Pākehā New Zealand, fuelled by the opposition political parties, against 'special rights and privileges' for Māori. Here Jill described their involvement in the writing of the interim health plan:

> *The tension in watching the words come out and watching the way it's [health plan] framed and reframed. And, you know, middle New Zealand's got to accept this, and we've got to sell an equity story. … We've been having discussions about 'it's not enough' and 'they keep taking stuff out'. And there's also conversations back that go, 'but we just need the Māori Health Authority to survive [beyond] the first couple of years and maybe a change of government. And so, if you guys push us too far, we're not going to get to be successful because we're going to be disbanded'. (Jill, 2)*

In the quote above, Jill described actively advocating for a strong equity position whilst being aware of the potential pushback from further up in the system, fuelled by the political and racial climate. However, Colin described how some officials working in the health system "*will self-censor in an election year about what issues they raise and when" (Colin, 3)* even without political direction to do so, and in doing weaken stronger equity stances.

Ultimately, participants implied the political influence on health system reform is the most significant factor. The quote below comes from the end of 2021, in the first of the interviews, not long after the announcements from the Labour Government about the details in the reform. There is an acceptance that the reform focus on equity is contingent upon political support and this support is subject to the reaction of the voting public. The last sentence of the quote reflects David's assessment about the ubiquitous nature of racism within Aotearoa.

> *I think there's going to be nervousness. I think what I have liked, but it could reverse very quickly, is that the government, particularly Andrew Little, has been clear about equitable or lack of equitable outcomes and that equity needs to be quite central to this. That could be reversed when everyone starts going 'oh special treatment for Māori blah blah blah'. (David, 1)*

Participants also critically viewed how the reforms were being 'spun' by the politicians. The quote below is from the first interview, not long after the health reform agenda had been released. The reforms supposedly had the aim of improving health equity, but participants were sceptical this was a disguise for an agenda of efficiency and centralised control:

> *You can see that a lot of the work that they're [Labour Government] doing is about centralising, getting control, being more efficient, kind of saving money so I think those are the drivers and I think equity is just kind of like [a] convenient vehicle that they're using, if they were really driven by equity you'd see a different framing of the legislation. (Ben, 1)*

There was also scepticism in that it was felt there was little substance in the pro-equity agenda, with concerns that it was largely superficial rather than signifying a real change in the culture of how the health system operates:

> *To be honest, I think we'll get a culture shift towards equity as a buzzword and as a focus, but trying to get that real shift in terms of Māori leadership, prioritisation, worldview, being equally, even equally in the culture, in the culture of the health service. Yeah, I think that's going to be hard. (Robyn, 2)*

The impact of politics on health policy was evident within the rollout of the COVID-19 vaccination campaign when Cabinet overrode advice from officials regarding offering vaccination at younger ages to Māori and Pacific (Waitangi Tribunal, 2021a).

> *I was quite disappointed in the Ministry. I thought, hell, how outrageous, we've got all these very smart people telling us we should be doing these things and we're not doing these things, are we stupid? And then you realise that actually we were agreeing with that advice it's just that the politicians chose to, for quite obvious reasons, 'cause we're racist, chose to ignore that advice and then suffer the consequences and really not be too worried by that. (David, 1)*

The quote above exemplifies the reach of party politics on health policy and, ultimately, on the attainment of health equity. The politics of continuing to appeal to the majority voting public outweighs the impact on minority Indigenous and ethnic health inequities. It also reflects David's view about how obvious the racism is within our political system.

Colin also strongly criticised the erosion of the public service, the lack of technical skills and capacity within the system, and the contribution this makes to the ability of party politics to dominate. They said, "*From what I could see in the system is you had a critique of it, but you didn't actually have people inside the machine trying to fix it" (Colin, 1).*

This next quote comes from the last interview in mid-2023 when the Labour Government was down in the polls – the predictions made earlier about a political move away from pro-equity, anti-racism stances had occurred and were impacting on what could be said and written about by those within the system.

> *Andrew Little, when he had launched, announced the reforms, and talked about the system failing for Māori and he talked about racism, he used the R word [racism]. … We were allowed to use the R word for a little while, but we started using the R word in the*

draft of those six draft strategies, and it was very clearly being told to us that 'we don't want to see that R word'. (David, 3)

Power

I think the people who've got power and control and influence will try and consolidate that obviously. (Michelle, 1)

Participants were clear that questioning who holds power within the system and how that power is wielded, consolidated, weakened or strengthened was an important lens through which to view the health system change. Participants described how Pākehā leaders and organisations who already held power emerged from the reforms with more power. In the quote below, Ben reflected on the experience of the previous primary health care reforms, where already large and powerful IPAs adapted quickly to reform themselves, foretelling how this would be repeated in the current reforms:

GPs [General Practitioners] and the IPAs pivoted very quickly towards taking over the PHO [Primary Health Organisations] space, so you're gonna see GP organisations pivoting and trying to create themselves as localities and still retain control and power. I think it's really important to put a power lens over this, and how power is going to drive what you're actually going to see. (Ben, 1)

The lack of a power analysis within the reforms and the relationship to facilitating equity or entrenching inequities was well articulated in the following quote from the first interview when Colin was considering the proposed reforms:

Better organised providers delivering an inequitable service will mean that they will just deliver it more inequitably, we actually have to rethink about who the providers are, and the context of the communities who experience inequity, and then build your system. If you consolidate the power relationships of the existing provider network, you'll consolidate the inequities that they are so good at, they can provide those inequities more efficiently. (Colin, 1)

The quote above makes the point that communities in Aotearoa that experience inequity are largely Māori, Pacific and non-Māori in low socio-economic areas. System reform needs to meet the needs of these communities and, importantly, be reflected in the providers that service them. Participants were concerned about the reform focus on structural change, particularly the amalgamation of the 20 DHBs into Health New Zealand. Again, participants had

a strong power analysis, and this was seen as the reforms privileging certain parts of the health sector over others:

> *The rest of the reforms I'm quite disappointed about. They will intensify hospital dominance of this system and we'll watch that to the expense of prevention, primary and community care, that we've actually consolidated District Health Board power not challenged it in any way. (Colin, 2)*

Participants instead advocated for an approach to change that devolved power back to consumers of health services and communities, that was more bottom-up than the current top-down hierarchy:

> *We might see this with the commissioning functions, if this results in power, proper power including money being devolved very quickly and very locally then that would be cool, that would be a measure of success. If power stays centralised with Health New Zealand and everything is centrally kind of procured and one size has to fit all then I think we are screwed. (David, 1)*

Participants were clear that if a 'transformation' of the system was going to occur, then the people leading the system either needed to change, or what they were doing needed to change. Tania said, *"It's hard not to panic when they're just all the same people" (Tania, 1)*. The same people with power remained in power; indeed, the reforms themselves were written, designed and implemented by people who have been in the system for years.

Some participants credited Te Aka Whai Ora with facilitating a slight shift in power and a challenge to the monocultural Pākehā dominance within the health system:

> *I suppose it is that culture shift as well within the health sector that is sending a different message about assumptions and people being able to have unfettered Pākehā power. There is a little bit of a sense that people need to rethink. (Robyn, 2)*

Colin articulated how the power of the very idea of Te Aka Whai Ora, in representing a population, places an emphasis upon the system meeting the needs of a population. This is a direct challenge to where power is located within the system:

> *First of all, the most exciting thing is the Māori Health Authority. It's revolutionary. And in public health terms, it's a population … so in the demand supply side terminology, it's the demand side actually given a place at the table with a population able to represent their interests and as such it speaks to the heart of the problem of health systems, which*

> *are not, they're not people-centric. So, the Māori Health Authority in health system terms is a huge leap forward. If we can get it from idea to act[ion]. (Colin, 2)*

Some participants saw the reforms, with their stated intention of improving equity, contributing to a more permissive environment for implementing equitable change and for encouraging people to pursue equity initiatives. For example, David, described how *"everyone was saying the right thing … so we actually took that as permission"* to take an equity approach without *"having to justify" (David, 2)*.

However, participants were clear, despite the hope vested in Te Aka Whai Ora, that ultimately, its power was curtailed within the Crown system, and its existence dependent upon political support:

> *[The] Māori Health Authority is always going to be subservient to Cabinet decisions, so it might make a Te Tiriti-informed decision but [this is] easily overturned by the higher power or higher authority. (Ben, 1)*

The power analysis from participants was reflected in the following quote asking critical questions around who ultimately holds the power and how the reforms set up mechanisms that privilege the Crown position and control Māori remits:

> *I've been asking so who are the iwi partnership partnering with? Is that at what level? And then there's a letter of expectations that comes from the Crown down to regions. … I'm like 'where's the letter of expectations from iwi?' (Laughing.) It's just like it's not a matter of responding, [it's asking], 'what's different?' (Robyn, 1)*

Participants also identified issues of power in relation to funding. Who provides the funding and how much funding is provided reflects levels of power, control and priorities within the system.

> *None of those things can be independent if the Crown is funding it directly. And that's the problem. Māori Health Authority has been funded by the Crown. (Michelle, 1)*

> *The 40 million or whatever it is, which wasn't exactly an impressive amount that was for the Māori Health Authority to use as funding. (Robyn, 2)*

Performativity

> *We'll write your, you know, a business case that's got the [Tiriti] articles in it. And we'll write some things because it meets your requirements, but actually, you're not going to*

> *do anything that was different than you were before. So that's really the same thing. It's just dressed up prettier. (Jill, 2)*

This subtheme describes how the system 'performs' actions around implementing Te Tiriti, equity or anti-racism. The most common way participants identified this happening was in writing about Tiriti and equity commitments in strategic plans, or in forewords to documents. For example, *"the new immunisation strategy … it's got all that stuff about Te Tiriti and autonomy and rangatiratanga and all that. And then it's nothing different" (Michelle, 2)*. Often these remain only words on paper, they do not translate into meaningful action. The words are a performance or a show without tangible action.

Also, as David noted, *"they say the right things [but] they may not have backed that up with the budget" (David,1)*. Inadequate resourcing was recognised by the participants as a barrier to acting on words. Having legislation that is explicitly focused on improving equity through the Pae Ora Act does create a permissive environment to enact change (see the 'Power' subtheme, above); however, Tania used the term "*legislative performativity*" to describe how "*it's easy for people to write and say, 'as documented in the Pae Ora Act, we blah, blah, blah, blah" (Tania, 2)*, as if referencing legislation is all the action required. However, participants did acknowledge that the words on the paper are required as it is the starting point, and those words can be used to hold the system to account:

> *I worked at the Ministry when we were asked to take it [equity] out of the legislation. And out of every document, and that was soul destroying. So absolutely, we need it [equity] in there. But that's not where it starts and finishes. … We're always tinkering at that, you know, what does the Statement of Intent say? What does the Annual Plan say? What does the Health Needs Assessment say, we always stay at that level rather than okay, so it says that, so now what? (Tania, 1)*

Another aspect of this 'performativity' participants described is the tokenistic adoption of certain aspects of Māori culture within health but no other substantive structural changes occurring:

> *People are doing karakia in all the meetings, which is great. And I love karakia and I'm perfectly happy to have a karakia at the start of every meeting but doing that and not doing the genuine other work is so, it feels so, it's such a cognitive dissonance. I find it really difficult. (Jill, 2)*

It was also observed that despite the intention of the health reforms to put 'whānau at the centre' the Ministry was still doing what it always did – no real change had occurred:

> *We're still acting like we used to act. We're all you know that bureaucratic arrogance, we know better. We will try to consult, but we will do it badly. We won't really, we won't really reflect the aspirations of the community. And what and even if we try to be brave, it gets watered down by the boring policy people. (David, 3)*

The lack of 'performance' of implementing equity solutions was identified as getting worse as the reforms progressed. In the following quote in the last interview in mid-2023, about a year into implementing the health reforms, Robyn critiqued the $5 billion commissioning proposal, a significant contribution to the reformed system, for its lack of focus on Māori health equity and Tiriti responsibilities:

> *The commissioning proposal, the first nine pages were the kind of rationale for it, and the approach. So, there's no kind of treaty-driven aspect to it or prioritisation or explanation of how embedding Te Tiriti principles or even, you know, articles or anything is reflected in the document or the approach. The only mention really is of Te Aka Whai Ora as a partner. Without explaining that it's another Crown agency. There's the use of the word whānau here and there and equity here and there, but not given any prominence. There's no talk of prioritisation of Māori … there's nothing which reflects a treaty dynamic approach or even that that's important … then you get to the last part, the appendix of priorities for 2023 and 24 … and the word Māori isn't mentioned once. (Robyn, 3)*

It is worth noting that Robyn, along with a group of public health colleagues, worked together on a submission to critique the commissioning proposal. As alluded to in the quote above, participants articulated the risk of Te Aka Whai Ora being seen as solely responsible for Māori health and *"everyone saying, 'oh great, they're gonna look after Māori'" (Tania, 1)*. Participants also articulated the concern that "*mainstream then will shed responsibility. I mean, the Treaty is a partnership for God's sake, of which the Crown is a partner and has responsibilities which haven't gone anywhere for equity" (Colin, 1)*.

A further risk identified was if Te Aka Whai Ora was seen to be solely responsible for Māori health, then the next step would be to attribute blame to Te Aka Whai Ora for a lack of improvement on Māori health:

> *There are going to be those acute demands on waiting lists and in falling-down hospitals and all the other stuff that mean we just get stuck and then the stats for Māori aren't*

going to improve, and so on. And we'll blame the Māori Health Authority for that. (David, 2)

By mid-2023, when the last interviews took place, participants were concerned that equity initiatives that had previously been developed and implemented had been stopped or at the very least interrupted due to the reforms. The good work on equity that had been occurring was, despite the stated intention of the Pae Ora reforms, doing the opposite.

So local initiatives that we're focusing on, you know, an equity solution for a local thing have just been stopped. Everything has to be funnelled up to the centre. And there's kind of like blocks that are happening up there. So enormous inertia that's happening at the moment. (Ben, 3)

Participants' concerns about the lack of action on equity connected to their questioning the overall intent for the reforms. As noted in the 'Politics Always Impacts' subtheme, above, in the first interviews participants questioned whether the drive for the reforms was really focused on equity or was rather about increased efficiency and centralised control. By the third interview, participants had identified that the efficiency agenda had trumped the equity agenda. This was an issue forewarned in the 2022 , which said the newly created health entities are guided by 'Treaty' principles only "as far as reasonably practicable, having regard to all the circumstances, including any resource constraints".

You will get this tension between efficiency and equity, where the system will pursue efficiency without due regard to its impact on equity. … We should try and achieve equity as efficiently as we can. But you can't trade off, equity and efficiency. If you put efficiency first, then we know that addressing equity will cost more. (Colin, 3)

People Changing Systems

How can we change this giant frozen fossilized system? It has to be through people, people have to do things differently. (Jill, 1)

Participants identified the connection between the role people play in changing the system but also how difficult lasting system change is. The role of leadership in establishing values is "*really critical 'cause they will send signals down to help the kind of expected behaviours they're gonna want to see" (David,1)*.

Participants called for transformative leadership to address the pervasive racism in the system. This leadership needed to be remarkable and inclusive to reach everyone throughout the

system. However, as reflected in subtheme about power, above, this was seen as difficult to achieve when there was no real change in leadership between the existing and new structures:

> *There's not a whole new workforce, is unlikely to be a whole lot of new leaders … that's where it might fall down, that we know it's gonna take some very magical leaderships to drive everyone to change. Like if we know, and we do know, that the health system and health services are institutionally racist … you're gonna need a very awesome leader to turn that around and that's the bit that worries me. (David,1)*

Pākehā health system leadership was critiqued as being out of touch economically, culturally and demographically. This was contrasted with a view of Māori and Pacific leadership:

> *So the Māori and Pacific leaders that I work with, on the whole, with some exceptions, you know, they're not leading for them, for their salaries and for their egos. They're leading because they see outcomes for their people. And that's the difference. That's definitely not my experience of DHB leaders. (Tania, 1)*

Participants also called out the role large external consultants, largely ex-DHB leaders, played in driving a structural change rather than a cultural change. These consultants were viewed as maintaining and reinforcing the current culture within the system, not initiating a new one:

> *We all know that cultural reform is what's needed not structural reform and I'm not seeing, in the culture that's been demonstrated, is not a caring culture. (Colin, 3)*

In the last set of interviews, participants' hopes for a positive culture change to one where the workforce was valued and encouraged to contribute to the reforms had largely been dashed:

> *The sense of a culture where workforce is valued and where people are being brought on board and feeling they can see their part in the transition … unfortunately, that hasn't been managed well at all. And there's a sense of just a lot of grief, I think not just about people's jobs, but it's just demoralising I think when people want to contribute. (Robyn, 3)*

Jill, in their first interview, described the power of the system to resist change and to reset itself: *"It's really interesting I think to be in a system while watching the same system revert to its type all the time despite the people in its best effort not to do that" (Jill, 1)*. This relates to the 'Performativity' subtheme described above, that often the system does not change at all, the action becomes the words on the page, and that's where it stays.

Working out where one is in the system and what one can do to change was identified as important. Several participants described examples, either of their own experience, or of others in the health system, in which they had developed 'workarounds' where they acted deliberately to bypass policy. Although this may have been effective in the moment, it was acknowledged this was not sustainable because, as David said, *"If I left, then there's no guarantee that that [workaround] will continue. So that's why it needs to be built into the system" (David, 3)*.

Keeping change manageable meant, especially, helping people to understand that they are a part of the system and although they are not responsible for the whole system, they can do something within their influence:

> *Giving people tools ... was a really key thing but being able to frame the issues in a non-deficit, non-individual kind of way, as kind of we are part of a system, this is the bit of a system that we can control, it's important to know about this bit and it's important to know about this but this is our wheelhouse that we can actually do something about. (Jill, 1)*

Although Ben acknowledged the need for "*transformational change, we need a revolution*", he also articulated the importance of each person in contributing to change:

> *If everyone's trying to make incremental changes in their own little space as well, there'll be a bit of an impetus, there'll be greater change eventually. But if we all step back and say, "I can't, there's no point doing anything we're in this horrible situation", means an individual can make no change. Well, nothing will happen. Be complete inertia. (Ben, 3)*

The location of where one was in the system was also seen to contribute to how change could be enacted. Michelle thought the best place to make system changes was *"middle management ... so you're close enough to the ground, but you don't have to, if you're clever, you ignore the top" (Michelle, 3)*. This was conceptualised as an important space to occupy because such roles have significant operational influence but can be distanced from political influence. David described the power in being a public servant, *"because often they will have power over money or over policymaking processes or whatever" (David, 2)*.

Expecting people to manage transformational change during a pandemic, a workforce crisis, and a winter illness surge was raised by participants as a limiting factor in the reform effectiveness. For example, *"part of the problem for the health reforms is that it's going to be difficult in some places to have those conversations 'cause people just don't have the energy"*

(Michelle, 1). Taking account of these external forces and how they impacted on people within the system was seen as important.

Participants supported the notion of working with people to change from a place of empathy and learning, one asking "*How do we change it without blaming them? Or how do we lift people up?" (Ben, 2)*. Robyn noted how, for Pākehā health professionals in occupations based on being highly competent with technical skills or expertise, a challenge is admitting they've done something wrong or need to learn and develop a new skill:

> *When you make mistakes, that's that real sense of being surrounded by positive support. I think that's what helps people learn. So, I think we've got to create more opportunities for us all to be in those situations. Because I don't think confronting people when they're feeling humiliated, and they've made a mistake - most people will entrench. (Robyn, 2)*

Although there was general support for working alongside people to support change, David had a pragmatic response to people not changing that does not ignore the ongoing harm from racism or excuse the behaviour.

> *How do we system lead around diversity and inclusion? And it's like, well, we can be kind people. But where's the, where's the line? It's like, actually, you're still racist. So you're not welcome here anymore. (David, 3)*

Potential

This final theme notes the hope and potential seen in the health reforms from the first set of interviews in 2021 and the steady decline in potential for positive change by the third interview in mid-2023.

In the first interviews, when the detail of the reforms was known and implementation was being planned, there was a general sense of optimism about the potential that the reforms could achieve, particularly in the formation of Te Aka Whai Ora:

> *Well, one I think the Māori Health Authority is really significant. It's potentially significant … one, it recognises the Treaty, in a way that other, that the government has never done previously, so it's really leading in that respect. And secondly, it's come at the right time now, provided it gets sustained support. (Colin, 1)*

There was, however, as already noted in the subtheme about power, above, considerable critique about the centralisation agenda and the consolidation of power within the secondary health sector.

By the second interview in mid-2022, just after the start of the new system, the potential for Te Aka Whai Ora was still noted and hope remained that the changes envisioned would improve health outcomes:

> *I've got some hope. Certainly, you can say that the establishment of a Māori Health Authority is a step in the right direction. We can critique that and say that it's not independent of the Crown or an extension of the Crown and that's a fundamental flaw when you have a look at Te Tiriti. Yes, but it's better than what we've got currently. So therefore, if it is better, it will deliver better health outcomes. (Ben, 2)*

By the third and final interview, in mid-2023, there was still a degree of optimism that more time was needed to see potential change:

> *It'll be interesting to see in another year where things are up to ... because they will have got over their structural stuff. Hopefully. I mean, there'll be people, permanent people in positions. I mean, that has pros and cons, right? Because it could be terrible permanent people, but it means that they have a chance to get on and try and actually work on the cultural change and the content. I don't have great hope we're going to have much more equity and access to hospital services and outcomes ... that's not going to happen in a year. But maybe there'll be some really good commissioning or some changes. (Michelle, 3)*

However, the hope for substantial positive change had largely been dashed:

> *But really, when you look at the overall investment, given the promise on the aspirations and the expectations, these things are relatively minor. And the kind of more fundamental changes that we're hoping for, we're still hoping for. (Robyn,3)*

The hopefulness of participants and the potential for positive health gains from the reforms gradually waned throughout the study period. Although not all hope was lost there was an overarching feeling that the reforms had largely failed to achieve the ambitious agenda.

Transforming Systems Summary

In summary, this theme describes key influences on health system reform. There is the undeniable impact of party politics, which determines what can be achieved within the remit of political acceptability. Another subtheme is the understanding of who holds and controls power and how this is reflected in the reforms and the resulting lack of impact on achieving equity. There is also the critique of performativity prevalent within the system which gives the illusion of substance and action. The fourth subtheme is the interaction between systems and people and

the requirement for both to change; and finally there is the hope in the potential of the reforms to make lasting changes to reflect Te Tiriti and improve Māori health outcomes.

Becoming Consciously Pākehā

> *You've got to know who you are, who your family is, and how you are who you are. (Ben, 2)*

The theme of 'becoming consciously Pākehā' is about how participants became aware of who they were and how, due to racism and colonisation, they were in positions of privilege and power within the health system and Aotearoa society. In the first interview Tania described feeling welcomed into Māori spaces but was aware of having to 'kia tūpato' (be cautious) and then receiving *"really lovely feedback about my kind of āhua in that space which is also really affirming"*. To be consciously Pākehā is to not take any aspect of being Pākehā, or being an ally, for granted but to be constantly reflecting, checking, evaluating and shifting as required. In the quote below, Jill described the need to think carefully about how they did this work and being aware of how Pākehā are 'positioned' in society.

> *Working in Māori spaces as a Pākehā to be really conscious all the time that how you do that in a respectful way, how you do that in a walking our partnership talk actual way and how you, how you're trying to avoid some of the pitfalls of performativity and taking up space that you don't need to in making decisions. And unlearning a history of bias and professional bias and kind of social bias and so positionality I guess the concept that helps be conscious about that. (Jill, 1)*

Being aware of our own racism as Pākehā is an important part of becoming consciously Pākehā. Participants were asked whether there was an 'aha moment' when they became aware of Tiriti justice and anti-racism issues. Ben shared an "epiphany" where he became aware of his own racism. He had started to notice the racism operating within the general practice clinic where he worked which led to him conducting an audit on his prescribing practices:

> *My audit demonstrated that my prescribing to Māori was less as a percentage than to non-Māori and that was really my epiphany, I guess. I term it an epiphany rather than an aha moment of 'what made me do that?' I hadn't considered myself to be racist although I acknowledge that there were times in my life in which there was racism that was operating at an overt level. I really started to think when I was with a Māori patient about*

> *what my thought processes were … made me really start to question myself at that point. (Ben, 1)*

In the following quote David shared how learning about Te Tiriti, local history and colonisation was the beginning of his consciousness raising:

> *I think the aha moment in sixth form when [I] learnt more around Parihaka and the peaceful resistance and the land. The fact that Waitara kind of kicked off the land wars. … So I think fundamentally it was always about fairness you know, so the union movement was about fairness and so I think once I learnt more about what Te Tiriti was all about, the terms of the different translations of the Treaty and what that meant in reality, what Māori thought and what the colonisers thought, and the fact that up the road in Waitara, which was also a very poor part of Taranaki, so you start putting two and two together, and you think, 'oh yeah maybe the situation we're in today it has something to do with what happened a little while ago'. (David, 1)*

One person described their growing awareness as "*a slow dawning*" (Colin, 1) while another said there wasn't *"really an aha moment. It's just kind of a slowly, I don't know like a blanket wrapped around you I guess" (Tania, 1).* Jill talked about a series of 'aha moments' and it being an "*ongoing journey of development and learning from other people when trying to consciously reflect on a whole lot of things" (Jill, 1)*. Thinking deeply about or reflecting on history and the Pākehā relationship with Māori were important to the development of becoming consciously Pākehā.

Although initially dismissing the idea of an 'aha moment', Robyn reflected on their first experience visiting a marae during a university course:

> *So we went out there for a noho marae to learn about tikanga and get an exposure to things Māori … so that was my aha moment I think, a classic thing of being Pākehā, feeling very nervous and just being hosted in such a beautiful way and then just having things explained and just starting to get a glimpse of that whole te ao Māori world … it was a transformational moment … to feel extremely comfortable and not be constantly feeling like you're doing something wrong or anxious and to actually be able to open up a bit and learn. (Robyn,1)*

There are four subthemes that all contribute to becoming consciously Pākehā: the development of Pākehā cultural identity; connection and contact with te ao Māori; an accountability for

Pākehā power and privilege which acknowledges ongoing colonisation and racism; and working with an ethic of service.

Pākehā Cultural Identity

> *It was a very Pākehā upbringing*. (Colin,1)

Participants were clear about their identity as Pākehā, naming this for themselves, acknowledging their 'growing up' as Pākehā, and their Pākehā worldview. Often, throughout the interviews, participants would call out an element of Pākehā culture or name a behaviour as being a particular Pākehā characteristic. Participants were aware of their family history, and many were raised with a strong sense of fairness, and an awareness and distrust of hierarchy. Holding strong values of social justice and fairness was common across all participants. For example, Jill described her core values: *"to know that it makes a difference in terms of equity whether it's access or outcomes … that's kind of my deepest value and that's both from a social justice fairness perspective but also from a Māori health Te Tiriti perspective" (Jill, 1)*. The courage to act based on their values was also evident, as Tania said, *"I'll stand alone if I feel like there's an injustice."*

Many participants were involved alongside their families in the anti-apartheid movement. The church and the trade union movement were influential for some participants' families, which was credited as the basis for their interest in pursuing social justice. For example, David commented, *"I think if you're born into a union household, you're probably gonna be a lefty unless something odd happens to you along the way" (David, 1)*.

For some, being able to perceive Pākehā culture as unique came about through travelling overseas and exposure to other cultures:

> *I think what was helpful for me was leaving the country and working in other cultures … the problem you have as the dominant culture is you can't see it. You know, it's invisible, even if you can intellectually see it … so I think it was helpful for me to see that my baggage was actually a culture. (Colin, 2)*

For all participants there was a strong belief in and respect for the rangatiratanga of Māori over Aotearoa and with that embracing of rangatiratanga and belief in Te Tiriti, there was a place for Pākehā to belong. For example, Robyn said *"it's the fundamental recognition of the rangatiratanga of Māori, in New Zealand, so I regard myself as manuhiri. And so, under Te Tiriti, because of that arrangement, have the sense of belonging here" (Robyn, 2)*. The importance of

Te Tiriti and pragmatically working to honour and implement Te Tiriti was important for participants:

> *I just see these things as complex and some things are straightforward. And the Treaty is one of those things, it's very, it's in black and white, as far as I can see. And so therefore, we've got to deal with, how to make that happen. (Colin, 1)*

There was a resounding reticence among participants about identifying as an ally. Participants were ambivalent about the identity of ally, many saying this is an identity they would not claim for themselves. They were hesitant to be seen as special or extraordinary, acting against racism or to progress health equity was seen as doing your job, something everyone should do. David explained, *"This shouldn't be something that we need to name. This should just be the way that we all are, clearly, we're a long way from that" (David, 3).* However, they were pleased to be seen as an ally to the extent that they were approached to take part in this project.

> *Yeah, but I wouldn't because I wouldn't feel like it's my place. I can't describe myself as an ally unless Māori feel like I'm an ally. So that's why that makes me really happy. Because I guess that would be my career goal. (Tania, 1)*

Participants recognised the fragility of being seen as an ally, and the need to constantly be reflecting and working on how best to do this work. This awareness of the fragility of relationships was founded on understanding how the impact of colonisation and prevalent racism, resulting in Pākehā power and privilege, can make it difficult for Māori to trust Pākehā:

> *So, I'm assuming that whenever I go into any environment like this [predominantly Māori or Pacific spaces], which I do, most of the time, I'm assuming that I'm not, that I'm not trustworthy. Or that I'm gonna earn, that I really have to earn that trust and that that's not going to happen overnight. And I have to keep working, working, working at it, which is why I say great that I'm an ally, but that's fragile. And if I was Māori, I'd still be quite cautious about stating people as being allies. (Tania, 1)*

The hesitance to be named as an ally was explained by Jill as connected to the critique of 'performative allyship' that has come out of the white responses to Black Lives Matter in North America. The quote below also emphasises the importance of Māori thinking of you as an ally, an understanding that it's a term that can be bestowed but not claimed:

> *I think the term ally is a North American, kind of badge to ... it's a kind of look at me, it's a virtue signal. And so, it's that aspect I don't like because I don't think that's useful. It's centring whiteness, I think. So, I think that's the bit I don't like about it. You know, it's okay*

> *if other people bestow it, it's like greenstone, you don't give it to yourself … it's the gifting that indicates relationship and trust and depth and longevity. (Jill, 3)*

The other important component conveyed above is the idea that claiming an ally identity is virtue signalling and centring whiteness. This relates to another part of the unique Pākehā identity that participants conveyed – the importance of being culturally humble. Participants described being aware of the dominance of Pākehā culture and the power that comes with that, and therefore the need to 'tread lightly':

> *You've always gotta be checking, checking your power I guess, and so yes, it's nice to be identified as an ally, I like that, but yeah one still has to tread very carefully then, what do you do in that space. (David, 1)*

Another aspect of being culturally humble identified by participants requires recognising that our worldview isn't the only way to work and being open to change. Acknowledging the depth of difference between Pākehā culture and te ao Māori was also important:

> *[The Māori] worldview is not something you can learn. You need to know about as much as you can, but you're forever being humbled by your ignorance of it. Yeah, that would be my advice. Be prepared to be humbled. (Colin, 3)*

Connection and Contact with Te Ao Māori

Becoming conscious of who participants were as Pākehā was developed and supported through connection and contact with te ao Māori. All participants had developed significant relationships with Māori over their lifetimes, despite many saying in their early years there was little contact with Māori. Particularly meaningful were "precious" (Colin, 1) relationships with kaumātua and the guidance they provided. There was a clear articulation of following Māori leadership, checking in. This relationality with Māori was shaped by recognition of Māori rangatiratanga over Aotearoa and a belief in Te Tiriti as a meaningful and relevant document for our nation, along with a desire to work to honour Te Tiriti:

> *Well, I think in my working with Māori, it's the relationships with kaumātua. They've been my pou in the ground if you like, when things really got complicated and tough, to go back to them and saying 'Is this what you [think]?' So, I mean, part of that is recognising them and continuing to [consider] what it means to work with them and recognise the legitimacy of their aspirations but also referring back to them. (Colin, 1)*

Relationships of trust with Māori colleagues and mentors were highly valued by participants in allowing them to have honest and challenging, yet safe, conversations. Relationships were developed over time and through working together:

> *I know that she'd be honest with me you know, at an emotional level she would, she knows me well enough to know when I'm running some failure narrative for some other reason or getting something wrong which actually I need to be told about [laughs] so having someone who you feel emotionally comfortable with but who will also be honest and challenging. (Robyn, 1)*

Participants learning from Māori included recognising diverse Māori realities, the diversity of Māori thought, perspectives, and cultural connectedness. Participant connection and engagement with Māori was deep and layered rather than singular and isolated. This recognition of multiple Māori perspectives required Pākehā accountability to the individual or Māori collective grouping they were working with:

> *So it doesn't matter what you do, there will always be many views on that. And that's totally legitimate. And some people will like it, some people hate it. And some people will say, that's well done. And some people will say, I shouldn't have done it that way. So, I mean, at some level, I always have to accept that that's going to be the case. And it's really making sure that the people that matter for the thing that I'm doing or for the programme, are comfortable with what's been done or that we fix it. (Jill, 3)*

At times during the interviews, participants would directly refer to Māori academics who had made significant contributions to their thinking. Seeking out and learning from Māori academics was also discussed by participants as a deliberate tool to engage with Māori thought and perspective:

> *I've had great mentors, I've worked with [names several Māori academics] people like that … the people up here [Tai Tokerau] as well have taught me a lot and also everybody's different and everybody's got different points of view and that's fine, right. It's not that there's a line on this. (Michelle, 1)*

Accountability for Pākehā Power and Privilege

> *You have to get better at your own understanding of your own privilege. And what that actually means and how you communicate that to fellow Pākehā. (Jill, 2)*

Becoming consciously Pākehā requires doing work on ourselves first, to realise how the colonisation of Aotearoa and structural racism positions Pākehā with power and privilege. Once we are conscious of how we are positioned, we can then become accountable. Ben advocated for understanding deeply who they are as Pākehā, where they have come from and what that means for how they function in the world:

> *You've got to know who you are, who your family is, and how you are who you are because of, transfer of money and power that's come down through the generations. So that's where I start off. And then I talk about kind of understanding the privileges that you have. And it's not just privileges relating to wealth, but privileges that relate to, not being discriminated against, because you're white. (Ben, 2)*

Participants were clear about the impact of colonisation and the existence of racism within society generally and *"the institutional racism which is racism that's kind of built into the system" (David, 2)*. Being able to identify, and help others to see, the racism in the system and "*how systems of oppression play out within the systems" (Jill, 2)* was important.

Participants also recognised how they were direct beneficiaries of this privilege and accompanying power. Ben described a particular event that prompted this recognition: "*I became more and more aware I guess that the way in which our medical centre was structured was that it was a pretty racist toxic environment" (Ben, 1).* As a part of this process, participants also acknowledged their own racism: "*I'm sure I don't spot it all the time and I'm sure I'm guilty of it myself" (Michelle, 2)*.

Participants articulated a clear understanding of power, power dynamics and the power that they have as Pākehā within the health system. Being aware of that power is the first step, the second is to consider what can be done with that power – including, importantly, how to let power go:

> *Because all of this is about power, and you have to understand when you're in a position of power. ... So, I am in a position of power and so you have to figure out what position you hold, what are you able to do with that power, and ideally how much of that power can you let go. (David,1)*

Accompanying this acknowledgement of power was awareness of the privilege this conveyed and, importantly, the accountability to use this privilege and the power to act:

> *I'm not afraid to speak my mind if it's necessary, I mean I've got nothing to lose, I'm very fortunate and that's the thing about privilege, oh I will say what I think and I mean, I try*

> *not to be hurtful or too blunt but when it comes to the crunch I'd rather say what I think, if I think it's wrong then, you know, 'cause you know, so what? I can work anywhere, I don't have to be a*** licking some boss or something I mean, it's the other side of privilege isn't it? So I do have that freedom. (Robyn, 1)*

Furthermore, participants acknowledged that their Pākehā privilege and advantaged positioning means involvement in anti-racism work is not a necessity; it allows them a choice to step away from anti-racism work and therefore it requires an active choice to engage, to be accountable. As the quote below describes well, Pākehā privilege means also not having to live with racism:

> *I reflect on a conversation, one of my senior Māori colleagues had with one of the senior leaders, Pākehā leaders, who was trying to do stuff, and she got to the point where she was overwhelmed. And she said, "Oh, it's so hard. It's so hard. As Pākehā you just get shot down, you put your head up above the parapet" ... and I remember, the visceral response that my Māori colleague had to that. Absolutely visceral response, this kind of claiming of feeling overwhelmed from a Pākehā perspective when the thing that you're dealing with is racism, and so I reflect on that quite often, and think it doesn't matter how tired I am, it's not the same kind of tired as living with racism. (Jill, 2)*

Being accountable for Pākehā power and privilege also extended to working with other Pākehā to encourage them to reflect on and consider their power and privilege and that this is the first step on an anti-racism journey.

> *It is for us to stand up ... that is certainly my role as well is to, in the background, to really try and give the person the context that it actually isn't about them ... and to give them the context of either digging in and feeling angry about it, because of the way it played out, or leaning in and learning and getting some partnership and getting on with the job in a different way. And so that's certainly the role that I have as a colleague, and I would hope someone would do the same for me. (Robyn, 2)*

Having a good understanding of how Pākehā are privileged in Aotearoa and then working with other Pākehā to understand the work they must do on themselves without burdening Māori was also important.

> *I often have Pākehā coming to me and saying, 'Well, how do I do this?' And I always start, don't start with anybody else, start with yourself. You've got to work all these things out yourself. So, nobody else is your external hard drive. (Jill, 1)*

Ethic of Service

> *I think I'm fulfilled by, by being of service, you know, actually doing something for, for people. (Ben, 2)*
>
> *And also like, it's not about me, it's not about me. Yeah. This is not about me at all. It's like, how can I support? But it's not about me.* (*Michelle, 1*)

'It's not about me' or words of similar intent were common across most interviews. Participants were adamant that they were not doing this work for themselves, they were doing it to contribute, to make a difference, to 'serve' a broader goal, to work towards anti-racism, improving Māori health and improving equity.

Several participants had experiences of working within Māori health teams or within Māori health organisations. In these roles, participants described the requirement to be clear about their role in relation to taking guidance from Māori leadership. The roles were to be of service in contributing useful skills that could be used to pursue Māori health outcomes.

> *What they were seeking was specific expertise to bring into a Māori space so it wasn't to try and be Māori … it was about we want your expertise to come and serve our purpose and it was about developing a level of comfort to do that and to say that's not my decision-making but it is my skills that can inform that decision. (Jill, 1)*

The quote below illuminates some limitations for Pākehā who choose to work within Māori-led teams. There is still agency and active contribution but there are also limits on leadership and decision-making.

> *I was just thinking it was a bit like when I was working in [place of work] and after I left the person that was employed, another Pākehā person, had a lot of conflict with some of the people in the department and it didn't go well. And she rang me, and other people in the department rang me to say, 'What's going on? Why, how come you could work with us, and she can't?' and 'Why can't I work with them when you could?' And the only analogy I could think of to say to her was, imagine you're a man going into a women's studies department. You couldn't be the director of research, because that's what she wanted to be, you've got to realise that you're not Māori and you're not going to be a Māori researcher. So, you've got to figure out why are you there? I mean, if you want to be the boss of research, you'd probably need to go somewhere else. …. And you can still ask questions, challenge people, and you could still say, why do you think we should do*

> *that? But yeah, you're not running the show. And if you want to run the show, go and do it somewhere else. (Michelle, 1)*

Due to the iterative nature of the interviews, initial themes developed from the first interview were discussed with participants in the following interviews. The conversation with Michelle about working for a Māori health organisation was discussed further in interview two. I started by asking what lessons or advice she would give to other Pākehā working within a Māori health team. The initial response was *"I think I'm maybe being too careful"* and Michelle went on to explain that in her immediately prior role she was the *"boss"* but in her current role *"I don't see myself in a leadership role, which, perhaps, is personally less self-satisfying, because I feel like I'm not offering everything that I could offer, to be honest."* Michelle also went on to explain that "*I feel a wee bit like I'm on eggshells some of the time, not mostly."* But as a Pākehā working within Māori spaces, her way of doing things *"might be too much in a straight line or in the wrong direction."* This sentiment reinforces the theme of 'becoming consciously Pākehā' where participants identified the need to be culturally humble, and *"tread lightly"*, being aware of the potential for Pākehā to create a dominating presence.

In her second interview, Jill reflected on the idea of working in service and how our positioning as Pākehā 'steeped in racism' requires us always to question whether we are doing the work for the right reasons and to avoid the trap of the 'saviour':

> *I think the being of service thing, it's a bit, it comes out of the allyship hesitation, I think because the allyship, white saviour kind of narrative, which is very kind of North American, it's an intentional avoidance of that. I think that well, it is for me, personally, and certainly some of my colleagues as well, it's trying to kind of consciously say, am I in this space for the right reason? What are my intentions of being here? Have I been asked to be here? If I stepped into a space that other people could be in much more usefully than me, you know, that kind of thing. It's that kind of, it's an intentional avoidance of the white saviour thing. It's because you're steeped in racism, from society, that's a big trope that is part of that learned, you know, shortcut heuristic shortcut kind of thing. So, you have to consciously yeah, not do that. (Jill, 2)*

Ben explained the difference between the concept of being a 'white saviour' and the idea of an 'ethic of service' as, *"so the white saviour is this ego driven, and in service, you're addressing, you're acknowledging your ego, and trying to mitigate against that kind of stuff" (Ben, 2)*.

In the quote below, Tania talked about keeping her pride in check when working 'with and for' and the need for reflexivity:

> *I'm not gonna stick my oar in unless I'm invited, and I guess I just feel privileged to be invited reasonably regularly. But that comes from those trusted relationships. But it's fragile. And it's certainly not something I'd take for granted. And you definitely do have to do a lot of swallowing of your pride, well it's not really swallowing your pride, but you do have to do a lot of reflective thinking when you're either not invited or you are invited and then it doesn't kind of go the way you had in your head. And I'm not the kind of person that likes to be leading and in the limelight. So, I guess that my whole career has been built on that, working with and for. And then every now and then I get grumpy because you know I feel undervalued but well, it's a small price to pay [laughs]. (Tania, 2)*

This subtheme builds on and connects to the theme of 'becoming consciously Pākehā' which is based on being aware of who and how we are and then working out where it is best to contribute.

> *Am I more use to change and to things progressing for Māori within a Māori organisation? Or in a Pakeha organisation? … One way of doing things differently in [region] could be to go back into a Pākehā public health [team] and try and do something different. (Michelle, 2)*

Another connection with the theme 'becoming consciously Pākehā' was the participants' reticence about claiming an ally identity, remaining humble, and not actively promoting themselves or the work they do as being anything special. This humility about their work is also a contribution to an 'ethic of service'. Participants gave examples of actions where they deliberately stayed in the background, for example ensuring their names were removed from grant applications or research proposals they had been involved in writing.

Jill grappled with accepting a leadership role that was specifically focused on Māori health. Here she describes the various considerations of working out where best to be, acknowledging that ideally that role would be led by Māori but also considering the responsibility of the health system to address Māori health inequity, and the high workload of the small team of Māori health professionals:

> *I'm trying to see this role was about a Crown agency, this role is about 'mainstream' services, doing better, doing things differently, prioritising different activities than it would if it was left to its own devices … and, you know, a lot of my Māori colleagues say,*

> *"We would love to do it, but we're already doing 1000 other things, and can you just do that one thing? Because then I don't have to do it." So, there's a bit of that kind of stuff as well. And it's how to know when is it better not to? And when is it better to? Yeah, I don't know, [if] there's any right answers for that. And I can only go with people trust me enough to tell me if they think it's wrong. And, and I'm not sure that that's foolproof either, of course, given the power issues, but yeah, I'm trying to consciously reflect on it. (Jill, 3)*

The quote above highlights the potential for uncertainty around what is the best action to take *"if there's any right answers for that"*, and ultimately going with trust in the relationships developed and being prepared to be told when one has got it wrong. Being conscious about being Pākehā also requires reflecting on the power dynamics within relationships and the constant need for reflecting on actions.

Tiriti-based Anti-racism Praxis

> *My happy place is action and that's why I really like anti-racism work because it requires action. It's not a passive thing, you've gotta find racism and you've gotta find how it operates and how it works and you've gotta do something about it. (Jill, 1)*

Unsurprisingly, there was a focus on action when discussing anti-racism. However anti-racist action requires Pākehā critical allies in the health system to be 'consciously Pākehā' – that is, action comes with reflection on who Pākehā are, how Pākehā are positioned, how Pākehā benefit from the current system, and the need to act or else be complicit with the racism.

The influence of a conscious Pākehā identity that informs anti-racism action is identifiable in the quote below. Firstly, there is a recognition of the privileged position, an expectation that you will be listened to, an acknowledgement of the racism Māori face, and therefore a responsibility to act:

> *We, as Pākehā, if we're in a leadership space, we can say things that may get listened to more than our Māori colleagues, who [are then described by others as] 'Oh, there she goes again, you know, bitching and moaning'. And that's just horrible. That's a whole racist thing as it is. But I think that's our, I think that's our responsibility, and to point out the failings. (Tania, 1)*

Honouring Te Tiriti

> *I suppose I have one favourite and that's Te Tiriti. (Robyn, 3)*

Tiriti-based anti-racism praxis is focused on honouring and implementing Te Tiriti. Participants recognised the inherent mana motuhake and tino rangatiratanga of Māori, understood what Te Tiriti says, how Māori understand Te Tiriti, and were guided by the articles of the Māori text to apply Te Tiriti in practice.

> *I think about those things in an articles way because most of the work that I do is in an Article Three way and that some of those programmes, we absolutely make sure we think about Article One, Article Two, because either we've done it beforehand and it's been prioritised because then people have said get on with it, or it's making sure that we've got leadership making the right decisions, or the Te Aka Whai Ora connection in terms of iwi Māori partnership boards. (Jill, 3)*

Participants considered who is designing the intervention, who is involved in governance and decision-making, what the outcomes are and how these are being monitored. Their goal was to make a difference for Māori health outcomes.

> *Ōritetanga is basically my whole philosophy. It's why I work in Māori and Pacific spaces. So that's the actions for me, there are the kind of evidence-based practice, which is where the whole disinvestment conversation comes into [consideration] and I guess this is Article One and Two as well, you need to be able to monitor the Crown, to report on achievements towards the articles. And if we don't collect and understand the data that we're using, then we can't get to Article Three. (Tania, 2)*

Participants described how a Tiriti-honouring approach requires more than advocating for Māori health outcomes, it also requires being clear about the difference between Te Tiriti and equity. They are not the same thing.

> *I've been arguing that the Treaty issues and the equity issues need to be dealt with separately. I mean, the Treaty issues, of course, have equity within them. But they're not symmetrical. So in a lot of the early reform stuff, they were conflated, as though they, there was only one thing, and they're actually two things with a big overlap. (Colin, 1)*

Participants explained that equity of health outcomes for Māori is a Tiriti issue, but it is not the only Tiriti response required of the health system. In the quote below, Tania described how a Tiriti approach requires a recognition of mana motuhake and rangatiratanga and how these can be honoured. Participants were clear about this difference, not conflating the issues and, importantly, working to support rangatiratanga.

> *Equity versus Te Tiriti? That's fascinating, and I just don't, I mean, I think that we've come a long way … we moved from the three P's and, but we've still got such a long way to go. And it's so much more palatable in public spaces to be talking about equity, than to be talking about Te Tiriti. So, you might say those words, but that doesn't necessarily mean [anything happens] and there's no tino rangatiratanga, there's no mana motuhake in the processes that the Crown is engaging, there's no real, even co-governance. (Tania, 1)*

The quote above highlights again the importance of language and how the standard story of acceptable public discourse frames the issues and subsequently the focus. Keeping a focus on equity of health outcomes for Māori was seen as a right guaranteed within Te Tiriti. Health equity for everyone in Aotearoa is also important as part of the broader social justice agenda. For Māori these rights are cumulative rather than either/or. So, equity for Māori is a Tiriti right and a social justice right. This is explained below:

> *The fundamental recognition of the rangatiratanga of Māori in New Zealand … is the overriding Treaty clause. Equity is something which, with Article Three, we need to focus on as well, with these health reforms, because that's another right for Māori. And then there's another social justice right for everybody, and to also have equitable health outcomes, but that's part of a broader social justice agenda. (Robyn, 2)*

Participants identified a role in taking responsibility to be the one at the table who raises the Tiriti issues – in other words, this means being a champion for Te Tiriti:

> *And then there's the whole issue of your responsibility as a tangata Tiriti to intervene or to support the whole process where everyone's looking to Māori to explain the Treaty … and with others to take responsibility for understanding or learning and responding as Pākehā, because people still do look to Māori staff, Māori leadership to be taking responsibility for showing what needs to happen or critiquing things. (Robyn, 3)*

Respecting Rangatiratanga

Respecting the rangatiratanga of Māori requires acting within a strategic Māori agenda, understanding Māori health priorities, and working to address health inequities.

> *You can't go off and do your own thing, you have to be guided, and you have to ask advice as well. I think that's critical, you know, kind of like, hey, where can I put my energy? Do you think, you know, talking to your leaders? You know, should I be involved in this? Do you want me to be involved in this? What should I be saying? I think this, is that right? So seeking guidance and direction. (Ben, 2)*

The focus on action, *"filling the gaps, doing the work"* was described as an important role, particularly to support Māori leadership *"to do what they need to do … it's easy to get caught up in the theory, [there's] actually a lot of work to do" (Robyn, 2)*.

Supporting Māori leadership is reciprocal, and being supported by Māori leadership in turn brings benefits, comfort and surety that what you are doing is right.

> *Because you know that you're not going out on a limb. Well, you might be going out on a limb in that particular group or meeting you're in, but you've got people, you've got people behind you. So you know that what you're advocating for is something that's been discussed you, you've got backing of people. (Ben, 2)*

Respect for rangatiratanga means knowing how, within the role you have, you can support Māori leadership. This might mean *"knowing when to step up and when to step back" (Robyn, 2)* or knowing *"when to step aside and get out of the way and when actually you need to hold the space because that's what you've been asked to do" (Jill, 1)*. In the following 'stepping up' example, Jill used her access to high-level decision-making to insist upon Māori participation in a discussion about planning the COVID response.

> *They've got a couple of chief executives in the room and the incident controller and I'm asking 'Why do we not have our Māori leaders here? Also our Pacific leaders?' And they say 'Oh no it's just a small conversation', and it was interesting because the Māori health lead later said to me, 'You were the only person who said that we needed to be there and if you hadn't said that we wouldn't have been there.' (Jill, 1)*

An example Robyn gave of stepping back connects with and reinforces the subtheme about an 'ethic of service' within the realm of rangatiratanga.

> *I think the elements of it in my mind are supporting rangatiratanga, and sort of mana motuhake in different settings, which might mean standing back from or taking the opportunity to support Māori leadership. Sometimes it's recognising spaces where there is Māori leadership, and there's no need for you to be, and just really affirming and respecting those spaces. It goes right from sort of structural iwi-based kind of leadership and understanding that and the diversity of approaches and all that sort of thing. And trying to navigate where you should be and where you're useful, and where you are implementing those aspirations, and then other places where you could be redirecting resource that you're using. (Robyn, 3)*

This was echoed by Michelle who advised *"standing aside and letting iwi Māori occupy the space themselves" (Michelle, 3).* Several participants talked about the importance of being invited to work in Māori spaces and to follow direction from Māori leadership:

> *The thing I've learnt personally, from the iwi Māori partnership board stuff, is that even if you've got things you think you can offer, you need to be invited in. And, yeah, they need to create the space they want. (Michelle, 3)*

Acting in Relation with Māori

This subtheme of 'acting in relation with Māori' builds on the combination of the theme 'becoming consciously Pākehā' and the subtheme 'ethic of service' described above. Acting in relationship with Māori requires Pākehā to be clear about their purpose, intention and motivation for doing the work and then acting with an 'ethic of service' in relation with Māori. To take action in relationship with Māori, then, you firstly need to know who you are in relationship with. Colin asked, *"What are those key relationships? Because you can't actually operate safely without them, or effectively. You have to be an ally to something or someone, [you] can't just be an ally for yourself" (Colin, 1).*

The relationships need to be safe, trusting and long lasting. As the quote below emphasises, this is work for the long haul.

> *So you need really deep genuine relationships with people, with organisations across community to have enough trust to do that, you have to earn it, you have to demonstrate it, you have to show people you've done it. And that takes a long time and a commitment to be there for the duration, you can't come in and out to do that. (Jill, 1)*

To act in a way that is consistent with Te Tiriti there must be relationship with Māori. In discussion with Colin about when he gained awareness of Te Tiriti, he described it coming through his relationship with kaumātua: *"So in terms of the Treaty [it was] more [about] the people who lived it … it wasn't a theoretical understanding of the Treaty it was more a practical understanding in terms of this other reality" (Colin, 1).*

Participants clarified that acting in relationship with Māori does not mean only acting on instruction from Māori. There is clearly a role for Pākehā positioned within Crown agencies to take action to address racism, and progress health equity and Te Tiriti.

> *So what do I do? What is it that I can actually do? And that's why I think that thing around power is really powerful … people who are public servants, because often they will have*

> *power over money or over policymaking processes or whatever. So, it's just helping them understand what is it they do as part of their job, that they could shift doing that slightly to be more pro-equity or anti-racist or Tiriti focused? (David, 2)*

Participants were also clear that there is a need to act without being a burden to Māori.

> *I saw some really interesting aspects of you know drawing on Māori staff which is important and useful and many Māori staff do wanna be involved but that deep cultural labour, that the additional labour that brought having to be the Te Tiriti expert on everything, to have to provide a name for everything, to do the karakia at every kind of meeting and stuff. How you do that, how you give people the tools to understand enough to be to be able to do the work without, you know, with involving Māori as they wish to be involved, but not burdening them and how do I get people to understand that that's necessary? (Jill, 2).*

Taking action in relation with Māori also has to be done strategically. The following subtheme describes how participants worked strategically within the system to progress Te Tiriti and equity for Māori, and address anti-Māori racism.

Acting Strategically

> *How far do you push? (Michelle, 1)*

This subtheme reflects the need for action to be tactical, intentional, considered, collective, and informed by those who we are allies for. There was broad agreement that naming and calling out racism was an important role for Pākehā critical allies:

> *It's like we just need to be really overt. And that is our philosophy towards all races, not just as good Treaty partners. But like, you know, hey, guys, let's not be racist, a just society is one that's not racist. Step one, vote; step two, don't be racist. (Tania, 3)*

However, participants described the subtleties involved in calling out racism, particularly about how and when, or even whether to do it. Robyn noted, *"There is a fallout for calling it within institutions, and you have to continually be trying to do that calculus about how to do it, whether to do it, what to do" (Robyn, 3).*

Although participants were clear that their privilege gave them a much greater degree of safety to call out racism, there were still consequences that had to be considered. David described being "*told off*" by someone from human resources, and being asked if he was a "*proper Ministry person*" *(David, 2)* for raising the institutional racism inherent within the recruitment processes.

When we discussed this at an interview a year later, the recruitment processes still had not changed, despite being repeatedly raised by David as an issue. So, David just went ahead and *"changed the templates myself, but HR haven't yet changed the templates."* This is an example of a workaround, described in the 'transforming systems' theme above, where people bypass a racist or inequitable policy or process. This has limited effectiveness as it does not change the entire system. David went on to raise the issue with other group managers who also agreed to change their recruitment processes, but acknowledged:

> *that's one way you can influence the system. But that's not safe enough, that's not secure. We could all leave and then you can get different people, so the system relies too much on people to do the right thing, rather than the system itself creating that requirement. (David, 2)*

The public health training and background of participants was identified as useful for working out when and how to speak up about racism. The quote below provides an example of adapting language to keep people engaged in the conversation. This tactic meets people where they are at but may be considered compromising if it doesn't challenge the racism directly.

> *Tania: That's that languaging thing. You can talk about governance and decision-making. But if you talk about rangatiratanga you're gonna lose your audience.*
>
> *Ngaire: [Big sigh].*
>
> *Tania: [Laughs] yes I agree with that sigh, I do, I fully agree with that sigh. But I guess, I get quite interested in that from a philosophical perspective, like public health is all about reading the room and selling your message to different audiences, even though it might be exactly the same message. You know, think about any health promotion campaign. Yeah, you've got to sell that message to the, to your audience appropriately. The fact that half of your audience are racist, and if you try and give them a clear message about that, that's not going to work. Yes, that's absolutely wrong. But what's the endgame?*

Participants described tactical or strategic action that was often done in collaboration with others:

> *We actively think about tactics and think about how we can [avoid] … pulling in different directions. And so for me I've got my own sense of how that might look. But I'm constantly checking in. (Robyn, 3)*

Part of being strategic was considering how far to push on any issue and weighing that up against what might be negative consequences, not just for themselves but, more importantly, for Māori colleagues. It was also about staying in relation with people, because becoming isolated or losing influence in the system would be detrimental to the cause.

> *Where I have intervened there's all these trade-offs all the time about like, if you actually say the words, white fragility, or racism or whatever, that you've got six months of having to renegotiate yourself back into a space of being effective … it's the cost of calling it out. And if the cost is on yourself, well, that's one thing, and then, you know, I can feel good about it. But you've got to, it's also trying to work out, like who else is affected by your calling it out in that way? And where does the fallout happen? It doesn't always happen on the person calling it out, it can actually make it worse. (Robyn, 3)*

Sometimes the decision was to refuse to do what was asked of them or ultimately resign from a role in protest at the racism. For example, "*I stood up in forums and disagreed with things and then eventually resigned because I couldn't tolerate a racist system" (Tania, 1).* However, resignation, although seriously considered by participants, was weighed up against staying and doing what they could within the circumstances. A strategic decision was required about what the best course of action would be, weighing up all the potential outcomes.

> *If you're employed by the Crown, you've got to deal with what the Crown says. Probably the biggest crisis came after the Brash Orewa meeting when Labour got frightened, and then started obsessively examining Māori contracts, and I had a lot of Māori contracts. So, at the time, I was trying to think, what's the right thing to do here? Do you resign? Or, I mean, that's really your only option? Or do you try and see it through and protect them as much as possible, and I chose the latter course of action. But clearly, I didn't agree with the Crown's action. On the other hand, … if I was to walk off, it would have left the providers even more vulnerable. So, you've got to sort of figure out what, what to do. (Colin, 1)*

Paradoxically, some participants grappled with decisions about pursuing or accepting more senior roles in the system as moving up within the system could potentially compromise their integrity and their ability to influence change. This connects with the subtheme, 'politics always impacts' described in the 'transforming systems' theme above. In this subtheme, participants described how *"politics always impacts and the higher up you are, the more impact it is" (Jill, 3).* Participants recognised that although they held power and privilege in the system, this was not limitless. They also faced constraints around what could be changed within the system. Robyn

noted that in her current level within the system, "*you can convince yourself that you're doing something useful. But once you get further up in the structure … I can't really see myself having a valuable contribution to make in Te Whatu Ora" (Robyn, 3).*

As mentioned in the 'politics always impacts' subtheme, the process of editing racism out of documents was an example of facing limits that was experienced by more than one participant: *"We've certainly watched the words [like] racism, I think we got one left out of all the instances we had there" (Jill, 2).*

Participants talked about using tools that are available within the health system that help to identify racism and where it is residing within the structures. The work of the Māori health team within the Ministry was specifically mentioned as doing useful work:

> *They're working with every directorate to come up with a Te Tiriti and equity plan. … They're running a whole lot of really cool things, not just for the Ministry, but the wider health sector, just like the Ao Mai Te Ra is not just the Ministry thing, it's by the Ministry, but for the health sector. But there's other work they're doing around it called equity by design, which is, again, for the whole health sector to look at. (David, 3)*

These tools included thinking critically, asking questions about the how and the who of decision-making processes, including, *"Why haven't we thought about these other things? Have we looked at all the components of this? Do we really understand what we're trying to do?" (Jill, 1).*

As well as considering their own actions, participants shared their thoughts about having a responsibility to support other Pākehā to change as a core part of anti-racism praxis. This included providing support to other Pākehā to act or supporting them when they take action, supporting Pākehā on their decolonising journey or helping Pākehā work out where to begin. This connects to the theme about Pākehā being accountable for Pākehā power and privilege. Participants provided examples of how they worked with other Pākehā, such as:

> *Trying to talk to her about, what does it mean to look at these things yourself? What does it mean to understand Te Tiriti in the New Zealand context? What does it mean to understand health inequities yourself? And where do you go for that kind of information and kind of start there, it's like the 101 cultural competency stuff. But really the message trying to be 'don't ask Māori to do this for you, you need to recognise this as a 'you' issue'. (Jill, 3)*

Persistence and being constant were also part of this theme of strategic action. Being the one who will say something, being the one that keeps focused on an issue and not letting it go.

> *There's been two and a half months of meetings, and then nothing happening. And so I've had to both advocate through continually saying what's happened to this? How is this decision being made? Blahdy, blahdy, blah. (Robyn, 3)*

Michelle described the frustration of having to explain a "basic 101 equity" position on COVID vaccination data reporting which took *"three months before the DHB changed reporting to do Māori vs non-Māori instead of Māori vs total population" (Michelle, 3)*. Persistence was needed because *"the system is so complex, and there's so many layers"* and time was also required to work through dismantling *"institutional block(s)" (Ben, 2)*.

Critically Reflecting

> *I feel like, even with all the exposure I've had, and all the mentors and support I've had … I still have to reflect and learn. (Jill, 2)*

Praxis is action and reflection. This subtheme emphasises the importance of reflection as a contribution to the journey of developing a Tiriti-based anti-racism praxis. Although it is important to start with the self, this reflection is also formed in discussion with others on this journey.

Critical thinking and taking a systems view are core competencies for public health. Participants, all with public health training or backgrounds, questioned themselves, others, and the system. An important component of critical thinking that participants described was focusing the gaze on the system, not 'blaming the victim'.

> *You know, the vaccine inequity here at the moment, it's like, people go, "Oh, well, they've had a chance to get vaccinated" that's what I'm hearing, you know? And it's like, well, hang on a minute, lets break that down a little bit … even if it was true, the outcome is inequitable, so we haven't done it the right way, obviously, you know? (Michelle, 1)*

Participants had been doing this work for many years; their journey involved 'becoming consciously Pākehā', being clear about who they are, what they offer, what their position is, and these elements of the journey developed through critical self-reflection, over time, with others. Participants identified having a critical lens on oneself involves self-interrogation:

> *Start with yourself. So, you can't go down this journey without reflecting on yourself, your own biases and racism, where you've come from, what kind of structures have enabled*

you to achieve but are keeping other people down, really being, having a critical lens on yourself. (Ben, 3)

Participants also shared the importance of making mistakes and remaining humble as a contribution to self-development as a constant evolving journey:

But I guess just be humble and listen. Everybody comes into any environment with their own assumptions and understandings. And most of the time those are severely limited. Yeah, I mean, I've definitely made assumptions and done things wrong. But yeah, it's the same, don't be afraid to make mistakes and then learn from them. (Tania, 1)

Participants accepted themselves, their identity, over time, through a journey of critical reflection:

Oh I think it's been a long journey to be honest, about where I am. That journey is always rooted in your whakapapa, your identity of who you are as a person and what shaped you as a child, and certainly there's things that shaped me as a child and later on in my adolescence and then you know, progressing through my medical career so I see things as being kind of like a stepwise process to kind of where I am at the moment and this is an ongoing process. ... I think in 10 years time when I look back on who I am now there'll be aspects of myself that I'll have a bit of a cringe factor about and thinking, oh, you weren't doing things the right way then, certainly I can look back just three years ago and think, oh, that wasn't very good you know, there's always an element of self-reflection critique as you, as you're moving forward in your journey. (Ben, 1)

Participants shared how being part of a collective network of supportive people enabled them to have critically reflective conversations as well as to support each other to act and to carry on when things got difficult. This means, in other words, having colleagues or friends *"where you can be comfortable in who you are but still be challenged*" (Robyn, 1).

*I've got a list of people I can text any hour of the day and night, who [are] often feeling very similar to me ... they've definitely kept me going through the tough times in the last year. Māori and Pacific and Pākehā. All wāhine toa ... I can just text like, **** me, something like that. And they'll go, 'You got this', even in the middle of a meeting ... and we all do the same for each other. (Tania,1)*

The importance of collective action was emphasised by some participants: "*So there would be a pou that was about collectivism ... that would be one of my foundational principles, that I'm not ever alone, you know, I never do anything alone" (Tania,1).*

Another important contribution to this subtheme is the need to hold on to hope throughout the journey and take a long view:

> *And then also, in 20 years time, something awesome will have happened. And it would have happened because of you're a part of that thing, you would have done your piece. And you may not finish it by the time you go, but you've created a foundation, you've built on the foundations for others. (David, 2)*

This subtheme of critically reflecting emphasises the connection between action and reflection and the contribution they make to a constant evolving journey.

Conclusion

This chapter has outlined the findings from the series of three interviews with each of the study's seven participants from December 2021 through to mid-2023. It has presented the three themes of transforming systems, becoming consciously Pākehā, and Tiriti-based anti-racism praxis.

Advancing health equity for Māori and addressing Māori-specific racism during the context of health reforms adds to the complexity of considerations for effective strategic action. Participants questioned how far to push Te Tiriti and equity whilst being conscious of the political influence on health system reform. There was a strong intention to do what you can when you can, constantly weighing up what is most effective in various scenarios. This required an analysis of how power operates within the system and, for Pākehā, an understanding of how they can choose to use the power they hold to enact change. Participants advocated for the devolution of power to whānau and communities to recentre where power is located.

Te Aka Whai Ora, clearly the highlight and hope of the reforms, was also credited by participants as beginning to facilitate shifting power relationships within the colonial health system. Several risks for Te Aka Whai Ora were described, including being seen to be solely responsible for Māori health and the 'mainstream' abdicating responsibility. The lack of funding needed to be truly effective and the tenuous political support for Te Aka Whai Ora were also described.

The performativity of the system was highlighted, and the tendency for Tiriti and Māori health equity commitments to remain words on paper – or, even worse, not to be evident at all. However, there is a role for people to effect change within systems. Transformative, values-based leadership that was empathetic and supportive facilitated change. Being clear about what action can be taken from where one is in the system was important to avoid paralysis.

Becoming consciously Pākehā is a journey of learning and development that begins with an awareness of who we are, and how racism and colonisation positions us with power and privilege within the system and society more broadly. Learning about colonisation and history, and exposure to and engagement with te ao Māori, all facilitated a conscious identity. Significantly, this positioning was clear about the rangatiratanga of Māori in Aotearoa and a strong belief in upholding Te Tiriti. An allyship identity was eschewed in favour of an orientation to 'an ethic of service' in contributing, making a difference and serving a broader goal of addressing Māori-specific racism and improving Māori health equity.

The clarity with which participants described engaging with the various articles of Te Tiriti and the application of the articles to their work was heartening. This is the basis of Tiriti-based anti-racism, illustrated in explicit examples of how to apply Te Tiriti within the health system. This requires purposeful connections that enable one to be 'in relation' with Māori, to ensure Pākehā action aligns with Māori strategy. This strategic action requires overt direct challenges to observed interpersonal racism as well as pro-active advocacy for Tiriti implementation. Strategic action requires careful use of language, staying in relationship, calculating the best course of action, mitigating consequences, supporting other Pākehā to act, and being persistent. The role of critical reflection and critical thinking was core to effective action. Critical reflection required constant self-interrogation and, ultimately, the self-acceptance and humility that allow one to carry on despite the potential to make mistakes. Critical thinking, an essential part of public health practice, placed the gaze on the system and the focus for change efforts.

The next chapter provides a discussion of the findings and brings together the findings from the literature reviews to propose a model of Tiriti-based anti-racism praxis for Pākehā critical allies.

Chapter Eight: Whiti Mai te Rā

Tihore mai te rangi
tihore mai
mao mao mao te ua
whiti mai te ra,
mao mao mao te ua
whiti mai te ra,

Clear up sky
clear up
stop stop stop the rain
come out sun
stop stop stop the rain
come out sun.

The song above was composed by Hirini Melbourne and is based on an old karakia for children, telling the rain to go away (Melbourne, 2002). When I met with one of my critical research whānau, Grant Berghan, to discuss the study, he told me how he had read my draft the night before, and then gone to bed, dreamt about the work and awoke with the words of this song in his mind. After talking for some time we realised the phrase 'whiti mai te rā' would be the perfect name for the Tiriti-based anti-racism model described below. Whiti mai te rā is apt in that the coming out of the sun, the clearing of the clouds and rain, represents the removal of racism – the goal of the model. It also represents clarity as this model, Whiti Mai te Rā, brings together the findings of the study and the literature reviews into a simple framework easily applied to practice. The description of this model shapes this discussion chapter.

The previous chapter outlined the findings from a series of three interviews with each of seven Pākehā leaders who worked in various parts of the health system. All the participants had been identified and endorsed by the critical research whānau supporting this study, as 'allies'. Allies are Pākehā committed to Te Tiriti, the pursuit of Māori health outcomes and the eradication of Māori health inequities. The interviews were analysed through a process of reflexive TA (Braun & Clarke, 2022a), and three themes were generated.

The first theme was 'transforming systems', and it articulated the role politics, power, performativity, people and potential play in enabling or hindering system change. The second was 'becoming consciously Pākehā', which described a set of understandings required by Pākehā to do the work of decolonisation and anti-racism. This conscious Pākehā identity took accountability for privilege, power, racism and colonisation and had an orientation towards an ethic of service. The third theme was 'Tiriti-based anti-racism praxis', action with reflection on who we are as Pākehā and how we are positioned in the system. This theme explored the

strategic and tactical action of working out 'how far to push' on any given issue. Action was based on Te Tiriti, respected and upheld rangatiratanga, conducted in relation with Māori and informed by critical reflection. This Tiriti-based anti-racism praxis is unique to Aotearoa (Came, Baker, et al., 2021).

The literature review in Chapter Three identified four cornerstones for Tiriti-based anti-racism praxis and the five parts of Te Tiriti provided a framework to outline what is required of Pākehā critical allies in the health sector. The international literature was reviewed in Chapter Four and themes about the terminology of critical allyship, structural and system change and the role of allies were described. There was strong alignment between the international and local literature.

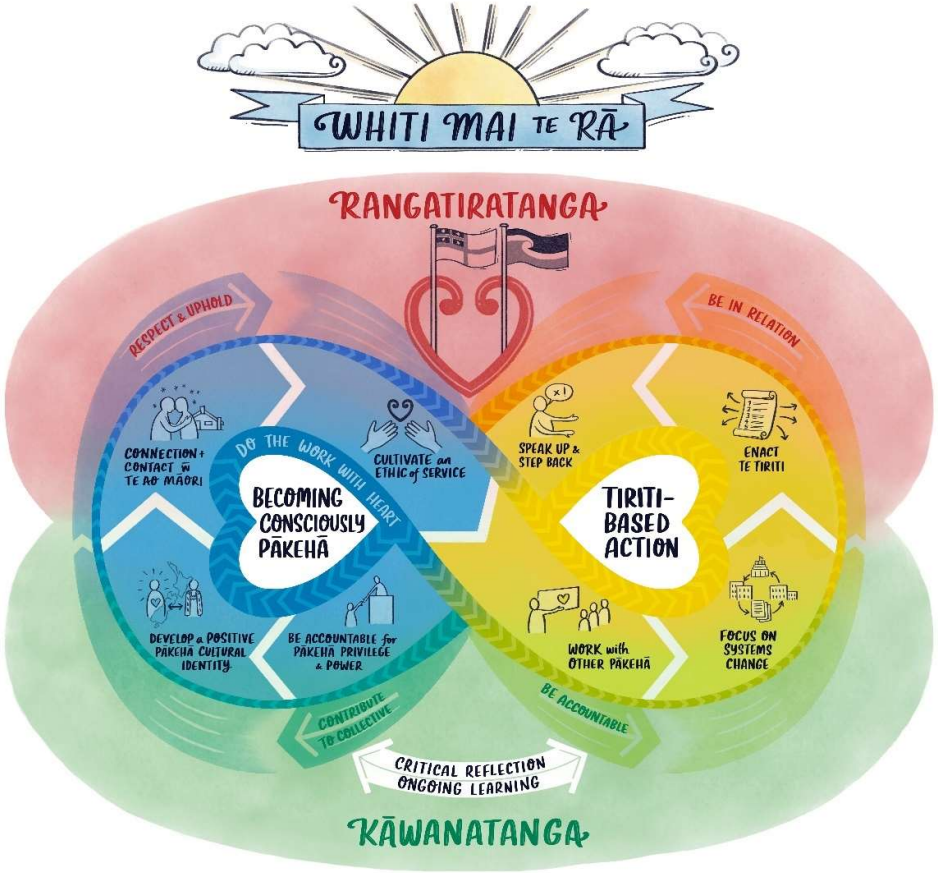
This chapter brings together the findings from the literature and the interviews to more deeply articulate what Tiriti-based anti-racism praxis addressing Māori-specific racism is for Pākehā critical allies working within the health system. I introduce the model 'Whiti Mai te Rā' and each concept at the start of this chapter rather than leave the model to the end, so each concept can be unpacked in greater detail throughout the rest of the chapter, and placed within the overall context of the model. The model[9] illustrated in Figure 19, below, provides an overview.

For a detailed description of how the model was developed with the visual artist and the involvement of the critical research whānau, STIR and Network Waitangi Whangārei, please see Appendix D. During the drawing up of the model we wanted to be clear that the model was influenced by rangatiratanga but also located in the relational and kāwanatanga spheres reflecting the Matike Mai Aotearoa (2016) models of constitutional transformation.

[9] Thanks to artist Jacqui Chan for her work on visually depicting the model Whiti Mai te Rā, five concepts constituting the Tiriti-based anti-racism praxis of Pākehā allies.

Figure 19

Whiti Mai te Rā – Tiriti-based Anti-racism Praxis of Pākehā Critical Allies



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There are five connected concepts that all contribute to Tiriti-based anti-racism praxis for Pākehā critical allies addressing Māori-specific racism. The first concept, respecting and upholding the rangatiratanga and mana motuhake of Māori over Aotearoa, is depicted by the red shaded sphere. This concept is specific to Aotearoa and is fundamental to Tiriti-based anti-racism praxis that informs the basis of all other concepts. The sovereign rights of Māori are affirmed, firstly within He Wakaputanga o te Rangatiratanga Nū Tīreni, Te Tiriti and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) (United Nations General Assembly, 2007). To respect and uphold rangatiratanga requires Pākehā to be in relation with Māori (Healy et al., 2012). This relationship needs to occur at an individual, cultural, institutional and constitutional level guided by Te Tiriti. To address the racism experienced by Māori requires acknowledging that the colonial settler nation of Aotearoa will never be free from racism until constitutional transformation occurs and the sovereign rights of Māori restored (Jackson, 2020).

The second concept is 'becoming consciously Pākehā'; this is depicted by the blue-shaded side of the figure eight shape. A critical, conscientised Pākehā identity is one that accepts the position of power and privilege that we hold in Aotearoa as the beneficiaries of colonisation and racism. Accepting this 'positioning' without guilt but with responsibility motivates accountability and action. Becoming consciously Pākehā happens within each individual but ultimately the transformation required for a Tiriti-based health system and future requires a collective effort. This work is not done in isolation as individuals; rather all our development occurs in relation with others – Pākehā, Māori, Pacifica, Tauiwi. This may be formalised through groups like Network Waitangi Whangārei (Network Waitangi Whangārei, 2022) or STIR: Stop Institutional racism (Came et al., 2017) but it might also be a core group of supportive friends and/or colleagues. 'Cultivate an ethic of service', and 'connection and contact with te ao Māori' are located on the top side of the loop, indicating that this is work more likely to be done within and influenced by the relational sphere, and engaging with the rangatiratanga sphere. The actions, 'be accountable for Pākehā privilege and power' and 'development of a positive Pākehā cultural identity', are located on the bottom side of the loop, indicating a greater alignment to the kāwanatanga sphere, represented by the green shaded sphere.

The third concept is 'Tiriti-based action', which is represented by the yellow-shaded side of the figure eight shape; it refers to undertaking anti-racist action within the system that is congruent with the five elements of the Māori text of Te Tiriti. It is visually depicted as connected to 'becoming consciously Pākehā' as these two concepts are inextricably linked since they support and reinforce each other. Tiriti-based action is informed by a critical consciousness.

Taking action and the learnings that ensue further develop a conscious Pākehā identity. The actions located on the top-side of the loop 'speak up, step back' and 'enact Te Tiriti', are located mainly within the relational sphere, reflecting the way in which the Tiriti-guided action of Pākehā is undertaken following Māori strategic political leadership and aspirations, located in the rangatiratanga sphere. The 'focus on systems change' and 'work with other Pākehā', on the bottom side of the loop, are mainly work for the kāwanatanga sphere.

The figure eight shape in the model brings together 'becoming consciously Pākehā' and 'Tiriti-based action' which reflects the nature of this work as a continuous cycle of learning and development, a lifelong journey. However the loop isn't closed and the perforated edges and gaps in the figure eight shape indicate that relationships and engagement within all spheres are continuously impacting and informing conscious identity and action.

The fourth concept is critical reflection. This is represented in the model by the white arrow connecting both sides of the figure eight shape, reflecting the way in which it is occurring consistently. Critical reflection informs the development of a conscientised Pākehā identity and Tiriti-based action, and both concepts are foundational to Tiriti-based anti-racism praxis. The use of the word 'praxis' is deliberate, in deference to the work of Paulo Freire (2005) who defined praxis as "reflection and action upon the world in order to transform it" (Freire, 2005, p. 51). The importance of critical reflection to praxis cannot be understated. Here the concept of critical reflection also includes critical thinking and the structural analysis required to examine power and how systems of power are manifested and maintained (Came & Griffith, 2018).

The fifth and final concept is doing the work with heart. This is represented in the model by the heart shapes enveloping the words 'becoming consciously Pākehā' and 'Tiriti-based action'. This final concept reinforces the importance of being in relationship with Māori at interpersonal, cultural and ecological levels. This also brings attention to the need to embrace people in aroha when doing this mahi, to do this work with care, respect and love for all humanity. This concept also requires having empathy for ourselves and others, as we Pākehā (as individuals and a collective) become conscientised and begin or maintain a journey of anti-racism and decolonisation. Working with values (Elias et al., 2024) and engaging the heart are core to effective anti-racism praxis (Rankine, 2020).

These five concepts combined depict my current understandings of Tiriti-based anti-racism praxis for Pākehā critical allies in the context of a reforming health system. An earlier articulation of Tiriti-based anti-racism was developed by a gathering of Tangata Whenua and Tangata Tiriti (Pākehā and Tauiwi) anti-racism activists resulting in a briefing paper (STIR: Stop

Institutional Racism & New Zealand Public Health Association, 2021) submitted as a contribution to a national action plan on racism (Ministry of Justice, 2021). In this paper, Tiriti-based anti-racism was defined as:

> The art and science of naming, reducing, disrupting, preventing, dismantling and eliminating racism. It takes a multiplicity of forms but centres around solidarity with those targeted by racism, an analysis of power and a commitment to reflective, transformative practice. In the context of Aotearoa it involves engagement with Te Tiriti o Waitangi. (STIR: Stop Institutional Racism & New Zealand Public Health Association, 2021, p. 9)

There are many similarities between this definition and my articulation: a commitment to Te Tiriti; being in relation/solidarity; an analysis of power; and a commitment to reflective transformative practice. The paper also articulated values for anti-racism work which align strongly with the concept of doing the work with heart. The main difference, which reflects my study's specificity to Pākehā critical allies, is my articulation of the importance of becoming consciously Pākehā and, as part of that, an orientation to an ethic of service.

Each of the five concepts – respect and uphold rangatiratanga, becoming consciously Pākehā, Tiriti-based action, critical reflection and doing the work with heart – are discussed below. Each of these concepts was developed considering the findings and the literature.

Respect and uphold rangatiratanga

> *It's the fundamental recognition of the rangatiratanga of Māori in New Zealand (Robyn, 2).*

Respect for, and the upholding of, rangatiratanga, is the foundation for a Tiriti-based anti-racism praxis for Pākehā critical allies, as it sets the basis from which all further understanding, and action is taken. It is about accepting the mana motuhake and rangatiratanga of Māori over Aotearoa and Indigenous people's right for self-determination. Mutu (2020, p. 269) described Indigenous sovereignty for Māori as "mana (ultimate power and authority derived from the gods) and rangatiratanga (the exercise of mana)". Rangatiratanga is "the right for Māori to make decisions for Māori" (Matike Mai Aotearoa, 2016, p. 8) and involves taking care of people, providing protection, and ensuring the wellbeing of the people and the whenua (Matike Mai Aotearoa, 2016; Mutu, 2020).

The phrase 'respect and uphold the rangatiratanga of Māori' echoes the work of Huygens (2007) who identified 'affirming Māori authority' and 'right relationships between Māori and Pākehā' as key counter-hegemonic discourses promoted and maintained by the largely Pākehā Tiriti worker movement. It is significant that this discourse is identifiable among critical allies working within the health system. The use of these anti-racism, pro-Tiriti narratives can support mindset shifts and lead to organisational change (McCreanor, 2020; Tarena et al., 2022).

Constitutional Transformation

Respecting and upholding the rangatiratanga of Māori belies the legitimacy of the Crown's right to govern over all people within Aotearoa. Māori sovereignty over Aotearoa was never ceded (Healy et al., 2012); indeed, it would have been "legally impossible, politically untenable and culturally incomprehensible" (Jackson, 2020, p. 145). However, the Crown, through violent force and settler population dominance, has assumed sovereignty over the colonial state of New Zealand. To respect and uphold rangatiratanga and adopt a Tiriti-based approach to anti-racism requires support for constitutional transformation (Came, Baker, et al., 2021).

Huygens (2011) advised that being aware of Māori aspirations is the 'strategic check' for Pākehā critical allies. Māori have always resisted colonisation and maintained a commitment to the honouring of Te Tiriti since 1840. Matike Mai is a vision for the constitutional transformation of Aotearoa based on He Wakaputanga, Te Tiriti and UNDRIP. Matike Mai was developed over three years, involving more than 300 hui and thousands of people, and as such it provides a strategic check for Pākehā. It is one of the most proactive responses to implementing a Tiriti-based future for Aotearoa New Zealand. Constitutional values were described, and six indicative constitutional models were envisaged which described three spheres of influence:

> We call those spheres of influence the "rangatiratanga sphere", where Māori make decisions for Māori and the "kāwanatanga sphere" where the Crown will make decisions for its people. The sphere where they will work together as equals we call the "relational sphere" because it is where the Tiriti relationship will operate. (Matike Mai Aotearoa, 2016, p. 9)

The argument for how Matike Mai can be applied to address structural racism in the New Zealand health system has already been made by Came, Baker, et al. (2021). See Table 11, below, for a summary of actions within the health system based on the three spheres of influence.

Table 11
Actions Required Within Spheres for Health System Transformation

Kāwanatanga sphere	Relational sphere	Tino rangatiratanga sphere
Te Tiriti compliant policy & quality assurance systems. Accountability to Māori Māori monitoring of the Crown. Racism risk registers Whole of sector anti-racism strategy. Anti-racism included in health professional training Transformative educational programmes. Ongoing Te Tiriti education.	Commitment to staying in high trust relationship. Engagement based on values of tikanga, belonging, balance, mana motuhake, kotahi aroha, and oranga. Acknowledge mana of the Crown and Māori structurally and interpersonally; moderated by tikanga. Te reo me ōna tikanga ordinary. Kaumātua and kuia have substantive roles. Māori-centred in decision-making processes.	Māori authority, control and decision-making over the design, function and configuration of health. A Māori health and wellbeing authority reflecting mātauranga Māori and Te ao Māori. Māori knowledge, experience, strategic thinking trusted. Te Reo me ōna tikanga practiced. Flourishing Māori health providers. Performance measured by Māori aspirations. Equitable funding.

Note. Summarised from "Addressing structural racism through constitutional transformation and decolonization: Insights for the New Zealand health sector," by H. Came, M. Baker, & T. McCreanor, 2021, *Bioethical Inquiry, 18,* 59-70.

The above outlines actions required from the Crown, represented by the New Zealand Government, and those responsible for governing the health system. The impact of politics on health system reform was a significant finding in the current study. In the context of a racist colonial state, where the majority settler population have usurped the Indigenous population, health policy is impacted by the majority Pākehā voting public's opinion. Health is political. The positions the government takes on addressing equity, implementing Te Tiriti and disrupting racism are all contingent on what is deemed by them to be politically acceptable. As one participant noted, *"At the end of the day, it is still a political decision by non-Māori about what this reform looks like" (Robyn, 2*). Pākehā critical allies supporting change within the health system can view their work as a daily contribution to structural change and, ultimately, constitutional transformation.

Be in Relation with Māori

To respect and uphold rangatiratanga requires being in relation with rangatiratanga, being in relation with Māori. Through Te Tiriti, this relationship is between the hapū of Aotearoa and the Crown. Within the context of the health system and Pākehā critical allies working to address anti-Māori racism and address Māori health inequities, this required being clear about being *"an ally to something or someone, [you] can't just be an ally for yourself" (Colin, 1).* In this study, participants described particularly important relationships with Māori kaumātua, with colleagues, friends, mentors, academics, in being guided by, invited to work alongside and, in some instances, directed. These relationships were long standing, trusting, safe, yet challenging. There was also a clear accountability *"making sure that the people that matter for the thing that I'm doing … are comfortable with what's being done or we fix that" (Jill, 3).* Relationships of accountability with Māori are at the heart of Tiriti-based anti-racism praxis for Pākehā critical allies.

The depth of these relationships and their significance for shaping a Tiriti-based anti-racism praxis is discussed further within two other core concepts: becoming consciously Pākehā and doing the work with heart.

Becoming Consciously Pākehā

> We need to become the Pākehā that Māori had in mind when they signed Te Tiriti. (Mitzi Nairn, as cited in Huygens, 2011, p. 77)

My use of the word 'becoming' is deliberate in emphasising that this is a constant evolving process of 'becoming'; it is not a destination where you arrive and become 'all knowing' or 'comfortable'.

From the study findings, four key components of becoming consciously Pākehā were identified: i) having a positive Pākehā identity, ii) developed and maintained in connection and contact with te ao Māori, iii) accountability for Pākehā power and privilege resulting from racism and colonisation, and iv) embracing an ethic of service. Having clarity on who we are informs what we do but perhaps most importantly how we do it. Land (2015) described solidarity work in south-east Australia as requiring 'acting politically with self-understanding'. Showden et al. (2022) described a continuum of engagement with Tiriti justice for activists in which the apex was critically reflective practice informing action.

At the 1990 commemoration of the signing of Te Tiriti o Waitangi, Canon Hone Kaa said:

> It's good that you Pākehā *are* who you are, and it's important that you *know* who you are…but you need to understand *how* you are who you are – and how *powerfully* you are who you are. (Hone Kaa, as cited in McCreanor, 2009, August 27, p. 1) (emphasis added)

As discussed in the thesis introduction, these words are particularly meaningful to me in helping understand the significance of being Pākehā here. The words are echoed in the words of one of the study participants, Ben: *"You've got to know who you are, who your family is, and how you are who you are" (Ben, 2)*.

Develop Critical Consciousness

Before we can act, we need to be clear about the position from which we are acting. Critical consciousness is described by Freire (2005, p. 35), an influential theorist for Pākehā Tiriti workers, as "learning to perceive social, political, economic contradictions, and to take action against the oppressive elements of society" resulting in us becoming 'subjects', "those who know and act, in contrast to objects, which are known and acted upon" (Freire, 2005, p. 36). Being conscientised is described as an awareness of power and white privilege and how this operates within the structure of a racist health system (Kidd et al., 2020). Curtis et al. (2019) named critical consciousness as crucial to their definition of cultural safety. Critical consciousness required health professionals to critique the 'taken-for-granted' power structures, critical self-reflection, a shifting of the gaze from others to self, challenging "their own culture, biases, privilege and power rather than attempt[ing] to become 'competent' in the cultures of others" (Curtis et al., 2019, p. 14).

Came and da Silva (2011) described Pākehā conscientisation as requiring three core concepts all of which are present within the concept of 'becoming consciously Pākehā' described here: firstly, becoming aware of one's own history and culture; secondly, becoming aware of others' history and culture; and, finally, motivation to act to address the injustice (Came & da Silva, 2011). The international literature review identified self-reflection, knowledge of colonial history, awareness of white privilege and power, and the avoidance of white saviour behaviour as components of critical consciousness.

Although some participants could describe a singular 'aha' moment or epiphany, where they realised either their own racism, the racism within the health system, or the impact of colonisation, some described a *"slow dawning"* a series of events and various relationships and connections with Māori that occurred over time. A conscious Pākehā identity accepts and understands the role our ancestors played in the colonial history but rather than wallowing in

the immobilising emotion of guilt (Huygens, 2018), there is instead an active response to become accountable. Tuck and Yang (2012) reminded us, however, that critical consciousness alone can be seen as a 'harm reduction' approach to settler colonisation if it does not address the cause of the issue through the return of land. Working towards structural change and the ultimate return of Māori rangatiratanga over Aotearoa must be the goal of critical allies.

Be comfortable with discomfort.

'Epistemological discomfort' describes what some Pākehā experience when they realise there is a different world or truth to the one they have constructed (Hotere-Barnes et al., 2015). Engaging with this discomfort is necessary in the process of Pākehā decolonisation (Fabish, 2014). For the Pākehā participants in this study, thinking deeply about issues, questioning ourselves, and "*trying to consciously reflect on a whole lot of things" (Jill, 1)* contributed to consciousness raising. Freire (2005) described the commitment from an oppressor to work in solidarity "requires a profound rebirth. Those who undergo it must take on a new form of existence; they can no longer remain as they were" (Freire, 2005, p. 61). Engaging with emotions of discomfort, allowing oneself to be uncomfortable, being cautious, being humble, are essential to critical allyship (Boudreau Morris, 2017). Becoming uncomfortable is a necessary part of working as allies, letting go of our cultural domination, and working out how to work alongside, with and for Māori.

Develop a Positive Pākehā Identity

The development of a strong and positive political Pākehā identity was part of becoming consciously Pākehā. Participants within this study described themselves as Pākehā and were conscious of their privileged positioning within the health system along with their Pākehā colleagues who "*come from a very Pākehā dominant social group and their work has always been in charge, and always valued for their technical skill" (Robyn, 2)*. This naming of self as Pākehā is not common among white New Zealanders of European descent, with only about 1 in 10 endorsing its use (Sibley et al., 2011). Nor is it common, particularly in colonial settler states such as Aotearoa, for members of the dominant group to recognise being part of a cultural group or being able to articulate or name elements of Pākehā culture (Black, 2010). Amundsen (2018) said identifying as Pākehā is a political act as it clearly places our identity alongside and in relation with Māori. There have been several studies published in recent years about Pākehā cultural identity development occurring through relationship with Māori (Amundsen, 2018; Brown, 2011; Forsyth, 2018; Hancock, 2020; Terruhn, 2015).

Engage with te ao Māori.

For participants in this study, becoming conscious of who they were as Pākehā was developed and supported through connection and contact with te ao Māori. This relationality with Māori was shaped by a foundational belief in the rangatiratanga of Māori over Aotearoa and a belief in Te Tiriti as a meaningful and relevant document for our nation, along with a desire to work to honour Te Tiriti. This underpinning value shaped their actions, interactions and relationships. The depth of relationships, the longevity and the resultant trust and safety felt within the relationships were significant. This finding is echoed by several other local studies exploring allyship (Came, Kidd, Heke, et al., 2021; Came & Tudor, 2016; Hotere-Barnes et al., 2015; Huygens, 2011; Margaret, 2013; Margaret & Came, 2019).

Practice cultural humility.

Although not a universal positioning amongst participants, Robyn described thinking about herself as *"manuhiri"* regarding the *"fundamental recognition of the rangatiratanga of Māori in New Zealand"*. This belief resonates with the writings of Martin (2000) and Beausoleil (2022) who both argued that thinking about ourselves as manuhiri positions us in relation with Māori and requires respect for Māori authority. When you are guest in someone's house or visitor to a new place, you follow the lead of the host as to what behaviour is appropriate. This humble orientation is quite different to colonial settler behaviour which assumes the right to impose one's beliefs and ways of being to, essentially, recreate a home in someone else's home. Land (2015) also discussed how humility relates to aspects of being a guest on someone else's land. She cautioned, however, about the "balance to be struck between the humility that is proper for a guest and an unhealthy subservience that stems from never disagreeing, even when key principles seem to be at stake" (Land, 2015, p. 194).

Participants also talked about the need to *"be humble and listen",* or to *"tread lightly"*, recognising that the Pākehā way of doing things is only one way among many (Margaret & Came, 2019). This awareness of the need to be culturally humble can also contribute to reticence about taking on an ally identity. The significance of being considered an ally by Māori was certainly appreciated by participants, describing this as "*a career goal" (Tania, 1)* and as a gift "*like greenstone, you don't give it to yourself … it's the gifting that indicates relationship and trust and depth and longevity" (Jill, 3)*. The participants felt, as Pākehā, that it was not our place to call ourselves allies. This is an identity best bestowed by the people you seek to support. There is also a fragility to being an ally – it is not like a tick one gets and that's it, rather it is a constant, evolving, lifelong learning journey in relationship with others (Came & da Silva, 2011; Hancock, 2018).

Be Accountable for Pākehā Privilege

As Pākehā working within the health system, we are likely to carry many layers of privilege, societal, institutional, interpersonal and internalised (Borell, 2017). These privileges result in unearned benefits that have arisen from the colonisation of Aotearoa by our ancestors. We work within a system where our worldview is reflected, a system we easily understand, and indeed we take for granted our knowledge of how the system works, we are seen as trustworthy, our opinions are respected and we are more likely to be listened to. Being aware of this privilege, the accompanying power, and how to employ this is in the service of improving Māori health was a key finding of this study. As Jill said "*you have to get better at your own understanding of your own privilege. And what that actually means and how you communicate that to fellow Pākehā" (Jill, 2)*.

Becoming consciously Pākehā is about acceptance of self, developed over time and the consistent practice of purposeful reflection. Being accountable for Pākehā privilege and power is an opposite response to Pākehā fragility (Crawford & Langridge, 2022), it is an acceptance of how our colonial settler history and ongoing monocultural white supremacist systems position Pākehā, but instead of being defensive it is active, it is responsibility as responsiveness (Beausoleil, 2015). It also requires knowing when to use Pākehā privilege and power and when not to, for example, in insisting upon Māori involvement in decision-making or refusing a speaking role on a kaupapa Māori topic.

Develop an Ethic of Service

A key part of how we do Tiriti-based anti-racism praxis is through an 'ethic of service', an orientation to work in service to make a difference, to address injustice. Participants were adamant that *"it's not about me"*. Several participants described working within teams focused on Māori health improvement or for Māori health organisations. In these contexts, they were particular in describing their role as providing useful knowledge and skills to contribute to a Māori-determined health improvement agenda. For Pākehā working for and within Māori health teams, there is a greater requirement to be conscious of how we contribute, when we speak up, when we step up or when we step back. One notable aspect of this is being clear about who is leading and has ultimate decision-making authority. As Michelle clarified, *"You can still ask questions, challenge people, and you could still say, why do you think we should do that? But yeah, you're not running the show."* Agency and active contributions are valued but within the mantle of Māori-strategic priorities and decision-making.

Having an 'ethic of service' is a rejection of 'colonising logics' which centres acting in self-interest and the "autonomous individual as the dominant model of personhood" (Hoskins, 2017, p. 4). This ethic of service and the orientation to work for the justice of others has similarities in the Levinas-inspired account of an ethical encounter of responsibility (Hoskins, 2017) and the feminist philosophy of an ethics of care (Brannelly & Boulton, 2017).

Other studies on Pākehā allyship, within the context of community activism and coalitions, have described how Māori require active, informed, engaged allies who contribute fully (Margaret, 2010; Nairn, 2009). Participants were not passive in their contributions, they did not require hand-holding or back-patting (Thomas, 2020), they were deliberate about using their time, energy and commitment to work in service and support of honouring Te Tiriti and improving Māori health. Crawford and Langridge (2022) identified 'serving/acting' as one of four key disciplines, alongside learning, reflecting and disrupting, required by Pākehā critical allies to address Māori and Pacific health inequities. Serving/acting required the recognition of power imbalances, "examining ego and motives and actively embedding cultural humility" (Crawford & Langridge, 2022, p. 107).

Land (2015, p. 200) identified ally behaviour as context-dependent and noted that there are times when there is a need "to manifest some kind of humility or self-effacement, and times when it seems necessary or possible to let go of self-consciousness, or to talk straight and be honest." Margaret (2010) also cautioned allies against becoming self-effacing and both Land and Margaret stress the requirement for constant critical reflection.

Tiriti-based Action

Following the lead of Māori kaumātua (Healy et al., 2012) and scholars (Durie, 1998b; Mutu, 2011) this thesis has argued, within the literature review and the methodology, for the requirement to refer to the Māori text of Te Tiriti rather than the use of Treaty principles, such as partnership, participation and protection, which dilute, obscure and complicate the intent of Te Tiriti (Waitangi Tribunal, 2019). In the study findings, participants described the various articles of Te Tiriti and how they applied these within their work. They were clearly able to articulate how the various articles of Te Tiriti were guiding their actions, for example, considering responsibilities to Article One about Māori involvement in governance over a specific health initiative or Article Two responsibilities to work on strategic Māori health priorities.

Advocating for Te Tiriti implementation to address institutional racism within the colonial health system was also a key role for Pākehā critical allies. Examples provided by participants included

being the one in the meeting to ask how Te Tiriti is being applied or to question whether a health issue identified as a priority would address Māori health inequity. Steinman (2020) described this as 'quotidian unsettling' everyday action that can be taken without the need to take credit, to be seen, identified or acknowledged as an ally. Came (2014) identified how racism and privilege manifest in the policy cycle within health: the tyranny of the Pākehā majority, incomplete evidence base, lack of cultural competence, flawed consultation and impact of Crown filters. All of these can be points of intervention for Pākehā critical allies to direct their attention.

Be Clear About the Difference Between Te Tiriti and Equity

Tiriti-based anti-racism praxis requires having clarity on the difference between taking a Tiriti-led approach and an equity approach. Equity for Māori is a Tiriti right and a social justice right. Health equity for all people in Aotearoa is part of a social justice agenda. Both are required to address health inequities but to address the determinants of Māori health inequities, which include racism and colonisation, a Tiriti approach is required (Reid, 2021). A Tiriti-led approach for Pākehā requires recognition of mana motuhake and rangatiratanga, supporting Māori leadership and taking action on Māori-determined health priorities.

System Level Change

This current study describes the actions Pākehā critical allies working in the health system can and do take to respect and uphold rangatiratanga. These actions are premised on recognising the colonial health system is largely monocultural, and maintains Māori health inequity through its bio-medical worldview that is institutionally racist and culturally unsafe for Māori (Graham & Masters-Awatere, 2020). Examples from the findings included advocating for Te Tiriti, being aware of and supporting action on strategic Māori health priorities, being deliberate about (re)directing resources to Māori health, and directly providing skills and knowledge to further Māori health through following Māori health leadership.

The literature, locally and internationally, is clear that addressing racism within health systems requires system level change using systems thinking. Multi-level, multi-strategy plans which implemented policy into mandatory practice, with accompanying monitoring and accountability frameworks, led by Māori with ongoing funding and resourcing are best practice (Came & Griffith, 2018; Hassen et al., 2021). Supporting Māori health leadership within the system is essential (Haitana et al., 2022; Kidd et al., 2020; Selak et al., 2020; Walker et al., 2023).

Cultural safety and power.

The choices we make when doing anti-racism work require an understanding of how power is operating within the system (Came & Griffith, 2018). Participants clearly articulated a power analysis and view of the system about who holds power and how it is wielded. This examination of power is a core component of cultural safety (Curtis et al., 2019). The structural analysis view taken within a cultural safety approach ensures that the systems and structures that privilege monocultural ways are interrogated along with the actions and/or inactions of individuals within the system (Curtis et al., 2019). Irihapeti Ramsden (2002), the originator of cultural safety in Aotearoa, was clear about the need for health systems to change to honour Te Tiriti. A cultural safety approach requires acknowledgement of "Māori as tangata whenua, and of the reaffirmation of that status in Te Tiriti o Waitangi" (Ramsden, 1990, p. 54).

Importantly a structural analysis view rejects the victim-blaming narrative dominant within Aotearoa, and also prevalent in other colonial settler nations (Sherwood, 2013). The myth of the meritocracy, that we all have the same opportunities to succeed or fail within Aotearoa (Came & da Silva, 2011), combined with colonial white supremacist thinking attributes the inequitable health outcomes that Māori experience to "inferior genes, intellect, education, aptitude, ability, effort or luck" (Reid & Robson, 2007, p. 5). A structural analysis view, however, focuses the gaze on the system and reveals how the system perpetuates and maintains institutional racism.

Being clear about where you are located in the system and being able to identify what one's particular 'powers' are and how they can be used effectively to change the system or make a difference to Māori health inequities was a core component of Tiriti-based action. The role of public servants who manage funding or write policy was identified as a particularly powerful role. Helping others within the system to work out their particular 'superpower' is also part of this practice.

The counter to this power, however, is that ultimately one's role is constrained with what is possible and permissible within the politics and the racial climate of the times. *"If you're employed by the Crown, you've got to deal with what the Crown says" (Colin, 1)*. This simply stated declaration ultimately sums up the limits placed on people within the system. Came (2012, p. 199), quoting Berghan (2010, p. 8), described this as the use of "Crown filters [that] serve to dilute and water down Māori content in policy as, depending on the racial climate, it is seen as political untenable". Berghan asserted that decisions at this level are not based on evidence but rather the political ideology of the day and elaborate processes of "risk

management". More than 10 years on, and with a reformed health system in place, this study would suggest that Crown filters are still active.

The role of leadership.

Recent reviews about what works to implement effective anti-racism and influence cultural change within organisations identified commitment, including resourcing, from the executive leadership, increasing Māori participation and partnership in decision-making, and ongoing monitoring of implementation plans (Ben et al., 2020; Hassen et al., 2021). The role of leadership was also raised by participants as crucial to influencing change to address institutional racism. Elias et al. (2024) emphasised the importance of anti-racism as a core value being inculcated throughout the organisation. This echoes the view of Reid (2021) who asserted that leading cultural change was required throughout the health system. However, the reforms initiated in 2021 saw little change in leadership. What was hopeful was the acknowledgement by participants of the slight shift in power towards a stronger voice and role for Māori leaders within the system, and a more encouraging environment to implement equity initiatives. For example, the formation of Te Aka Whai Ora and Iwi Māori Partnership boards were described by Robyn (2) as supporting a "*culture shift as well within the health sector that is sending a different message about assumptions and people being able to have unfettered Pākehā power."* However, by interview three this hope had largely dissipated as people had seen equity initiatives stalled or halted, particularly in the lead up to the 2023 general election. The challenge, and opportunity, for critical allies will be to continue to use what remains of the existing legislative framework to pursue health equity.

Ultimately, public health is political, and transformational change in the system is also political. The role for Pākehā critical allies is to be aware of the political situation and act with what is in our power to do so; when there is a positive environment, we need to respond quickly and make change where we can. When the political environment changes and it is less pro-active towards Te Tiriti, Māori health equity and anti-racism, we need to be aware that the racism in the health system will be amplified. There is a role to keep pushing and advocating and step up as Pākehā. Although we might be facing blocks within the system, we will not be experiencing the racism within the system.

The potential and limitations of workarounds.

One of the ways in which pro-equity or Tiriti-based action happens within the system is 'workarounds' where people actively choose to go outside of what is official policy. One of the examples given in this study was recruitment processes identified as institutionally racist, and despite this being pointed out repeatedly, nothing changed. David, however, was able to use his

influence and discretion to change the recruitment processes for his team. Silcock (2020) built upon the study of O'Sullivan (2016) and identified the role of discretionary and autonomous decision-making by health professionals to improve Māori health outcomes outside of official policy. Silcock (2020) called the use of this discretionary power a 'political act' to support rangatiratanga and prioritise improving Māori health outcomes. She identified the crucial role of critical consciousness in motivating occupational therapists to see how their practice can either maintain the "dominance of Euro-normative systems and social structures as the naturalised order of things" or be disruptive and decolonising (Silcock, 2020, p. 37).

Although policy workarounds or discretionary decision-making by conscientised health professionals does make a difference for those who the decision impacts, it does not fundamentally change the system. Came (2012) found the discretion of Crown officials resulted in actions and inactions that manifested in institutional racism. Further to this, the Waitangi Tribunal (2019) *Hauora* report found the 'permissive' and semi-devolved approach to primary health care implementation was supposed to support local innovation but it actually contributed significantly to Māori health inequities. A study by Masters-Awatere et al. (2020) identified some workarounds to provide culturally safe care for Māori but overwhelmingly they found colonial values dominated the health system. The health reforms implemented in 2022 were largely estimated by participants to have failed to achieve significant cultural change; as Robyn (3) commented, the "*fundamental changes that we're hoping for, we're still hoping for*".

Work With Other Pākehā

"Where is the helpful space to be?" This question, posed by one of the participants of this study, asks us to consider, as Pākehā working in the health system, committed to Te Tiriti, "Where is it best to locate ourselves?" This was a familiar question to me, and part of the genesis of this research project. In 2020, I found myself sitting at the table of the DHB where decisions about strategy and funding were made. However, I still felt that I had very little influence to change the system. How could I be more effective? How could I be a better ally? Where was the helpful space to be?

One of the answers to this question is to work alongside other Pākehā in their decolonisation and consciousness-raising journey. Taking responsibility to work with our fellow Pākehā on a decolonising journey is a role expected of us from Māori (Te Huia, 2016) and a political challenge given by Māori to Pākehā decades ago (Awatere, 1984). The challenge from Māori to 'educate yourselves' was picked up by the Pākehā Tiriti workers movement and Pākehā have been educating other Pākehā since the 1980s (Nairn, 2009). This is also a crucial role within the

health system, in Pākehā supporting and working with Pākehā colleagues to change. There were many descriptions from participants about the conversations they had and the work they did with Pākehā colleagues. These conversations encouraged Pākehā colleagues to "start with yourself" and do their own learning about colonisation, racism and the contribution to health inequities. Such conversations encouraged colleagues to consider where they were within the system and what influence they could wield from where they are.

A component of 'being consciously Pākehā' is to be accountable for other Pākehā. This accountability involves seeing ourselves as part of a cultural collective (Beausoleil, 2020) and taking responsibility to work with other Pākehā. This included encouraging other Pākehā to do their own work, since *"nobody else is your external hard drive" (Jill, 1)*, but also working alongside others in supportive ways to encourage other Pākehā to consider and reflect.

Several participants shared the importance of collectively organising strategic Tiriti-based action. Building a movement within the health system of health practitioners who were actively anti-racist, and knowing when and how to intervene, could be a systemic response to racism within the health sector (Kidd et al., 2022). Although STIR is recognised as a health-specific anti-racism movement (Came et al., 2017), we are a small group with no formal structure. The Public Health Association and the Health Promotion Forum have both championed Te Tiriti in the past. There is a need to continue building on this work and to further a movement within public health for critical allyship and solidarity work within the health system.

Speak Up

Speaking up about racism or advocating for addressing Māori health inequities should be lauded within the system which ostensibly has these as core values and goals (Ministry of Health, 2022a). However, the reality is that there are 'costs of calling out' racism. Doing so requires strategic action, tactics, calculated risk and courage to challenge the status quo. A contributing factor that motivated participants in acting on racism was recognising that, perversely, there was more attention paid to the racism when it was pointed out by Pākehā. It was safer for Pākehā to call out racism than their Māori colleagues, as we are not already marginalised, overlooked or discriminated against because of racism. Participants were motivated to persist in the face of the seemingly intractable nature of institutional racism by an appreciation that addressing racism was nowhere near comparable to experiencing racism (Ngata, 2020, July 17).

A backlash against anti-racism efforts within organisations should be anticipated and pre-empted (Came & Griffith, 2018; Elias et al., 2021). Participants described being 'told off' or

experiencing periods of being isolated and having reduced influence on decisions; others had resigned due to untenable situations, were not promoted or found it difficult to get a job within the system. One way participants mitigated the impact of calling out racism was through their choice of language, for example, talking about governance and decision-making rather than rangatiratanga. Another example given was having a conversation with a colleague in a one-to-one discussion rather than a direct challenge in a public meeting. In both these examples the overall goal of an anti-racist, pro-Tiriti health system was kept in sight. Staying in relation with colleagues and being able to continue to use the influence they held to mitigate against further and worse outcomes were also seen by participants as valid reasons for what could be viewed as potential compromises on direct action.

Some of these conversations about choosing when, how and if to speak up were held with participants in mid-2023, just a few months after Rob Campbell was sacked by the Labour-led Government from his appointed role as Chair of Te Whatu Ora. Campbell was dismissed for criticising, on social media, the opposition National Party position on the government's Three Waters policy (Ensor & Lynch, 2023, February 28). This was the context in which these conversations took place: the sacking of an ally for Te Tiriti and Māori health equity for speaking out publicly on a health issue.

Call-out non-performativity.

Another key role for Tiriti-based anti-racism praxis was to call out the non-performativity within the system. Ahmed (2016) first used the word 'non-performative' in 2002 to describe how institutions commit to doing anti-racism through words but without doing anything. Non-performativity is the declaration of doing something but doing nothing.

Instead of the words being a precursor to action they become the action. The non-performativity of the health system in regard to addressing Māori health has been highlighted by Māori scholars and the Waitangi Tribunal (Curtis et al., 2022; Kukutai & Cormack, 2021). For example in *He Korowai Oranga*, the Māori health strategy, there is a commitment to achieving Māori health equity; however, the Crown acknowledged this strategy has not been fully implemented (Waitangi Tribunal, 2019). The Tribunal commented that this the commitment to equity "is admirable; however it is rendered ineffective if the strategy amounts to mere rhetoric" (Waitangi Tribunal, 2019, p. 71).

The non-performativity within the health system reforms identified by participants in this study included "legislative performativity" in which simply referencing the legislation would become the action. A clear role for critical allies within the system is to call out the non-performativity as

they see it. CTA is a tool used to critique health policy in regard to the five elements of Te Tiriti o Waitangi (Came, O'Sullivan, et al., 2020). This tool, with its emphasis on reviewing Te Tiriti public policy compliance, is a preliminary stage in holding the system to account. We need to make sure articles of Te Tiriti and anti-racism are in Crown documents. Ahmed (2016, p. 4) was clear that to make a critique about the non-performativity within documents is "not to stop using the words. Words are tools. We have to use the tools that are handy." Holding systems, organisations, and the people who work for them, to account over the words they do say is important work.

Part of anti-racism praxis was tactical action and persistence over time to keep going to dismantle the "institutional blocks" or metaphorical walls (Ahmed, 2016). Being persistent in the face of non-performativity is required. First, there is a need to recognise that the system needs to change, then taking action to change and having the persistence to keep going, dismantling each block when the walls against change are put up. Everyday actions (Aquino, 2020), even small actions, count towards a movement towards Tiriti justice (Margaret, 2010).

Critical Reflection

> *There's always an element of self-reflection, critique as you're moving forward in your journey. (Ben,1)*

The Tiriti-based anti-racism praxis described in this study requires 'becoming consciously Pākehā' and strategic 'Tiriti-based action'. Both these concepts are developed through continuous critical reflection. The significance of critical reflection for the concepts of 'becoming consciously Pākehā' and 'Tiriti-based action' has already been discussed above. However, the importance of critical reflection and the connecting role it has for both these concepts, combined with the overall importance of critical reflection to praxis, justifies further explicating this concept.

Although reflection and action can often be viewed as two separate concepts, albeit connected, Freire (2005) re-iterates the significance of critical reflection:

> Action and reflection occur simultaneously. A critical analysis of reality may, however, reveal that a particular form of action is impossible or inappropriate at the present time. Those who through reflection perceive the infeasibility or inappropriateness of one or another form of action (which should accordingly be postponed or substituted) cannot thereby be accused of inaction. Critical reflection is also action. (p. 128)

The work of being an ally is a lifelong journey (McGloin, 2016). Part of the journey necessarily involves making mistakes, and through critical reflection, learning from them. Participants had a clear message: *"Don't be afraid to make mistakes and then learn from them" (Tania,1)*. Allowing oneself to potentially make a mistake but to carry on is also important – a fear of failure or discomfort at not knowing everything should not stop the journey. Being a support for colleagues when they do make a mistake was also identified as a particularly important role for Pākehā critical allies within the system.

Critical reflection also requires critical thinking. As Tania (1) said, "*part of my philosophy is also critiquing everything, so [that means] critiquing people's assumptions".* All the participants had public health experience. Values strongly held by all participants included social justice and equity, both of which are core to public health here in Aotearoa and internationally (Kewene et al., 2024). The hauora-ā-iwi public health competencies for Aotearoa have Te Tiriti, equity and cultural safety as central concepts (Crengle et al., 2023). Several of the competencies align closely with the findings from this study. For example, the first foundational competency is to be able to practice in accordance with Te Tiriti (Crengle et al., 2023); in this study, the application of Te Tiriti is identified as core to Tiriti-based anti-racism praxis.

Doing the Work with Heart

This final concept emphasises the importance for Pākehā critical allies of being in relation with Māori at an individual level as family, friends, colleagues and mentors, but also of being in relation with te ao Māori, te reo me ona tikanga, Māori ways of thinking, and of being in relation with this land. At all these levels, interpersonal, cultural and ecological, this relation is premised on care, concern, respect and love. These relationships require Pākehā to be aware of, and then let go of, the default colonial practices of dominating, and being indifferent or defensive (Huygens, 2018).

Te Tiriti o Waitangi established a relationship between the various hapū of Aotearoa and the Crown, and through this a relationship between Māori and Pākehā (Healy et al. 2012). Colonisation severely damaged this relationship, creating a "deep, and ongoing, betrayal of trust" which requires "an emotional and restorative response" (Huygens, 2018, p. 268). Pākehā who seek to be in relation with Māori need to be aware of the potential for mistrust (Davis & Shpuniarsky, 2010) and, as Tania (1) said, need to "*keep working, working, working*" at being an ally.

"Māori culture is a culture of relationships" (Porter, as cited in Healy et al, 2012, p 31) or, as Hoskins (2017) asserted, "the relation is everything". Aroha is essential to being in relation (Mead, 2003). Aroha means "to follow the breath, which implies attentive care and empathy for self and other: to follow one's heart; to go with the flow" (Stewart, 2021, p. 93). Being in relation with Māori requires understanding Māori philosophical values such as aroha, although Pākehā may never fully know the nuances and multiple layers of meaning and contextual application (Hancock, 2018). If we are to be allies then we must understand that "aroha is seen by Māori as the prerequisite for the possibility of any productive social or political alliance" (Hoskins, 2012). Further to this aroha is a "powerful ethical force" that, even when it is not reciprocated, is still the correct and expected behaviour (Hoskins, 2012).

Being aware of and engaging with emotions is important in seeking relationships of justice (Huygens, 2011). In this study, participants described interpersonal relationships with Māori that were "precious" to them. They described relationships that were lifelong, trusting, safe, honest and challenging. Although it was not explicitly stated, they described relationships bound in love.

As humans we know that love is the most powerful emotion of all. In the words of Pākehā poet Glenn Colquhoun,

> I have walked a cultural coastline for many years and I still believe in those most old-fashioned of sentiments, love and aroha, those giant feelings in the chest that make us respond to each other, our inner tides and waves tugged without mercy by the great moon of the heart. (Colquhoun, 2015, p. 55)

Pākehā critical allies working in the health system also had an important role in educating, supporting, relating, connecting and caring for other Pākehā who were on their journey of change. Empathy and surrounding people who were on a journey of change with support was important, as Ben (2) said: *"How do we change it without blaming them? Or how do we lift people up?"* How do we work with other Pākehā to 'call them in' (Beausoleil, 2022)? Rankine (2020) identified effective on-line anti-racism interventions required affective (engaging with feeling and emotion) and discursive (engaging with language and narrative) rather than rational debate (providing people with facts). Influential 'decolonising emotions' were empathy with Māori, anger at injustice and hope for a Tiriti-based future.

As noted within the literature review, although there is much guidance on what can be done to implement Te Tiriti, and address Māori health inequity, this work is not as simple as developing a

checklist or a set of rules; rather, doing this work with heart is an invitation to "feel our way through" (Hancock, 2018, p. 237). We show love through action particularly when we act for justice (Delahunty, 2015). A politics of love, described by Max Harris (2017, p. 173) has a facet of political action motivated by love, whereby everything "is driven by a desire to direct warmth towards others, as opposed to being motivated by power or prestige or self-interest." This description aligns with the 'ethic of service' articulated by participants in which they clearly eschewed the notion of self-interest, insisting *"it's not about me"*.

Moana Jackson proposed an ethic of restoration to replace the term decolonisation, which required "a change of mind and heart as much as a change of structure" (Jackson, 2020, p. 149). He said this ethic of restoration aligned with the politics of love which is committed to radical equality among people, animals and the environment (Jackson, 2020). The values, evolved from Matike Mai Aotearoa (2016) to support this restorative process, are all based on relationships: tikanga, community, belonging, place, balance, conciliation and structure (Jackson, 2020). These values facilitate good relationships between all people, create a sense of belonging for everyone, maintain harmony in relationships and guarantee a conciliatory and consensual democracy (Jackson, 2020).

Conclusion

This chapter has drawn together the findings from the literature reviews and the interview analysis to outline the Whiti Mai te Rā model, based on five core concepts, that describes Tiriti-based anti-racism praxis of Pākehā critical allies working to address Māori-specific racism and improve Māori health inequities within the health system. The five concepts, respect and uphold rangatiratanga, becoming consciously Pākehā, Tiriti-based action, critical reflection and doing the work with heart, although separated here to make it possible to describe and delineate the various elements, in practice come together as a whole. There are threads within each concept that are woven throughout, for example, the significance of relationships.

The first concept 'respect and uphold rangatiratanga' requires an unconditional acceptance of the rangatiratanga of Māori over Aotearoa, a corresponding limitation on the kāwanatanga of the Crown and a belief in a Tiriti-based future. This perspective sees the current health system that we work within as just that – a colonial structure designed and operating within the worldview it represents. There is a role for Pākehā critical allies to work within this system to address racism and take action on Māori health inequities. There is also a role to resource and support kaupapa Māori health services operating alongside the colonial health system. Having clarity on the difference between Te Tiriti and equity approaches recognises the mana motuhake and

rangatiratanga of Māori and that the right to health is guaranteed within Te Tiriti. Equity for all people in Aotearoa is part of a broader social justice agenda. Ultimately, if Pākehā critical allies do not see their work as contributing to rangatiratanga and structural change, then it will be limited and potentially tokenistic. Advocating and working for constitutional change may not be where Pākehā start on their journey as critical allies, but it is the strategic focus of the movement.

Becoming consciously Pākehā is one of the pillars of Tiriti-based anti-racism praxis. A critically conscientised Pākehā identity is formed through connection and relationship with Māori. To be effective allies for change, Pākehā require an understanding of who they are as a distinct cultural group within Aotearoa, and of how to use their position of privilege and power within the health system to work for change. There is an orientation of an 'ethic of service', having cultural humility, and using skills, knowledge, and accountability to Māori to pursue justice and equity.

Tiriti-based anti-racism is guided by the five elements of Te Tiriti. Systems change and systems thinking to embed anti-racism throughout is required. Critical allies can undertake 'everyday', strategic action to support Māori aspirations and health priorities. Courage and persistence in the face of institutional blocks is required. Stepping up includes calling out racism and the 'performativity' of the system and stepping back includes making space for Māori leadership. Taking action, and the learnings that ensue, further develops a conscious Pākehā identity. Becoming consciously Pākehā and Tiriti-based action are inextricably linked and inform each other through a continuous cycle of learning and development, a lifelong journey.

Critical reflection informs both becoming consciously Pākehā and Tiriti-based action. Iterative cycles of reflecting on who we are and what our response (action) is and then reflecting on our response furthers the journey of personal development as well as the next cycle of action. Critical thinking to interrogate systems further supports Tiriti-based action at a system level.

The final concept of 'doing the work with heart' emphasises the role of being in relation and the motivation of doing this work out of care, respect and love for all humanity. Ultimately, this work requires an orientation to engage with emotion – we reach people through their hearts.

Chapter Nine: Conclusion

Introduction

Within this thesis, I set out to explore and describe the experiences of Pākehā critical allies advocating and acting for Tiriti implementation, improving Māori health and addressing anti-Māori racism during health system reforms. I also wanted to explore how the complexity of navigating health system change impacted on these efforts. Lastly, reflecting my activist scholarship orientation, I wanted to establish how these experiences could inform further responses to addressing racism, specifically anti-Māori racism, and provide guidance to other Pākehā working within the health system.

Rather than working with all non-Māori, the focus on Pākehā critical allies recognises that we are all structurally, if not also biologically, as in my case, descended from the colonial settlers (Bell, 2014), and therefore we benefit from the colonisation of Aotearoa. This focus also reflects my identity and a responsibility to work with my people developed over years of involvement with Tiriti education, public health advocacy and anti-racism. This focus on Pākehā doesn't negate that work by other Tangata Tiriti is also required, indeed we must collaborate and work collectively to address racism and enact Te Tiriti within Aotearoa.

The focus on addressing Māori-specific racism acknowledges the ever-present, daily experience of racism for Māori in Aotearoa which occurs as a direct result of settler colonisation. This focus does not dismiss the fact that racism is also experienced by Pacific people and all people of colour in Aotearoa; rather, it focuses the gaze on addressing racism through dismantling colonial systems of oppression and the role of the descendants of the colonisers in doing so.

This final chapter provides an overview of how this thesis contributes to local and international understandings. The implications for research and practice are discussed, along with the limitations of the research, before final concluding comments.

Contribution to Local Understanding

This study is a unique contribution to the understanding of critical allyship working towards Tiriti justice. Firstly, it explores the role of Pākehā critical allies within the health system. There have been other Aotearoa studies looking at allies working towards racial and Tiriti justice, e.g., Margaret (2013), Showden et al. (2022) and Newcombe (2019). However, these studies explored allyship within the community and not specifically within the health system. As far as I've been able to ascertain, no study looking specifically at the role of Pākehā critical allies within the health system addressing Māori-specific racism and Māori health inequity, has been conducted

before. This study is also distinctive in that it occurred during health reform implementation and involved multiple interviews with leaders working in the sector. I have not been able to identify a similar study, locally or internationally, providing a rich description of participant experiences over a period of system reform and focusing on how health equity and anti-racism are impacted. Accordingly, this first section provides an overview of the key findings and is set out in relation to each of the three research questions.

Findings in Relation to the Research Questions

A rich description of Pākehā critical allyship.

What are the experiences of Pākehā critical allies advocating and acting for Tiriti implementation, improving Māori health and addressing anti-Māori racism during the health system reform?

Being a Pākehā critical ally requires 'becoming consciously Pākehā' – knowing *how* we are who we are. The use of the word 'becoming' emphasises the constantly evolving process of 'becoming'. 'Conscious' is a reference to critical consciousness – an awareness long-recognised as a requirement for decolonisation and the development of critical allyship. 'Pākehā', a word given to us by Māori, acknowledges this relationship and that Pākehā is a unique ethnic identity in Aotearoa.

Becoming consciously Pākehā requires having an awareness of how racism and colonisation positions us with privilege and power within the health system and Aotearoa society. To be consciously Pākehā is to not take any aspect of being Pākehā, or being an ally, for granted but to be constantly reflecting, checking, evaluating and shifting as required. Being aware of our own racism as Pākehā is an important part of becoming consciously Pākehā. Learning about colonisation and history, and having an exposure to and engagement with te ao Māori, all facilitate a critically conscious identity.

Being consciously Pākehā respects and upholds the rangatiratanga of Māori in Aotearoa and a strong belief in Te Tiriti as a foundational document for Aotearoa, and through this it builds a place for Pākehā to belong and contribute. An allyship identity was eschewed in favour of an orientation, grounded in being culturally humble, of 'an ethic of service'. This ethic of service reflects a desire to contribute, to make a difference and serve a broader goal of addressing Māori-specific racism and improving Māori health equity.

Long-standing, safe, trusting, yet challenging, relationships of accountability with Māori are at the heart of Tiriti-based anti-racism praxis for Pākehā critical allies. Connection and engagement with te ao Māori is deep and layered, not singular and isolated. Recognising diverse

Māori realities requires specific and negotiated accountabilities. Respect for Māori leadership and rangatiratanga requires following Māori strategic direction and being clear about one's role and contribution.

The impact of health system change on critical allyship.

How does the complexity of navigating health system change impact on these efforts?

Advancing health equity for Māori and addressing Māori-specific racism in the context of health reforms increases the complexity of considerations for effective strategic action. Health system reform and health policy are ultimately political choices by the government of the day. In this study, Pākehā critical allies, along with their Māori colleagues, faced strategic decisions about how strongly to advocate for a Tiriti and Māori health equity agenda whilst being aware of the pushback from further up in the system, fuelled by the political and racial climate. There was a strong intention to 'do what you can, when you can', with a constant weighing-up of what was most effective in various scenarios.

At the beginning of the reform period, in early 2021 and mid-2022, there was momentum and action on health equity and anti-racism approaches. However, during 2023, once there was a political shift away from pro-equity, anti-racism stances, fuelled by the Pākehā racial backlash and political opposition, there were direct impacts on what could be said and done to advance equity and anti-racism within the system.

An analysis of how power is wielded, consolidated, weakened or strengthened was an important lens through which to view the health system change. These reforms consolidated power within the huge conglomerate of Te Whatu Ora. There were strong calls from participants for the devolution of power to whānau and communities to recentre where power is located. A bottom-up transformation of the health system is required rather than a top-down, 'power-over', centralised model.

Calling out the non-performativity of the system was highlighted along with the tendency for Tiriti and Māori health equity commitments to remain words on paper or, even worse, not to be evident at all. There is a role for people to effect change within systems. Identifying where one is in the system, what influence one has and what action can be taken is important to avoid paralysis. Transformative, values-based leadership that is empathetic and supportive facilitates change. Māori health leadership throughout the system is essential and there is a role for Pākehā to actively support this leadership.

Although Te Aka Whai Ora was clearly the highlight and 'ray of hope' of the reforms, its power was limited through legislative, structural and resource constraints. If Te Aka Whai Ora had continued, it would have been interesting to see whether the slight power shift towards Māori authority within the system could have been sustained and strengthened. The decision by the National/Act/New Zealand First coalition Government to disestablish the Māori Health Authority was devastating and was met with vigorous challenge and opposition. The one clear hope within the reforms had been trampled on before being given any chance to flourish.

Chapter Two reviewed over a century of Māori health development in the pursuit of Tiriti justice within the colonial health system. Each time the health system is reformed, Māori renegotiate a relationship with that system, an unrecognised and unresourced effort. History provides a powerful lesson that Māori health improves when Māori lead Māori health. Although the current iteration of a Māori health authority has been removed from legislation, the idea of a Māori health authority will never diminish.

Guidance for Pākehā critical allies.

How can the experiences of Pākehā critical allies inform further responses to anti-Māori racism and provide guidance to other Pākehā working to decolonise the health system, achieve health equity and end racism?

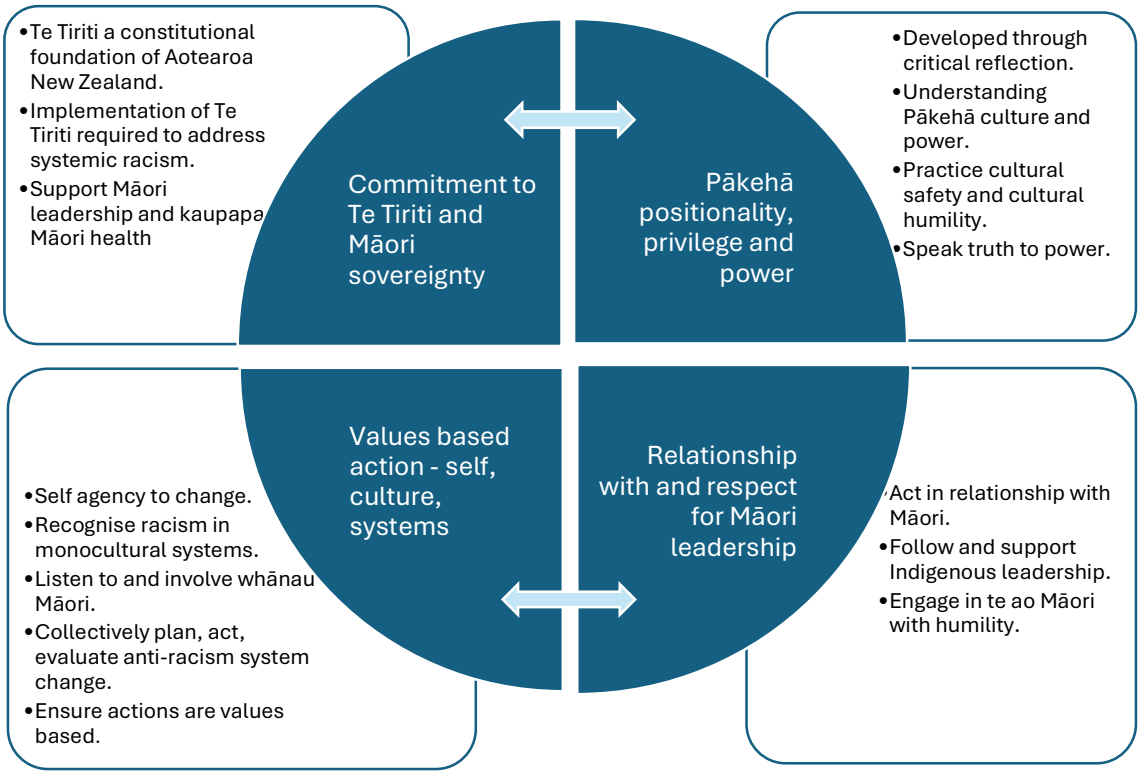
In Chapter Three, four cornerstones for Tiriti-based anti-racism for Pākehā allies were outlined, based on Aotearoa-specific literature. These are summarised in Figure 20, below. These findings arose from a deliberate citational praxis that prioritised, although was not exclusively limited to, literature from Māori.

The findings from the interviews with Pākehā critical allies built upon the analysis in Figure 20 and consolidated an understanding of a unique Tiriti-based anti-racism praxis by Pākehā critical allies focused on addressing Māori-specific racism and improving Māori health inequities. The theme Tiriti-based anti-racism praxis had five subthemes: honouring Te Tiriti, respecting rangatiratanga, acting in relation with Māori, acting strategically and critically reflecting.

Tiriti-based anti-racism praxis requires honouring and implementing Te Tiriti through the direct application of the Māori text. Having clarity on a Tiriti approach and an equity approach requires understanding that equity of health outcomes for Māori is a Tiriti right and a social justice right. The application of Te Tiriti within the health system is more than equity of health outcomes for Māori – it also requires recognition of mana motuhake and rangatiratanga, Māori leadership, decision-making and authority.

Figure 20

Four Cornerstones for Tiriti-based Anti-racism for Pākehā Critical Allies



Being a champion for Te Tiriti in all spheres of influence requires clarity on the strategic Māori agenda, understanding Māori health priorities and working to address health inequities. Respect for rangatiratanga means knowing how, within the role one has, one can support Māori leadership. This may require stepping up or stepping back. Acting in relation with Māori requires Pākehā to be clear about their purpose, intention and motivation for doing the work and then acting with an 'ethic of service' in relation with Māori.

Taking action in relation with Māori also has to be done strategically. Anti-racism work is tactical, intentional, considered, collective, and informed by those who we are allies for. Challenging racism effectively involves considering language, when and how to act. Working with other Pākehā to support and encourage action and reflection was also essential. This work requires persistence and commitment over time.

Praxis is action and reflection. Critical reflection and critical thinking are essential to developing anti-racism praxis. Critical reflection requires constant self-interrogation and, ultimately, the self-acceptance and humility to carry on despite the potential for making mistakes. Critical

thinking, an essential part of public health practice, places the gaze on the system and the focus for change efforts.

Contributions to International Understanding

In Chapter Four, the international literature review examined studies on non-Indigenous, white, settler allies addressing anti-Indigenous racism and Indigenous health inequities within colonial health systems. This literature largely consisted of ethnographic accounts from Indigenous scholars and/or non-Indigenous people describing their experiences, rather than empirical evidence. The exception to this was Wilson et al. (2016), and that study was not specifically focused on 'allies'; rather, it was based on non-Indigenous health professionals working in Indigenous communities. So, although my study is context-specific to Aotearoa, the full account provided here of Pākehā (white) critical allyship contained applicable learnings for non-Indigenous critical allies within other colonial health settings. In countries such as the United States, Canada and Australia, where Indigenous peoples are in a minority, addressing racism within colonial health systems requires critical allyship. This study provides significant guidance to white critical allies seeking to disrupt systemic racism.

Being an ally is not an identity; rather, it is a constant relational practice (Davis et al., 2022; Rix et al., 2024). This study reinforces this finding with a resounding rejection from participants about claiming an ally identity. Rather, an alternative, unremarkable positioning was proposed that rejected any claims of exceptionalism. This orientation towards an 'ethic of service' as part of becoming consciously Pākehā is a refreshed way of articulating the positionality of critical allies that may provide insights in other settings.

Local and international literature stresses the importance of relationship, and the inherent complexities involved, considering the pervasiveness of racism, white privilege and white cultural hegemony in colonial settler society. The description of 'becoming consciously Pākehā' and the orientation to 'an ethic of service' as part of Tiriti-based anti-racism praxis contributes a nuanced perspective on how critical allies work alongside and for Indigenous peoples. Although this research is specific to Pākehā, there are learnings and insights for other critical allies.

The international literature, chiefly from Canada, described Indigenous-specific racism in the health sector and beginning articulations of Indigenous-specific anti-racism approaches. The Tiriti-based anti-racism praxis model outlined in this thesis is a contribution to this developing field and is an expression of a decolonising approach to anti-Indigenous racism.

In the Whiti Mai te Rā model described in Chapter Eight, there is a strong alignment with international literature on critical allyship, for example the connection between critical consciousness and informed action. Clare Land (2015), writing from south-east Australia, described undertaking critical self-reflection alongside public political action that addresses structural privilege. This parallels with my articulation of the iterative relationship between 'becoming consciously Pākehā' and 'Tiriti-based action'.

In the methods section, I described the use of reflexive TA (Braun & Clarke, 2022a) and how I incorporated participant and critical research whānau reflections into theme development. Although a small adaptation, this may be useful for other researchers, particularly activist scholars working with groups they have relationship with and accountability to.

Within the field of activist scholarship, with attention paid to accountability, usefulness, accessibility and reach (Joseph-Salisbury & Connelly, 2021), this study provides an honest reflective description of my multiple layers of accountability to, and engagement with, the Tiriti justice movement.

Implications for Research and Practice

Within this section I describe how a deep engagement with Te Tiriti has implications for research in Aotearoa and, secondly, how Te Tiriti can shape anti-racism practice.

The Role of Te Tiriti Within Research

This thesis makes several substantial contributions to a Tiriti-based future for Aotearoa. Threaded throughout this thesis is a focus on Te Tiriti, reflecting my belief that the honouring of Te Tiriti will restore relationships of integrity between all peoples in Aotearoa. Te Tiriti provides a framework for presenting the findings from the local literature review, under sections on: whanaungatanga (development of relationships); kāwanatanga (taking action within the system); tino rangatiratanga (Indigenous sovereignty); ōritetanga (prioritising equity); and wairuatanga (doing the work with heart). Te Tiriti is proposed as a methodology of transformative research for non-Indigenous scholars in Chapter Five. In Chapter Eight, Te Tiriti is the foundation for the model proposed for Pākehā anti-racism praxis.

The deliberate relational citational praxis developed within the review was inspired by the work of Māori scholar Hana Burgess et al. (2021), and builds on the conscious consideration of who, how and why particular scholars are cited. Pākehā researchers, Newcombe and Amundsen (2022) and Showden et al. (2022), researching Pākehā, were also specific about engaging with Indigenous knowledge. This deliberate relational citational praxis reflects Te Tiriti and

Indigenous sovereignty by recognising Māori as tangata whenua and the obligation of Pākehā, and colonial settlers, to engage with and to prioritise, within literature reviews, Indigenous knowledge. This deliberate citational praxis has a contribution to research here in Aotearoa, and internationally, to the politics of citation (Mott & Cockayne, 2017).

Citational practice is central to feminist research ethics (Xin Liu, 2021): *who* contributes to knowledge production is a feminist and anti-racist position. However, there is a caution that citational practice risks appropriating and re-centring white narratives despite good intentions (Xin Liu, 2021). Hunt and Holmes (2015) asked how white settlers engage with Indigenous knowledge whilst also taking responsibility for white privilege and the role of changing power relations. Scholars seeking a critical citational practice that reflects the contextual and geographical nature of racism and settler colonisation must do so within a context of being in relation and having clarity on their positionality.

In Chapter Five, I outlined an innovative methodology for research within the transformative research paradigm. All research in Aotearoa has obligations to Te Tiriti and to contribute to the advancement of Māori. Over the last 20 years, there has been increasing focus throughout Aotearoa society to consider how Te Tiriti o Waitangi can be honoured, and this is mirrored in guidance provided to health researchers. Just as Te Tiriti provides a place for all within Aotearoa, Te Tiriti can also guide research methodology, particularly for Pākehā and Tauiwi who are motivated by social justice and envisage a Tiriti-based future for Aotearoa. By engaging directly with the Māori text and critically reflecting on their roles, responsibilities and accountabilities, health researchers can design health research to address institutional racism and improve health equity. This focus on decolonising action must be paramount within the research agenda. Table 12, below, outlines the five elements of Te Tiriti, and their application to research and methodological questions.

Table 12
Te Tiriti Methodology

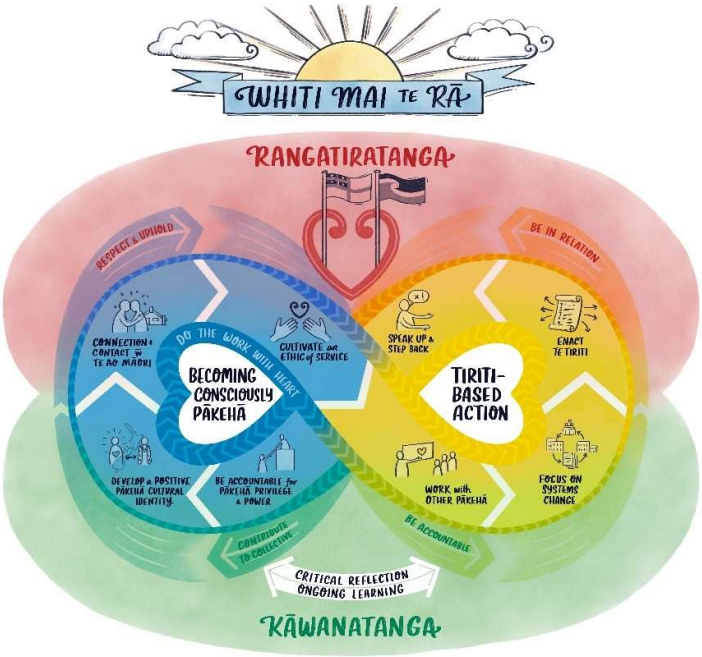
Te Tiriti element and application	Methodological questions
Preamble – whanaungatanga, relationships of mutual respect based on peace and justice; Recognition of paramount authority of Māori; recognition of Te Tiriti as foundational document of Aotearoa. Research aims to improve peace and justice. Respectful, collaborative, accountable, long-standing relationships with all involved in the research.	How will this research respect existing Māori authority, strengthen relationships and contribute to Māori health priorities? (Came et al., 2023; Health Research Council, 2019). How will Māori contribute to the research proposal including research dissemination? How will Māori benefit from this research? (Reid et al., 2017). How is Te Tiriti reflected in and central to this research? Recognition of Māori sovereignty requires knowing who are the hapū and iwi (tribes) in the local area, who do you need to talk to about this study? Who are you in relationship with, regarding this research? How can the relationships that have been formed throughout the study process be sustained now and into the future? (Barnes, 2013).
Article One – kāwanatanga The right of the Crown to govern non-Māori; role for Māori in kāwanatanga/governance. Researchers have accountability to Māori. Research considers structural mechanisms.	How are Māori leading and contributing to the study development, and to establishing the priorities of the research? Do Māori say these arrangements are satisfactory? (Came et al., 2023). How are processes, actions and decision-making shaped by Māori worldviews/perspectives? (Came et al., 2023). How does this research contribute to the implementation of Te Tiriti within the system or structure?
Article Two – guarantee of tino rangatiratanga (paramount and ultimate power and authority) Māori leadership in research design and delivery. Advocating for Te Tiriti and addressing institutional racism.	Is this research more appropriate to be carried out in whole, or in part, by Māori researchers as an expression of rangatiratanga? If not, do Māori people say matters of tikanga (Māori processes and protocol) or specific Māori interest need to be considered and how are Māori experts contributing to this research? (Came et al., 2023). How does this research respect tino rangatiratanga? Does this research undermine tino rangatiratanga in any fashion? How does the research ensure the integrity of the te ao Māori worldview is upheld? How does the research address institutional racism?

Te Tiriti element and application	Methodological questions
Article Three – ōritetanga, equity In return for granting the Crown kāwanatanga, care and protection of Māori rights and equity. Research outcomes required to benefit Māori health.	How will this research consider the responsibilities, rights and capacities of Māori citizens and ensure equity of outcomes as Māori people define them? (Came et al., 2023). How does this topic advance health equity for Māori? (Health Research Council, 2019). Does the research take a strengths-based approach in relation to Māori or does the study perpetuate a deficit focus (thinking particularly about data and how data is presented and discussed)? (Kukutai et al., 2023; Reid et al., 2017).
Oral declaration – guarantee that Māori custom, authority and law protected; Respect for Māori worldview. Reflection on researcher positionality, cultural worldview and how these impact on research design. Knowledge of colonial history, institutional racism and resulting Pākehā privilege. At least basic understanding of tikanga Māori and te reo.	Are you the right person to be doing this study? In what ways does your cultural position help or hinder this study? (National Ethics Advisory Committee, 2019). What is your positionality? How did we / our ancestors come to be here? What is your worldview? What is your privilege? How does this manifest within the research? How do we check ourselves? How will this study support Māori to live as Māori and according to Māori values and customs? (Came et al., 2023). How does the research incorporate Māori ethical considerations and processes? (Health Research Council, 2019). Is this study seen as a useful contribution to a Tiriti-based future?

Whiti Mai te Rā: Model for Tiriti-based Anti-racism Praxis

The Whiti Mai te Rā model outlined in the previous chapter provides a guide for Pākehā critical allies. The dissemination strategy set out in Chapter Six outlines the potential reach of this research throughout Aotearoa. Although focused on the health sector, the findings are applicable across a range of sectors throughout Aotearoa. The model outlines five core concepts: respect and uphold rangatiratanga, becoming consciously Pākehā, Tiriti-based action, critical reflection, and doing the work with heart. Figure 21, below, depicts the model.

Figure 21
Whiti Mai te Rā - Tiriti-based Anti-racism Praxis of Pākehā Critical Allies



In summary, this model describes the Tiriti-based anti-racism praxis of Pākehā critical allies in the health system and requires respecting and upholding the rangatiratanga of Māori over Aotearoa as a fundamental principle. It also requires 'becoming consciously Pākehā', having a clearly articulated cultural identity, formed and maintained in relation with Māori, and that is accountable for Pākehā power and privilege, that recognises ourselves as beneficiaries of racism and colonisation, and that embraces an ethic of service which is purposeful in its intent to work to address racism and improve Māori health. This conscientised Pākehā identity informs a strategic Tiriti-based anti-racism praxis that is unique to Aotearoa, that upholds the intent of Te Tiriti, enacts the articles, and is conducted in relation with Māori. Ongoing critical reflection contributes to both a conscious Pākehā identity and Tiriti-based action, which form an iterative continuous journey of learning and development. Hope, love and courage combined with a commitment to genuine, respectful relationships embraces the praxis.

Limitations of the Research

One of the key strengths of this research is how context-specific it is, being grounded in and related to what is occurring currently in Aotearoa. However, this can also be viewed as a limitation as the specificity of exploring the experiences of Pākehā critical allies during a period of health reforms, focusing on addressing anti-Māori racism and Tiriti implementation, limits the

transferability to other contexts. Allies from within other colonial settler nations may find applicability, particularly those working within health systems addressing anti-Indigenous racism. As described above, there is alignment with international literature and nuanced understandings to be gleaned from the detailed description of Pākehā critical allies' praxis.

Although feminist theory influenced this study, no gender analysis was undertaken in the data analysis of the interviews. This does not mean it was not feminist research (Brinton Lykes & Crosby, 2014). A gender analysis may still be possible if further analysis of the data was undertaken with that specific lens. From my intimate knowledge of the data, I am unsure whether much would be gained from such an endeavour.

During this study, a CTA of the Pae Ora (Healthy Futures) Bill and Te Pae Tata, the interim health plan, were undertaken collaboratively with STIR colleagues. However, this work could have been extended to other documents central to the health reforms. Reviewing, analysing and critiquing other documents produced over the course of the health reforms may have provided further insights into what decisions were made about equity, Te Tiriti and racism. The non-performativity of the system, raised by participants and evident within the CTA undertaken, could have been further exposed through such an analysis. Further CTA could also have provided another layer of data triangulation.

Finally, a fourth interview could have been conducted after we learned about the disestablishment of Te Aka Whai Ora. This would have contributed to documenting the impact of this action within the system, and recorded Pākehā critical ally responses and reactions. However, this would have further extended the data gathering and taken the study beyond the timeframe and resources allocated.

Concluding Comments

This thesis explored the Tiriti-based anti-racism praxis of Pākehā during a period of health reforms that commenced in July 2022. It explored the role of Pākehā working in the health system who were combating anti-Māori racism, focusing on improving Māori health outcomes and reducing Māori health inequities. Racism and colonisation contribute significantly to the determinants of Māori health and, as such, action on racism and decolonisation is required to improve Māori health. The flip side of oppression is privilege, and it is generally Pākehā, as descendants of the colonisers, who are privileged within the colonial health system and Aotearoa. There is a role for Pākehā to use this privilege to decolonise and address anti-Māori racism in the health system. As an activist scholar, my intention in this work was to contribute to effective practice. The model outlined here, Whiti Mai te Rā, the coming out of the sun, provides

guidance and, importantly, hope that change is possible. My hope is that this work supports other Pākehā to act and join those of us already on a journey towards a Tiriti-based future.

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Glossary

Ahua	Condition, character
Aroha	Affection, sympathy, charity, compassion, love, empathy
Aotearoa	New Zealand
Atihau nui a Pāpārangi	Whangānui river tribe
Hapū	Sub-tribe
Hauora	Health, wellbeing, vigorous
He kupu whakataki	Preamble
He Wakaputanga o te Rangatiratanga o Nū Tireni	The Declaration of the Sovereignty of New Zealand
Iwi	Tribe
Ka Whawhai Tonu Mātou	Our struggle without end
Kaitiaki	To care, to govern
Kaitiakitanga	Guardianship, stewardship
Kapa haka rōpū	Māori cultural performance group
Karakia	Prayer
Kaumātua	Elder
Kaupapa	Topic, policy, matter for discussion, philosophy
Kaupapa Māori	Māori approach, practice, by Māori for Māori
Kāwanatanga	Governance
Kia tūpato	Be careful, proceed with caution
Kotahi	One, unity,
Kuia	Elder woman, matriarch
Mahi, mahi pono	Work, doing just work, good work
Mana	Prestige, authority, power, influence, status, charisma
Mana motuhake	Self-determination, independence and autonomy
Manaaki	Support, care, hospitality
Manaakitanga	Hospitality, kindness, generosity, support
Māori	Indigenous people of New Zealand
Manuhiri	Visitors
Mātauranga Māori	Māori knowledges
Moana	Ocean
Mokopuna	Grandchildren
Ngāpuhi	Northern tribe

Ngātihine	Northern hapū
Noa	Safety, unrestricted
Noho marae	Marae stay usually overnight
Oranga	Wellbeing
Ōritetanga	Equity
Pākehā	New Zealander of European descent
Pono	Be true, valid, honest, genuine, sincere
Pou	Pillar
Rangahau	Research
Rōpū	Group
Tangata whenua	Local people, hosts, people of the land
Tangata Tiriti	Person committed to Te Tiriti usually non-Māori
Tapu	Risk, restricted
Tauiwi	Non-Māori
Te ao Māori	The Māori world
Te Ara Tika	Māori ethical framework
Teina	Younger sibling
Te reo	Māori language
Te ritenga Māori	Māori custom
Te Tai Tokerau	Northland
Te Tiriti o Waitangi	The Māori language text
Te Wakaminenga o ngā Hapū o Nū Tireni	The general assembly of the hapū of New Zealand
Tika	Truth, correctness, justice, fairness, righteousness, right
Tikanga	Principles, beliefs, values and practices
Tino rangatiratanga	Self-determination, sovereignty, autonomy, self-government
Tuakana	Elder sibling
Tūpuna	Ancestor
Wahine	Woman
Wāhine toa	Strong women
Wairua	Spirit
Wairuatanga	Spirituality
Waka ama	Outrigger canoe
Whakamana	Empower, uplift

Whakapapa	Ancestry
Whānau	Family / extended family
Whānau ora	Family wellbeing
Whanaungatanga	Relationship, kinship, sense of family connection
Whenua	Land

Appendix A

AUTEC approval letter

10 November 2021

Heather Came-Friar
Faculty of Health and Environmental Sciences

Dear Heather

Ethics Application: 21/393 **Learning about anti-racism praxis from the experience of Pākehā allies during health system reform in Aotearoa / New Zealand.**

We advise you that the Auckland University of Technology Ethics Committee (AUTEC) has **approved** your ethics application at its meeting of 1 November 2021.

This approval is for three years, expiring 1 November 2024.

AUTEC wishes to thank the researchers for the quality of the application.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.
8. AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project. For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: ngaire.rae@outlook.com; jacquie.kidd@aut.ac.nz

Appendix B

Participant Information Sheet

23rd November 2021

Project Title

Learning about Te Tiriti based anti-racism praxis from the experience of Pākehā allies during health system reform in Aotearoa / New Zealand.

An Invitation

Kia ora, my name is Ngaire Rae, a Pākehā researcher, who lives in Whangārei with my family. In April this year I left full time work, after 25 years as a health promoter working throughout Tai Tokerau, to do my PhD at AUT. I have a Marsden Fund scholarship to complete my PhD as part of the broader Reimagining Anti-Racism study being led by my supervisors Dr Heather Came and Dr Jacquie Kidd. In 2019 I was appointed to the Northland DHB as the Deputy Chair. My involvement in the health system has made me aware of the institutional racism throughout. I see, as do others, the potential to address equity and racism within the current health system reforms. Within this context my research aims to contribute to Te Tiriti based anti-racism praxis by learning about the experience of Pākehā allies during health system reform in Aotearoa. You have been identified as a Pākehā ally and potential participant for the study. I am writing to invite you to participate in the research.

What is the purpose of this research?

I am aiming to find out about the anti-racism praxis of Pākehā allies as they advocate and act for anti-racism, implementation of Te Tiriti o Waitangi and ethnic health equity during the current health system reforms. I am wanting to talk to between six and 10 people, who work in the health system, who are involved in some way with the health system reforms and who are identified as Pākehā anti-racism allies. I would like to interview each participant, individually, up to four times, to talk about their experiences, responses, strategies and reflections about their anti-racism praxis over the next 12 to 18 months as the health system is transformed. I have been working with a critical research whānau comprising of Māori and Pākehā health leaders, who are providing political and cultural advice and critique throughout the research process. Importantly the critical research whānau have endorsed you as being a Te Tiriti o Waitangi and anti-racism advocate and ally. After the interviews are completed the preliminary findings will be presented back to participants and the critical research whānau to check validity, discuss significance and develop a dissemination strategy. The research findings will form the basis of a PhD thesis, academic publications, and presentations. It also anticipated that the findings would inform workshops and possible training for people interested in developing Te Tiriti based anti-racism praxis within the health sector, and possibly more broadly throughout Aotearoa.

How was I identified and why am I being invited to participate in this research?

As discussed above you have been identified and / or endorsed by the critical research whānau supporting this study as a Pākehā anti-racism ally. I obtained your contact details from publicly available information or you had given consent for your contact details to be given to me. The critical research whānau is made up of six health leaders (four Māori and two Pākeha). You also meet the other selection criteria which is to be working in the health system and involved in some way in the health reforms.

How do I agree to participate in this research?

If you agree to participate in this research, you will need to complete a consent form. This can be done when we meet in person or a copy can be sent to you via email for you to sign, scan and return to me.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

This research will involve you participating in up to four interviews over the course of the next 12 to 18 months. Each interview will take about an hour. The following is a broad outline of what each interview will cover.

1. First interview: whakawhanaungatanga and whakapapa; who I am; origins of study; my values / positioning; who you are; your journey to date as an ally; your role in and initial thoughts about the health reforms.

2. Second interview: te ao hurihuri – the changing world. How are the reforms progressing? What has been challenging? How have they responded? What are they observing?

3. Third interview: what do they see as anti-racism praxis within health? Does this operate differently during transformative change?

4. Fourth interview: ka mua, ka muri: looking back to look forward. Where have we got to? What are their reflections? How has this process been for them?

If we can meet face to face then the interviews will be held in a location convenient to you, for example at your place of work if appropriate. If we are unable to meet in person then the interviews will be done online using a platform such as Zoom or MS Teams. The interviews will be recorded and will either be transcribed by myself or a professional transcriber who has signed a confidentiality agreement. If you want, a copy of the transcript will be sent to you after each interview and you can edit as you wish.

After the interviews have been completed and the initial findings generated, a meeting with all participants will be held to discuss the significance of the findings, check validity and discuss how best to share the research findings with others. It is possible this meeting will be held face to face, depending on the location of all participants, but most likely it will be an online meeting and take a maximum of two hours. A similar meeting will also be held with the critical research whānau.

As well as the meeting described above, a plain language summary of the research will be provided to all participants.

A koha will be given to participants at the completion of the study to thank them for their time and contribution.

What are the discomforts and risks?

It may be uncomfortable describing and discussing Pākehā privilege and racism. Our discussions may also involve the racist behaviour of organisations and individuals.

How will these discomforts and risks be alleviated?

The focus of the discussion will be on responses to racism so we, and other Pākehā, can learn about effective anti-racist praxis. There is no pressure for you to disclose individuals or organisations however if they are mentioned, no identifying details of people or organisations will be published in any of the research outputs. You are able to stop the interview at any time and you don't have to answer a question should you wish not to.

What are the benefits?

It is hoped that you will find participating in the interviews an opportunity to consider and reflect upon, and potentially lead to, a refinement and development of your anti-racism praxis. The aim of the study is to also help other Pākehā to be actively anti-racist and advocate for Te Tiriti and equity approaches, and to contribute to the broader agenda of a Te Tiriti based health system.

This study will also benefit me personally as it is part of my PhD study.

How will my privacy be protected?

Although the critical research whānau will know who the potential participants are, through the process of endorsing potential participants as allies, they will not know the final selection of participants. You will be known to me and the transcriber who will have signed a confidentiality agreement.

You do have the option of choosing to be identified in the study with your name, role and organisation you work for being identified, or a combination of identifiers e.g. your name. If you choose to be identified a short biography (approved by you) will be included in the final thesis. You can also choose to have no identifying details published in the research reports and a pseudonym will be used.

If you participate in the meeting with other participants to discuss the findings you will then be known to the other participants. You can choose not to participate in this meeting and alternatively an individual discussion will be held with you about the initial findings.

What are the costs of participating in this research?

Participating in this study will take some time – between six and eight hours (four interviews and a group meeting).

What opportunity do I have to consider this invitation?

It would be appreciated if you could respond to me within a month.

Will I receive feedback on the results of this research?

As discussed above you will be invited to participate in a meeting after the initial findings have been established to discuss the themes, consider the validity, significance and possible ways of disseminating the research findings.

Along with the thesis, academic papers and presentations, a two page plain language summary of the findings will also be produced and you will be sent a copy.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Heather Came, heather.came@aut.ac.nz , (09) 921 9999 ext 7799

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, ethics@aut.ac.nz , (09) 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Ngaire Rae, ngaire.rae@outlook.com, phone 021 773468.

Project Supervisor Contact Details:

Heather Came-Friar, heather.came@aut.ac.nz, (09) 921 9999 ext 7799, Head of Department – Public Health, Auckland University of Technology, Private Bag 92006, Auckland 1142, South Campus MB217.

Approved by the Auckland University of Technology Ethics Committee on 1st November 2021, AUTEC Reference number 21/393.

Appendix C

Consent Form

Project title: Learning about Te Tiriti based anti-racism praxis from the experience of Pākehā allies during health system reform in Aotearoa / New Zealand.

Project Supervisor: Dr Heather Came-Friar, heather.came@aut.ac.nz, (09) 921 9999 ext 7799, Head of Department – Public Health, Auckland University of Technology, Private Bag 92006, Auckland 1142, South Campus MB217.

Researcher: Ngaire Rae, PhD candidate, ngaire.rae@outlook.com, 021 773468

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 23rd November 2021.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that this study involves up to four interviews held over the next 12 to 18 months.
- ○ I understand that the interviews will be held in person, at a time and place convenient to me, however if it is not possible to meet in person, interviews will be held online via video conferencing.
- ○ I understand notes will be taken during the interviews and they will also be audio-taped / recorded and transcribed.
- ○ I understand that the recordings may be transcribed by either the researcher or a professional transcriber and that the transcriber has signed a confidentiality agreement.
- ○ I understand that I can receive a copy of the transcript of the interview, to check that it is accurate and that I can make changes to the transcript if I want to.
- ○ I would like to be given a copy of the transcript Yes / No
  I would like to be (choose one)
  - ○ emailed a copy, if yes, my email is_____
  - ○ posted a copy, if yes, my address is_____
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that I can choose how to be described in any of the research outputs (choose from the options below).
  - ○ I consent to being identified in the research by name.
  - ○ I consent to being identified in the research by name and role / health profession.
  - ○ I consent to being identified in the research by name, role / health profession and organisation.
  - ○ I consent to a biography (reviewed and approved by me) being included in the research thesis.

- I DO NOT consent to being identified in the research.

○ I understand that if I choose to participate in the meeting to discuss the findings of the research that I will then be known to the other participants, and the identity of my fellow participants is confidential to the group and I agree to keep this information confidential.

○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.

○ I agree to take part in this research.

○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature:

.....

Participant's name:

.....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 1st November 2021 AUTEC Reference number 21/393.

Note: The Participant should retain a copy of this form.

Appendix D

Development of Whiti Mai te Rā Model

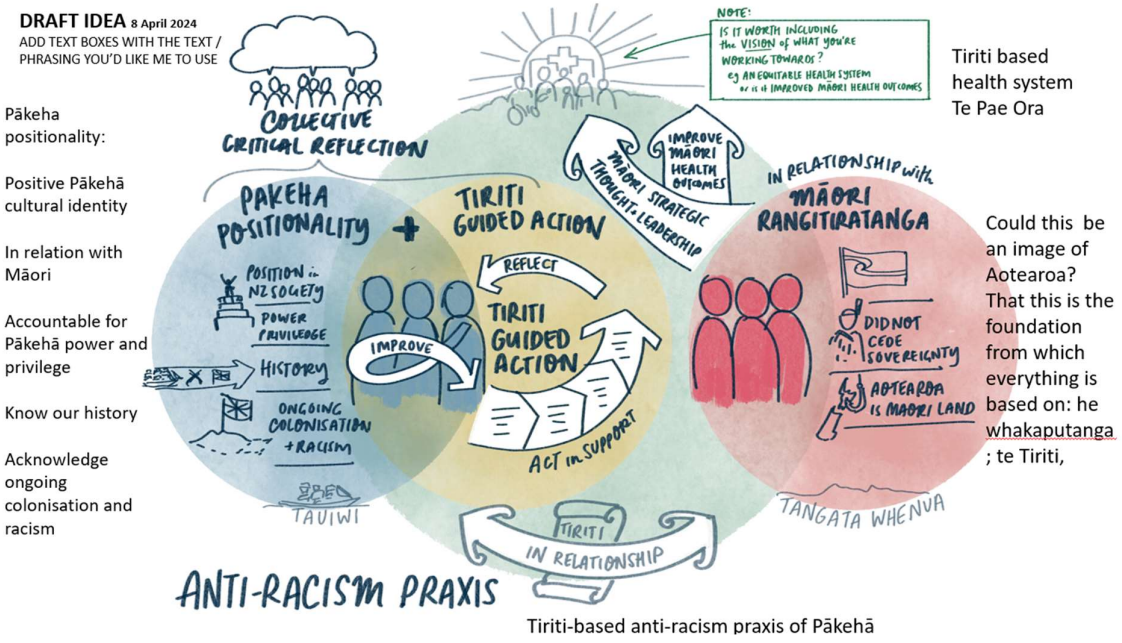
This appendix provides a detailed discussion and visual record of how the model Whiti Mai te Rā was developed. My PhD is part of the Marsden funded project 'Re-imagining anti-racism in the health sector'. As part of this, some funding was allocated to my PhD to develop a visual model. The intention of this model was to simply explain the core findings of the research, to communicate clearly, mainly with Pākehā, about our role and our work in doing Tiriti-based anti-racism.

I first met with Jacqui Chan to discuss my themes and findings in early April 2024. I had no preconceived ideas about what this visual conception of my work would look like.

The figure below was where we landed after an initial discussion about my findings and the themes. I am still using the term Pākehā positionality which reflected this initial name for this theme. Note here the reference to Matike Mai spheres.

Figure D1

Sketch One



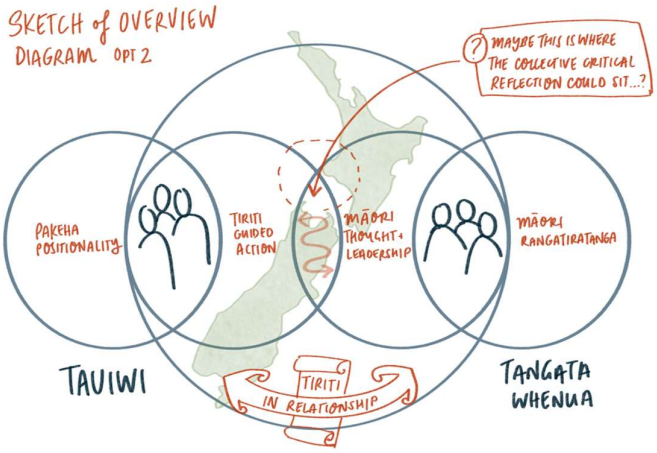
Note: image copyright of the author.

After our second conversation and my edits and clarifications (seen on the above image in text boxes), there was another version of sketches we worked through. My critique of this first sketch was that it was too 'busy' and it wasn't clear what the central concepts were.

These next two sketches show the development of the figure eight or infinity loop, which was to make clear the connection between 'positionality' and 'Tiriti guided action' a core part of the current model.

Figure D2

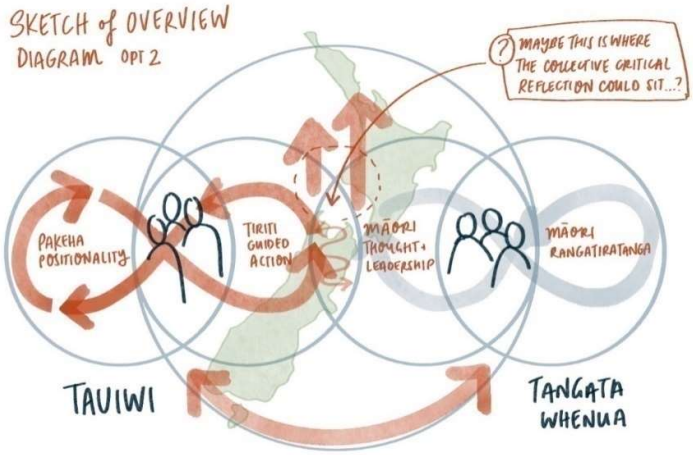
Sketch Two



The next figure includes the concept of critical reflection and how this is crucial to both and also links 'positionality' and 'action'.

Figure D3

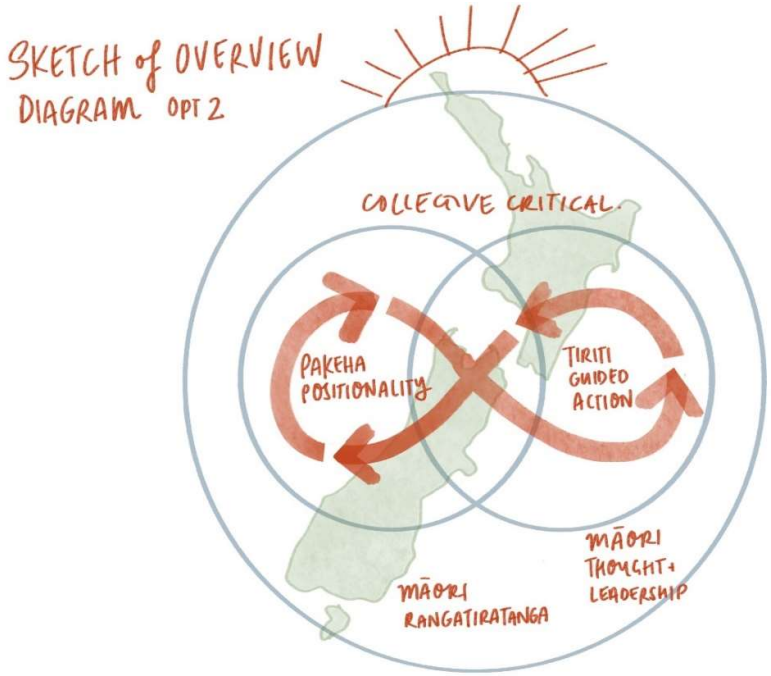
Sketch Three



Then there were a couple of other iterations to emphasise the central concept of respect and upholding of rangatiratanga. The sketch above had this off to the side rather than influencing all the other concepts.

Figure D4

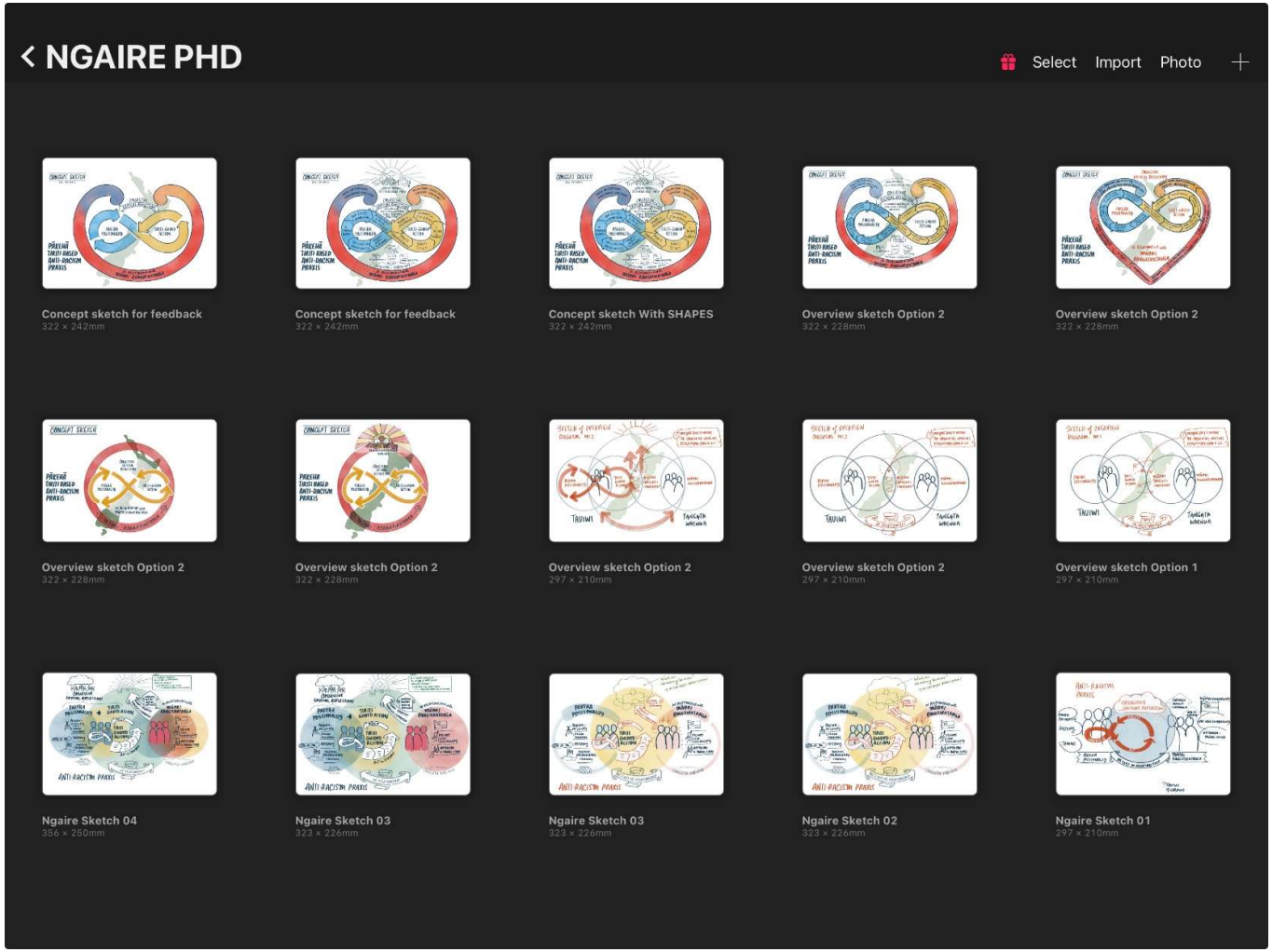
Sketch Four



The image below shows the development from the first diagram we discussed through to the diagram sent to the participants and critical research whānau for comment. This was all done over the period of a week, in April 2024.

Figure D5

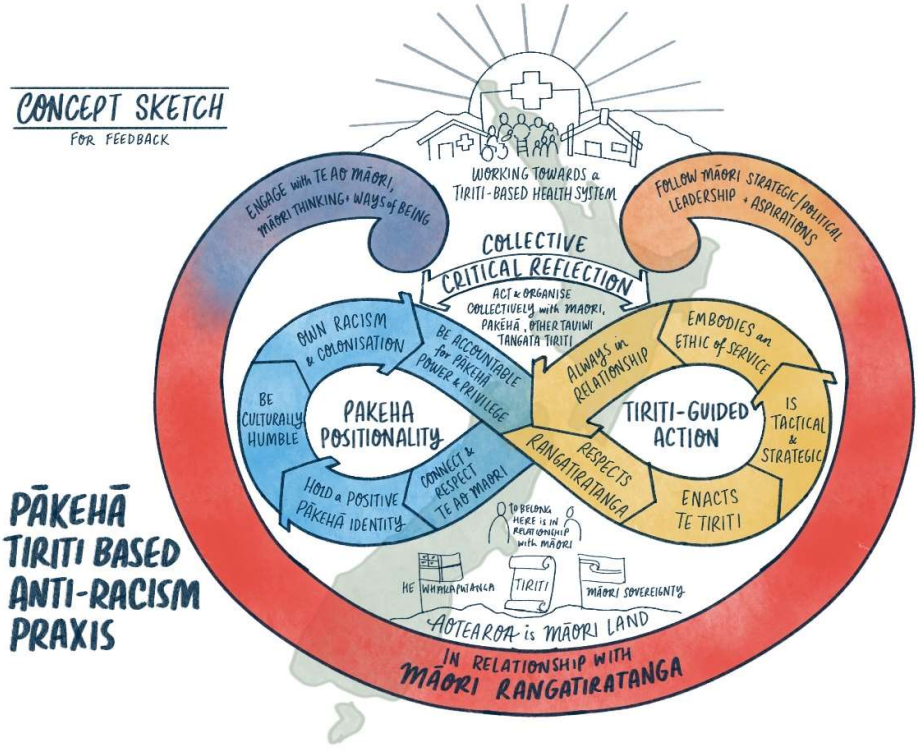
Overview of Sketch Development



The first version of the model that was sent to the critical research whānau and to the participants for feedback is Figure D6 below.

Figure D6

Draft Sketch for Feedback

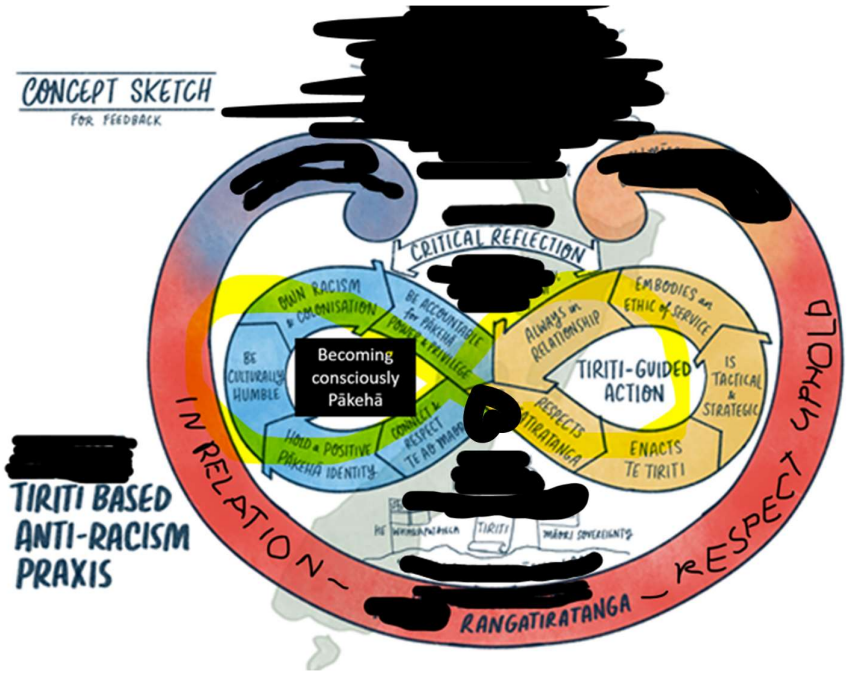


The participants all provided positive feedback about the diagram with no critique. One of the critical research whānau responded and provided feedback on the image at the top that looked too much like a church rather than a hospital. They also critiqued the use of the word Māori as redundant and othering.

During this time my thinking about the themes had developed and I was no longer using the theme name Pākehā positionality. This had been renamed to 'becoming consciously Pākehā'. I had also started integrating my study findings with the literature reviews and wanted to ensure a stronger emphasis on systems change was reflected in the actions, and the importance of 'doing the work with heart' was represented. Following my mark-ups and edits, the following messy version was discussed with Network Waitangi Whangārei and STIR as well as being re-sent to the critical research whānau along with a one-page description of the model.

Figure D7

Marked-up Sketch



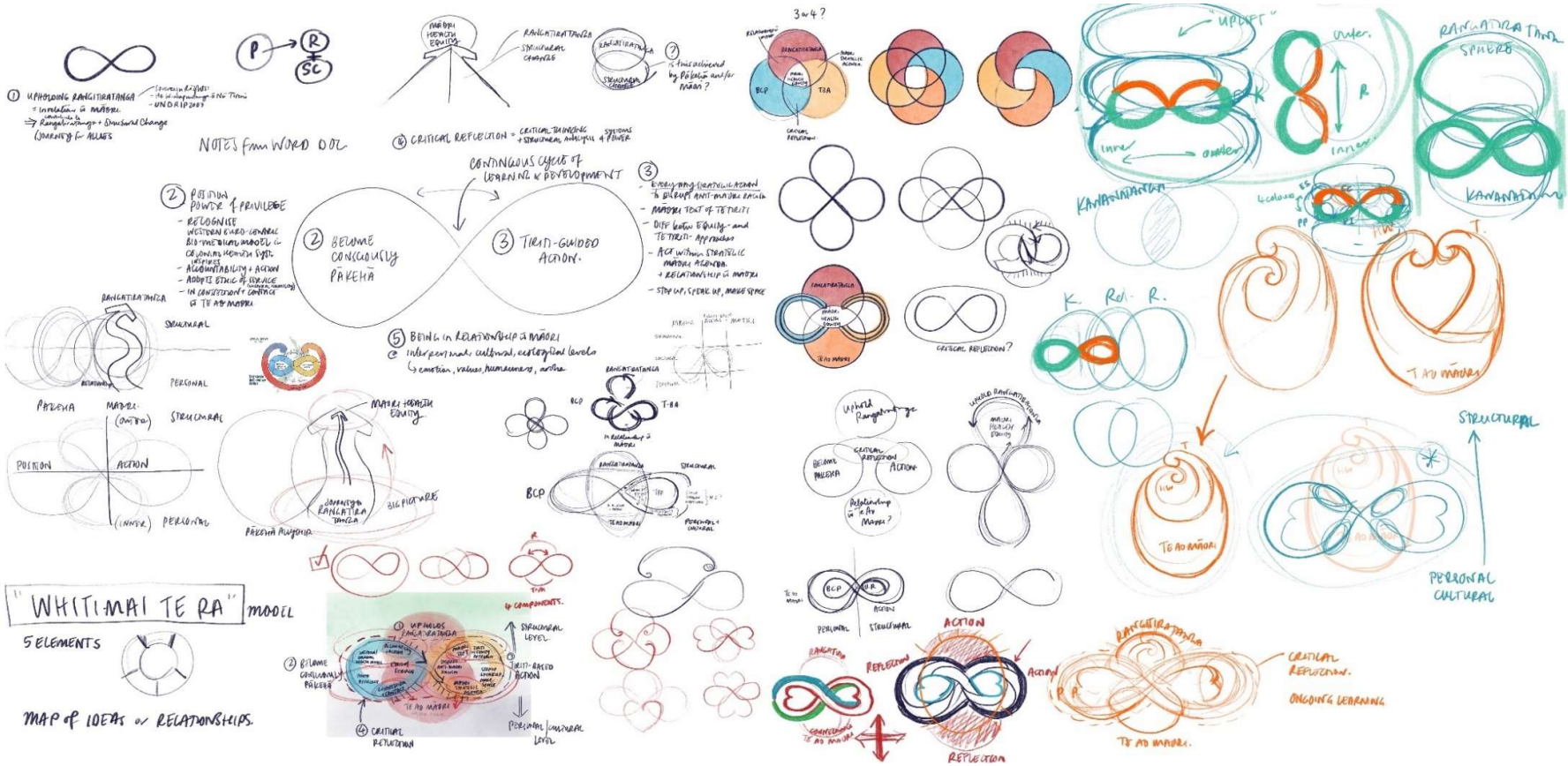
Feedback from STIR colleagues was that it looked like Pākehā were being positioned in the centre of rangatiratanga. Other feedback from one of my supervisors was that they had a sense of burden when they looked at the diagram, that as a Māori wahine they saw it as Māori having to take responsibility for Pākehā positionality, that Pākehā could do nothing without permission of Māori – creating a burden. Both aspects of this feedback were concerning to me as I didn't want this to be the perception.

So I deliberately re-engaged with the critical research whānau to get their feedback. It was during these conversations with the critical research whānau that a name for the model was conceived, and a reconnection back to the original conception of Matike Mai spheres of influence. These conversations, some over the phone, some online video conferencing, some over coffee, text or email, were all considered and incorporated into the final model presented in the thesis in chapter eight.

The final figure below are the sketches by artist Jacqui Chan as we talked through the final changes to the model.

Figure D8

Sketches Developing Final Version



The images in the top right-hand side formed the basis of the final version presented in Chapter Eight. We debated showing the spheres vertically rather than how they are normally depicted in a horizontal manner. We felt this helped to clarify, and more accurately reflected the positioning of the work of Pākehā critical allies as happening within the relational and kāwanatanga spheres whilst supporting and upholding the rangatiratanga sphere.