

Flexible resources and experiences of racism among a multi-ethnic adolescent population in Aotearoa New Zealand: an intersectional analysis of health and socioeconomic inequities using survey data

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Authors' contributions

RJP, SL and RSK designed, planned and led the writing of this article. RSK developed the conceptual framework. RPJ and SL contributed to data extraction. SL conducted the data analysis. SL, RJP and RSK contributed to the analysis plan and interpretation. TC, TF, RPJ and SL were involved in the planning of the Youth2000 surveys, secured funding, planned and conducted the surveys. RSK and RPJ drafted the introduction and discussion. RSK drafted the conceptual overview and aims sections. RPJ drafted the methods. SL, RPJ and RSK drafted the results. SL, RSK, TC, TF and RPJ edited the final version of the article, managed references, figures and tables, approved the final manuscript and were responsible for the decision to submit the manuscript.

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Abstract

Background: As societies become increasingly diverse, understanding the complex nature of racism for multiple ethnic, social, and economic identities of minority youth is required. Here we explore the experience of racism *between* and *among* privileged majority groups and targeted minority (Indigenous and ethnic) adolescents in New Zealand. Using the concept of structural and embodiment flexible resources which act as risk and protective factors, we examine the social and health impacts on minority youth.

Methods: We use data from the Youth2000 survey series administered in 2001, 2007, 2012 and 2019 to representative samples of students in school years 9–13. Ethnicity, country of origin, and migrant generation were used as measures of structural resources and perceived whiteness as a measure of embodiment resource. Racism and its impacts were measured as socioeconomic inequities (household, neighbourhood, and school–level deprivation); interpersonal discrimination (unfair treatment, bullying, safety); and health inequities (forgone healthcare, symptoms of depression, attempted suicide).

Findings: The structural resource measures were associated with socioeconomic and health inequities. Racialised migrants from poorer countries and Māori experience high levels of poverty. Racialised migrants also experience persistent poverty extending over three generations. Minorities perceived as ‘white’ experience less discrimination and have more advantages compared to visibly racialised groups. Regression models show that both structural and embodiment resources mediate ethnic disparities in socioeconomic status, interpersonal discrimination, and health while ethnic disparities in interpersonal discrimination and health were not strongly mediated by economic factors. Trend analyses indicate consistency in these patterns with ethnicity–based inequities persisting or increasing over time.

Interpretation: Racism is a fundamental cause of social and health inequities. However, racism is not a singular phenomenon and not all minorities experience it equally. Individual experiences of racism are mitigated by flexible resources (structural and embodiment factors), with dominant systems maintaining the privilege of wealth and whiteness. Taking an intersectional approach, we point to the complex pathways that protect or increase vulnerabilities in adolescents.

Research in context

Evidence before this study

Research on racism typically focuses on the asymmetrical and linear relationships between privileged/majority and targeted/minority groups highlighting the contribution of racism to negative health effects such as ‘chains of risk’ and ‘weathering’. There are limitations of a linear causative approach when applied to migrant populations in multi-ethnic societies. Young migrants are increasingly identifying with multiple identities and are becoming more socially mobile and adaptive to dominant cultural settings - factors that enhance positive health outcomes. At the same time, they have ongoing experiences of racism. These contradictions call for a new non-linear approach to investigate diversity of identities and associated racism experiences. Although ‘flexible resources’ as protective factors that mitigate inequity is an established concept in the literature, this has not been applied to the context of intersectionality and identity, characterised in minority youth.

Added value of this study

Our study investigates heterogeneity *among* minority young people, and how their multiple social identities give them differential access to ‘flexible resources’. We extend the concept of flexible resources into two types: structural resources or those that affect access to determinants of health (ethnicity, country of origin, generational status) and embodiment resources that are based on societal attitudes to perceived whiteness, and examine their impacts on the health of ethnic minority adolescents in New Zealand. Our analysis demonstrates that there are significant variations in discrimination among ethnic minority youth based on flexible resources they have access to.

Implications of all the available evidence

Racism is not a singular phenomenon and not all minorities experience it equally. While racism is a fundamental cause of health inequities, the linkages between the two are complex. Flexible resources provide a better understanding of the mechanisms of racism for adolescents who have multiple ethnic, social and economic identities. An intersectional lens helps to better develop targeted interventions for young people experiencing racism and to address broader system level bias and discrimination.

Introduction

In 2019, a white supremacist killed worshippers at two mosques in Christchurch, New Zealand (NZ), a painful reminder of deeply rooted racism entrenched in society. Racism is not new to NZ. Indigenous Māori were colonised by white European settlers in the 18th century and deprived of their land, resources and authority to self-determination, despite signing Te Tiriti o Waitangi (a treaty with the English Crown). In the late 20th century, changes to immigration legislation brought increased migrants from Asia, Africa, the Middle East and Latin America significantly altering the demographic profile of the country. Currently, over a quarter (27%) of NZ's population is born overseas, up from 19% in 2001.¹ NZ Europeans and Other Europeans (hereafter referred collectively as 'Pākehā') are still the largest group, comprising 70% of the population, followed by Māori (16%), Asian (15%), Pasifika (8%), and Middle Eastern/ Latin American/African (MELAA) ethnic groups (1.5%). NZ's migrant populations (i.e., non-Pākehā and non-Indigenous Māori) are a heterogeneous group; there is considerable diversity in the countries of origin, socioeconomic status, length of time lived in NZ, and visa and residency status among others.

The ongoing impact of colonisation is evident in contemporary structures and policies, systematically disadvantaging not only Indigenous Māori, but each wave of non-white migrants making NZ their home. There is a robust body of work on racism among Indigenous Māori^{2,3} and Pasifika communities;^{4,5} in contrast, other ethnic minority groups are relatively under-researched despite evidence of Asians and migrants facing high levels of racial discrimination.^{6,7,8} The experiences of racism is particularly understudied in the context of ethnic minority youth who comprise around 20% of NZ's total youth population, many of who have multiple identities or markers of social difference, such as being first/second-generation migrants, of belonging to diverse cultures and socioeconomic groups, and being visibly different. Existing research point to high rates of discrimination, bullying and psychological distress among migrant youth overall.^{2,9–11} However, the heterogeneity among ethnic minority youth means that young people experience inequality and discrimination differently.⁹ It is this diversity of experiences of racism and the underlying societal structures that our study seeks to understand.

Conceptual overview

The term 'racism' is dominantly understood to be the asymmetrical relationship between a 'privileged' (in NZ, usually white/ European/ Pākehā), and a 'targeted' group (typically, Indigenous communities and people of colour, namely, those of Pasifika, Asian, MELAA ethnicity). Racism encompasses acts of marginalisation and oppression at an individual, institutional, and societal level with historical legacies and systems enabling these acts.¹² There are two broadly contradictory schools of thought on the effects of racism on health. Social epidemiologists consider racism as a "a fundamental cause" of inequity, i.e., although there are associations with socioeconomic inequities, racism is not entirely reducible to it. Rather, racism has an "enduring connection"¹³ with health disparities even when intermediary pathways such as poverty or unemployment have been removed. The persistence of racialised disparities, reflects differential access by privileged and targeted groups to 'flexible resources', such as access to institutional structures of power, individual resources such as wealth or knowledge, and social psychological attitudes. Thus, the paucity of flexible resources for targeted groups produces chains of risk,¹⁴ weathering,¹⁵ allostatic overload,^{16,17} and scarring,¹⁸ that accumulate as negative health effects.

Contrary to this view, intersectionality researchers argue that the pathway from social identity to adverse outcomes are neither direct nor shared equally by all in the targeted group.^{9,19} Members within the targeted group – just like the privileged – also have access to differential sets of flexible resources. Flexible resources as adapted here are the attributes and endowments of individuals' identities that "can be used in different ways in different situations"¹³ giving different minorities an array of choices, opportunities, and vulnerabilities. Although these flexible resources do not erase racism, the countervailing effects of income, position, networks, and relationships may act as protective factors. For instance, members from a minority group who are wealthier have better outcomes compared to those from poorer backgrounds.^{20,21} Other studies have shown that perceived whiteness, or what is colloquially called 'passing as white', among minority group members improves health and social outcomes.^{22,23} Similarly, the benefits of ethnic density – i.e., clustering of racial/ ethnic minority groups in own-ethnicity neighbourhood – on wellbeing is well established in the literature.²⁴

In this study, we develop these conceptual arguments into an 'intersectional' framework that explores the effects of differential flexible resources on racism. An intersectional analysis that examines racism effects *between* privileged *and* targeted groups as well as *between and among* targeted groups²⁵ is particularly relevant in the context of multi-ethnic societies like NZ. In our paper, we consider two kinds of flexible resources: (a) *structural* resources which include factors that improve access to social determinants. Examples include income,

employment, education and wealth. For migrant populations, these can also include country of origin (whether high or low-income country); their migration generational status (recent migrants or second or later generation); and ethnicity (of European or non-European origin); (b) *embodiment* resources which portray the advantages and discriminations arising from visible racialisation, specifically the advantages of 'perceived whiteness'. Figure 1 represents the spectrum along which members of privileged and targeted groups may be differentially located depending on their particular sets of structural and embodiment resources.

The overall aim of the study is to examine the effect of flexible resources (structural and embodiment) on the experience of racism *between* privileged *and* targeted groups in NZ. The analysis was guided by four specific questions: (a) does access to structural resources mediate the effects on socioeconomic and health outcomes for minority groups? (b) do embodiment resources or perceived whiteness of individuals from minority groups mediate experiences of discrimination and health outcomes? (c) in what way do structural or embodiment resources differ in their effect on migrant experiences of racism and health outcomes? (d) is racism, as seen through the Youth2000 study waves, increasing in NZ?

Methods

Data sources and definitions

This study uses data from the Youth2000 survey series administered in 2001, 2007, 2012 and 2019 to representative samples of NZ secondary school students (in school years 9-13). Detailed methods of these anonymous, comprehensive, cross-sectional adolescent health surveys are available elsewhere.²⁶⁻²⁸ In brief, the surveys used two-stage cluster sampling. Computer-generated random numbers were used to select schools from a list of all secondary schools with over 50 students, and then to randomly select students from the roll in each participating school. In 2019, we additionally stratified the school sample by educational region, that is by selecting 50% of eligible schools within each of the three included educational regions. Youth19 (primary analysis in this paper) was conducted in the Auckland, Tai Tokerau and Waikato regions in the North Island of NZ, which account for approximately 47% of NZ's high school population and are the most ethnically diverse areas in NZ. In 2001, 2007 and 2012 (used for trend analysis together with Youth19), schools throughout NZ were sampled, but in this analysis, only data from Auckland, Tai Tokerau and Waikato regions are used to make the populations comparable.

We considered the following measures for the two facets of flexible resources as these were the most closely aligned for our purpose within the Youth2000 survey series: ethnic group, country of origin, and migration generation (structural); and perceived ethnicity (embodiment). Supplementary Table 1 provides the rationale for use of the identified flexible resources and the definitions.

Outcome measures

A range of outcome measures from those available within the surveys were selected across each indicator of flexible resource. Supplementary Table 2 provides a description of the survey questions and measures used. In summary, the measures included:

- Economic measures: household deprivation; neighbourhood deprivation; and school decile
- Interpersonal racism: experiences of unfair treatment and bullying; and perception of safety
- Indicators of health: forgone healthcare (an indicator of health disparities among ethnic minority populations), cost as a barrier to healthcare, symptoms of depression, attempted suicide.

Unfortunately, we are unable to use "direct measures of structural inequality" (such as parental income, or students' educational achievements) as these were not collected in the Youth2000 dataset. This lack of data is intentional for the Youth2000 series as (a) young people are often not in a position to comment on their parental income status (which they may not know), and (b) educational achievements, such as grades, could be potentially mis-used to stigmatise particular communities (often, racialised communities).

Analysis

Analyses were conducted with Stata version 17.0, and all were adjusted for inverse probability weights to account for unequal probability of selection, survey design, and clustering using the svy command in Stata. Logistic regression was used to explore variations in economic, interpersonal, and health outcomes for Indigenous and migrant youth adjusting for confounding by age and sex, and for mediating effects of household

deprivation, and three different measures of flexible resources shown in Supplementary Table 1. Results are expressed as odds ratios with 95% confidence intervals.

Each survey was approved by the University of Auckland Human Participants Ethics Committee (Reference Numbers 1999/014(2001), 2005/414(2007), 2011/206(2012) and 023450(2019)).

Results

Population demographics

Demographic details of participating adolescents for each survey wave are shown in Table 1. Eighty-eight students (1.1%) did not identify as male or female and were excluded from the analysis. Missing data for outcome variables ranged from 0 to 10.4% and is shown in Supplementary Table 2. There were slightly more female participants than males in all waves except 2007, and fewer adolescents aged 17 and over in 2001 and 2007. The proportion of adolescents who identified with only the majority ethnicity, Pākehā, has only decreased slightly over time, from 35.3% of the student population in 2001 to 33.3% in 2019. The proportions of first-generation migrants with different ethnic backgrounds have remained fairly constant over time, with European migrants increasing from 5.6% in 2001 to 6.6% in 2019, the proportion of racialised migrants (i.e., migrants from non-western countries) remained at close to 16% over the time period, and the proportion of Pasifika migrants decreased from 5.7% to 2.8%. However, the proportions of second-generation migrants have increased more, with second-generation European migrants making up 5.7% of the student population in 2001 and 11.8% in 2019, and racialised migrants increasing from 4.0% to 16.4% over the same period. There have not been substantial changes in regions of origin.

Flexible resources and socioeconomic outcomes

a) Structural resources

Prevalence data for the three structural resource indicators are shown in Figure 2. Socioeconomic outcomes varied according to structural resource measures, with minority ethnicities and migrants from poorer countries more likely to experience inequities. Racialised migrants and Māori experience high levels of poverty at home, in their neighbourhood and at school compared to European migrants from western countries and Pākehā. They were more likely to report family concern around money for food, power, rent and transport, and not sleeping in their own bed because of hardship. They were also more likely to live in poorer neighbourhoods and attend high deprivation schools.

When disaggregated further, the category ‘racialised migrants’ showed differences among migrant groups. Those from low- and middle-income countries (South Asia and Africa) experienced higher levels of poverty compared to migrants from high-income countries (East Asia and Western Europe) and Pākehā. However, while most Pacific Island countries were classified as upper middle-income, Pasifika migrants experienced the highest levels of poverty. Socioeconomic inequities were persistent over generations especially for Pasifika and other racialised migrants. The results indicate that, for Pasifika migrants, socioeconomic inequities were most pronounced for first-generation migrants who have lived in NZ for less than 5-years. Inequities start to abate with time in NZ, indicating that migrant-generation can act as a structural resource, although inequities compared to European migrants persist even for those who have been in NZ for three or more generations. For other racialised migrants the trends with time and generations in NZ are less evident, suggesting that migration-generation does not have a strong effect as a structural resource.

b) Embodiment resources

Prevalence data for perceived whiteness (embodiment resource indicator) were associated with interpersonal racism (Figure 3). Racialised migrants who were perceived as ‘white’ were advantaged with regards to how they were treated by society compared to non-white passing racialised migrants. Those perceived as Māori, African, and MELAA migrants experienced higher levels of discrimination by teachers, health providers, and the police, compared to minorities perceived as white and also compared to Pākehā. They also reported greater ethnic bullying compared to ‘white passing’ racialised migrants and those who were white.

Flexible resources and health outcomes

a) Structural resources

Health outcomes varied according to structural resource measures. Racialised migrants and Māori had higher levels of forgone healthcare, and higher levels of reporting symptoms of depression and attempted suicide compared to European migrants and Pākehā. Racialised migrants from low- and middle-income countries (South Asia and Africa) and the Pacific, had higher levels of forgone healthcare, symptoms of depression and

attempted suicide. By migration generation, first-generation Pasifika migrants had the poorest health outcomes, but forgone healthcare and symptoms of depression were at similar levels as European migrants by after three or more generations. For other racialised migrants, forgone healthcare and symptoms of depression were slightly higher than for European migrants in the first-generation but were lower than for Europeans by the third-generation, indicating generational differences in health outcomes.

b) Embodiment resource

The results do not show a clear association between symptoms of depression and perceived whiteness. Racialised migrants who were perceived as ‘white’ do not appear to have had advantages related to symptoms of depression or suicide attempts accorded to Pākehā or over those perceived as non-white. Indeed, being socially assigned to one’s own ethnicity appears to have had advantages related to symptoms of depression for some racialised groups (South Asian), but not others (Pasifika).

Structural versus embodiment resources: regression analysis

Regression analyses show that, after adjusting for age and sex, ethnic minority groups had higher levels of socioeconomic deprivation than Pākehā. This is particularly high for Pasifika migrants who were more likely to worry about money for food (OR 4.55 (95%CI 3.38–6.1)), and live in the most deprived neighbourhoods 13.24 (7.55–23.23) (Table 2). Ethnic minority groups also experience higher levels of interpersonal discrimination and ethnic bullying compared to Pākehā, with adolescents from MELAA and South Asian ethnicities experiencing much higher levels of ethnic bullying (5.79 (2.72–12.32) and 5.38 (3.22–9.00), respectively). Māori and Pasifika groups had higher levels of forgone healthcare, and Māori, Pasifika, East Asian and MELAA all had higher levels of symptoms of depression than Pākehā. Adjusting for household deprivation did not reduce these effects (i.e., the ORs did not reduce closer to 1), suggesting that ethnic disparities in these outcomes were not strongly mediated by economic factors. We then adjusted for flexible resources. Migrant generation mediated some of the effects of ethnicity on socioeconomic and discrimination outcomes, but little of the effects on health outcomes. Being from an ethnic minority but coming from a higher income country only reduced the size of ethnic disparities on bullying. Being an ethnic minority but perceived as white had the largest mediating effect of ethnic disparities, particularly for socioeconomic and discrimination outcomes, but not for health outcomes. This suggests that both structural and embodiment resources can mitigate, but not eliminate, the experience of racism.

Flexible resource and racism: trend analysis

Figure 4 indicates selected socioeconomic, interpersonal and health outcomes from 2001–2019 by migration-generation for European, Pasifika and other racialised migrants.

The findings show that concerns about money for food had increased for Pasifika and other racialised migrants over the 19-year period, irrespective of generation status. Neighbourhood deprivation had increased for first- and second-generation racialised migrants and remained high across the whole period for Pasifika migrants. Ethnic bullying had also slightly increased over time, especially for third-generation racialised migrants. Prevalence of symptoms of significant depression saw declines from 2001 to 2012 but increased again in 2019 for all groups. Overall, the trend analyses indicate persistent and increasing ethnicity-based inequities in socioeconomic status, interpersonal discrimination, and health.

Discussion

This study investigated the effects of flexible structural and embodiment resources on socioeconomic and health inequities (representing the effects of racism) among ethnic minority and migrant youth in NZ. We have also included the unique profile of Māori youth recognising their distinct experiences as Indigenous peoples although findings and implications specific to Māori will be reported in future publications led by Indigenous researchers.

Overall, the findings suggest that Indigenous and ethnic minority youth are consistently more adversely impacted compared to Pākehā groups. Furthermore, ‘race’ is a fundamental cause of health inequity, meaning that disparities in health cannot be explained by socioeconomic factors alone. However, there are variations in the experience of racism among minorities, mitigated by flexible resources. Country of origin is one such example with ethnic minority migrants from high-income home countries like East Asia faring socioeconomically better than migrants from, South Asia or the Pacific. The former are more likely to live in affluent neighbourhoods, go to better resourced schools, and have fewer worries about meeting daily basic needs. Similarly, the embodiment of whiteness is another flexible resource, found to impact minority youth’s everyday interpersonal interactions. Those perceived as white had perceptibly better social experiences, more so than whether they were from high income backgrounds. A third significant finding related to intergenerational

355 persistence of disadvantage among racialised migrants; our results show that it can take several generations
356 before disadvantages begin to abate, particularly for Pasifika populations. A fourth and important finding points
357 to the persistence of widespread and consistent disadvantage among Indigenous Māori adolescents in
358 comparison to all other ethnic groups supporting the ongoing colonial impact of racism for Maori youth. Finally,
359 our trend analyses demonstrated that experiences of racism and health inequities are persistent and increasing
360 over the two decades that the Youth2000 surveys have been conducted.

361 These findings are significant because they reinforce but also counter conventional understandings of racism.
362 Firstly, as shown previously,^{20,21} economic advantage is a significant protective factor; there is potential for
363 mitigating health risks and social mobility for minority youth who have the access to and the benefits of higher
364 incomes. Conversely, Indigenous and migrant youth who come from poor backgrounds appear to have worse
365 outcomes. Secondly, the findings add to the limited body of literature^{22,23} on the effects of colourism or
366 perceived whiteness and how it shapes everyday social relationships, a facet of racism that is often
367 underestimated in health research. Thirdly, the results throw light on migration generation as a significant factor
368 in social and health outcomes. While there is considerable focus on first-generation migrants as being
369 vulnerable, it is generally accepted that second-generation migrants are better at acculturation, i.e., negotiating
370 dominant cultural norms. Our results firmly counter this view. Second-generation migrant youth particularly
371 Pasifika are as vulnerable as first-generation migrants, although this is unrecognised in research. Finally, the
372 findings highlight some areas where there was a direct relationship between structural and embodiment
373 resources; young people who had the least favourable structural and embodiment resources were the worst
374 impacted (e.g., racialised migrants from poorer countries and those perceived as non-white experienced higher
375 levels of forgone healthcare and symptoms of depression). However, in other areas particularly in symptoms of
376 depression and attempted suicide, direct relationships were not as clear. For example, some racialised groups
377 (Africans and South Asians) experience high levels of depression, but low levels of attempted suicide. These
378 results highlight the complexity in understanding the impact of flexible resources on mental health outcome
379 indicators and require further in-depth analysis based on purposefully collected data.

381 Our intersectional analyses framed around flexible resources as a central concept has been a useful lens to bring
382 out the diversity of experiences of racism, and with it, provide insight into NZ's fabric of inequity. The findings
383 demonstrate the close associations between identities and racism, and that not all identities are equally linked to
384 racial disadvantage. The study also highlights the benefits of nuanced sociologically-grounded analyses in order
385 to draw out heterogeneity and complexity of how racism works.^{9,19} However, while this transdisciplinary
386 approach offers an innovative way to understand and measure racism, the translation from the conceptual to the
387 empirical is developmental. This is especially true with regards to the use of Youth2000 data which was not
388 specifically collected for this purpose. Consequently, we were constrained by the variables available. Fit-for-
389 purpose data collected specifically to study diverse flexible resources would refine the measures used in the
390 statistical analysis, and also strengthen the conceptual framework. However, given the significant findings, this
391 study may be considered a proof-of-concept analysis. The concepts of flexible resources and intersectionality
392 have given us a demonstrably complex, and original, insight into the ways that racism manifests in a multi-
393 ethnic society with many minority groups.

394 The Youth2000 surveys used rigorous sampling methods and their strengths and limitations have been described
395 previously.⁸⁻¹⁰ In our analysis, we were not able to adjust for survey non-response, so our estimates may not
396 represent the general population of NZ students. The cross-sectional study limits inferences about the direction
397 of causal associations, and unmeasured confounding may have influenced our findings. Due to low sample sizes
398 and the risk of information being potentially indefinable, we are not able to separate out data for the MELAA
399 group. Therefore, the findings on experiences of racism for particular groups, for example anti-Black racism or
400 Islamophobia, cannot be fully captured by the data we have used. Further research using other dimensions of
401 flexible resources needs to be developed to get a fuller understanding of the complexity of racism in society.
402 Additionally, social gradients operate differently across the spectrum of mental health outcomes, which are not
403 fully captured in our analysis. Our study also did not consider gender, disability, or other dimensions of social
404 difference, which often have critical impact on socioeconomic and health outcomes. Our analysis, drawn from
405 quantitative survey data, would also benefit from qualitative rich accounts of how aspects of identity foster
406 disadvantage or advantage. Finally, this study focused on adolescent groups where there are some public support
407 systems in place to counter the effects of negative flexible resources and may not be applicable for other age
408 groups. Similar studies for younger children and adult populations may render starkly different results and
409 therefore need to be independently conducted.

410 The findings offer broad directions for policy and programme interventions. Anti-racism interventions should
411 recognise the differences in exposures and experiences of racism among and between targeted/minorities and

privileged groups based on their multiple social identities. Public social service, educational scholarships, and healthcare provision, particularly for Indigenous and minority adolescents from financially strained communities will have a significant impact on social mobility. For migrant youth, these should be targeted for each generation recognising that adolescent exclusions occur for up to three migrant-generations. Economic support alone, however, is not enough. There is also a need for educational interventions and diversity training around the impacts of perceived ‘whiteness’ and racial bias for key care providers especially teachers, health service providers, employers, landlords, and the police. Initiatives that enable young people’s sense of pride in their own cultural diversity and respect for that of others are also critical to health and wellbeing outcomes.

NZ is a thriving bicultural and multi-ethnic society and is known to the world as one of the most welcoming countries with high levels of acceptance of different ethnicities and cultures. Yet, there is also a lingering legacy of colonial systemic disadvantage and discrimination. This study, a granular examination of racism, portrays a picture of heterogeneity, complexity, and, even, contradiction. Health researchers must grapple with these complexities if NZ and, indeed, multi-ethnic societies globally are to be racism-free.

Data sharing

Individual participant data collected for the study will not be made available as per the Adolescent Health Research Group (NZ) data access policy (<https://www.fmhs.auckland.ac.nz/en/faculty/adolescent-health-research-group/collaborations-and-access-to-datasets.html>). The data dictionary defining each field in the set is available (<https://www.youth19.ac.nz/projects>).

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