The Biopolitics of Māori Biomass:

Towards a New Epistemology for Māori Health in Aotearoa/New Zealand

Isaac Warbrick

Taupua Waiora Centre for Māori Health Research

Auckland University of Technology

Andrew Dickson

School of Management

Massey University

Russell Prince

School of People, Environment and Planning

Massey University

Ihirangi Heke

Māori Health, Physical Activity & Outdoor Education Consultant

Integrated Hauora Initiatives Ltd

Abstract

In this paper we consider what impact a biopolitics that creates a compliant self-governing weight-focused population has had on Māori health in Aotearoa/New Zealand. We frame this discussion with three vignettes that in different ways demonstrate the deleterious effects of the individualisation of health on Māori. We argue that the current biopolitics is best explained as 'the health of Maoris' not 'Māori Health'. To counter this current biopolitics we put forward an alternative epistemology, the 'Atua Matua' framework. This epistemology pays respect to a Māori view of health that is holistic, encompassing physical, emotional, spiritual, cultural and familial well-being and does not give ground to the requirement for individualism so prevalent in neoliberalism. Finally we consider what this new epistemology might offer to the public health agendas in Aotearoa and other countries where indigenous populations suffer ill health disproportionately. Thus our implications have potential not only for Māori health, but human health in general.

Introduction

We begin this paper by presenting three vignettes, in the tradition of auto-ethnography[1], that frame our commentary. The first two, in quite different ways, demonstrate the deleterious effects of the individualisation of health on Māori. The third introduces an alternative epistemology. These cases are presented to provide context to the rest of the paper.

Vignette One: "A Subject of Science" by Isaac Warbrick

> *I 'stumbled across' the harm caused by weight-loss messages during a study on the impact of exercise on the health and well-being of Māori men. Following an intervention, the men came together to discuss its impact on their health and well-being. A number of subtle observations were made by myself and colleagues who analysed these transcripts.*
>
> *First, it was difficult to find one mention of weight or weight-loss during these discussions. The men raved about the strong friendships they had developed with each other, improvements in mood and energy levels, and how they just felt better about life in general. The second observation was made after the discussions were completed when, under obligation of ethical requirements and the interest of hard working participants who wanted to know how their efforts paid off, clinical findings were reported to participants. Picture now, the enthusiasm of a previously sedentary man, freshly motivated to exercise regularly after an intervention that he claims has made all aspects of life better. Also picture me, now a close friend with this participant, presenting to him results where there is little to no change in the clinical markers measured, the most noticeable of which is 'weight'. Not surprisingly, the good feelings and subjective*

sense of achievement were 'dashed in a moment' with the appearance of a number on a page spat out by a scientifically calibrated scale. The disappointment and discouragement was palpable and often, the 'hooked' habitual exerciser gave up on exercise then and there citing "what's the point"?

Vignette Two: "Saving Gen Y" by Andrew Dickson

When I first watched this television show I saw it as an opportunity lost. I saw eight kids encumbered by much more than just their fat bodies, splayed across all sorts of screens around Aotearoa/New Zealand. Eight kids who certainly didn't need that kind of help. I wrote an opinion editorial for the New Zealand Herald, called 'Unethical weight-loss mantra is 'Enslaving Gen-Y' (Dickson, May 16, 2013), and in this I pointed to the biggest tragedy in the show – the 'editing out' of Ihi Heke's[2] kaupapa (purpose or agenda) from the content featured. I was not surprised by this editing of course – weight-loss related reality television relies on the weigh-ins, the number on the scales. Everything else around this is either build-up to a weigh-in or 'post' a success/failure diagnostic exercise. The media here need sound bite sized fodder, and more-so something which is visually stimulating, in this case something 'disgusting' (Lupton, 2014). At the time of writing the opinion editorial I didn't know Ihi Heke at all, but I did my research and discovered a kaupapa that extended further than a set of scales, or even a set of exercises. A kaupapa that would have created a very different television experience. But that was not to be.

Vignette Three: "Atua Matua" by Ihirangi Heke

I have been working on an alternative health framework, the 'Atua Matua Māori Health Framework'[3], which values ancestral knowledge as the primary process that Māori

should pursue, with improved health, fitness (and weight loss) being an incidental outcome of understanding where they come from. The Atua Matua Māori Health Framework was initially developed as an attempt to provide a set of environmentally-based Māori concepts that could help Māori move from the current deficit mainstream model focused on weight and sickness to a Māori ancestral framework. The rationale for taking this step was an attempt to assist Māori in recognising their historical connection to the environment, and its role in sustaining Māori for centuries. Well known Waikato Māori academic, Tamiaho Serancke had this to say about the framework:

"…any teaching and learning must be imbued with equal spaces of Māori knowledge, as well as their non-Māori counterparts/Western ways of thinking. The Atua Matua Māori Health Framework refocuses Maoritanga (Māori concepts) at the core, does not ignore other views or values, but indeed invites holistic approaches within the applied practices and protocols of this space, both Takaro (Māori games) and Sport, Fitness, Recreation. "

Rarely if ever is such an approach, aimed at empowering individuals and valuing differences represented in the mainstream health sector

We can conclude from these vignettes that something is seriously wrong. Weight has become a hot topic from an economic, social and health standpoint. This fascination with weight is levelled particularly at Māori in New Zealand whose health has been a source of sustained societal concern for many decades. While Māori have traditionally seen health concerns from a holistic perspective, highlighting the balance and connections between wairua (spiritual), tinana (physical), hinengaro (psychological), and whānau (family and relationship) aspects of

health (Durie 1985), the majority of public health services in New Zealand have adopted a very individualistic approach with a disproportionate focus on particular markers of illness. Body mass is one of the most important and storied markers, with regular references made by the media and mainstream public health science to the "exceptionally high" (Taylor et al., 2010, p390) rate of obesity and overweight outcomes amongst the Māori population. The argument put forward to sustain this concern revolves around the various associations made by modern science between 'elevated' body mass and diseases of the cardiovascular system, type 2 diabetes, gout, as well as a range of other medical issues; issues that have a higher prevalence among Māori when compared to New Zealanders of European Origin (NZEO) (Winnard et al., 2013). As such when Māori visit health professionals, they are often told that their high cholesterol and uric acid levels, gout and the high concentration of glucose in their blood *is caused by* being overweight or obese. The prescription that generally follows is weight loss, something that critical health scholars and some scientists know is at best extremely difficult and at worst close to impossible to maintain (Aphramor, 2005; Gluckman & Hansen, 2012). This prescription of weight loss is derived from a mainstream science that has become complicit with a neoliberal biopolitics of the body. In New Zealand, and indeed throughout most developed countries, weight-loss is seen as not only entirely reasonable, but in 'fact' the only ethical position that an overweight or obese person can inhabit (Dickson, 2014). This moral frame has achieved sensational success as a discourse in society, spread by the media, the health industry and perhaps more insidiously by the capital goals of the wider diet industry (Dickson, 2011) as they attempt to produce docile consumers. Although Māori are familiar with this moral frame, having been portrayed negatively in media for generations (Burrows, 2009), the impact of weight loss messages has had less attention.

The moral assumption that the individual is 'in charge' is in direct conflict with Māori views which places greater value on the health of the environment first and collective health of whānau as a reflection of environmental health (Durie 1999, Panelli and Tipa 2007). With this in mind, in this paper we consider the effect that the goal of compliant self-governance focused on weight loss has had on Māori health – an effect apparent in the first two vignettes above. We counter this by presenting an alternative epistemology; one that pays respect to a Māori view of health that is holistic, encompassing environmental, physical, emotional, spiritual, cultural and familial well-being. Crucially, this view does not ignore body mass, but understands it in a completely different way.

In the next section we discuss the role of biopolitics, and specifically the mode of self-governance under neoliberalism. We suggest that this produces a view of 'Maori health' that is better characterised as little more than 'the health of Maoris'. This we contrast with the possibilities offered by adopting a new 'Māori Health' epistemology, using the example of Ihi Heke's conceptualisation that was lost in the 'Saving Gen Y' case.

Thinking Biomass through Biopolitics

The Foucauldian notion of biopolitics describes the politics of managing the health and welfare of a population (Foucault 2008; Lemke 2011; Hokowhitu 2014). For Foucault, the emergence of the figure of the 'population' as a problem to be managed and governed has occurred over the last few centuries alongside the growth in techniques for counting, measuring, comparing and assessing people as individuals and collectivities. Biopolitics draws the link between how populations are imagined and understood as a problem – for example as overweight, unhealthy, unequal and so on – and the seemingly mundane techniques through which that reality is constructed – for example with statistical tables, diagrams and

graphs – and performed – such as through public health programmes that target the problems being imagined and displayed. Importantly, from a biopolitical perspective, the intention is not to 'test' whether these techniques are accurately portraying 'reality', but to ask how they are linked to the way the problem of population is understood and to consider the consequences of that understanding (e.g. Lakoff 2015; Villadsen and Wahlberg 2015; Wahlberg and Rose 2015). When problematic sub-populations emerge through particular biopolitical techniques, we need to ask what these consequences might be for how people in those sub-populations will be subjectified and disciplined.

In 1985, Professor Sir Mason Durie presented a health model, Te Whare Tapa Whā (Durie 1985), which advised a physical-health dominated system of four components of well-being that were important in a Māori perspective of health. Each component, represented in this model as a load-bearing wall within a whare (traditional house) afforded equal attention to ensure the house (health) remained whole. While this model, and others presented since, allowed non-Māori a glimpse at the holistic nature of Māori views, the four components were never intended as an exhaustive list that would enable non-Māori to entirely comprehend Māori views connected to health (Salter, 2000; O'Connor, 2007; Burrows, 2009; Heaton, 2011; Sinkinson, 2011), even though that is now how it is portrayed. Salter brings attention to this 'sanitisation' process within the education sector during the development of the Health & Physical Education curriculum, suggesting a "watering down" and "progressive sanitisation of its meaning and importance" (2000, p. 10). He goes on to discuss the potential impacts of this sanitisation, concluding that "this view is like to be *interpreted* by Māori to align with existing cultural understandings but *interpreted* quite differently by non-Māori with a world view predicated upon dominant discourses" (ibid, p.11-12, emphasis in original). In

essence the inclusion of Durie's model within mainstream health in Aotearoa in the 1980s was bound by the times to become a sanitised subject of biopolitics.

Durie's argument about Māori health occurred at a time when political rationalities and approaches to the problem of governing populations were shifting in important ways. Foucauldian governmentality scholars have argued that through the second half of the 20th century an approach to governing that they have labelled 'advanced liberalism' emerged (Dean 1999; Rose 1999; Rose, O'Malley et al. 2006). These are techniques that act through the individual as a calculating actor, expecting them to take account of their own well-being by paying attention to their personal outcomes. So for example, rather than collectively 'provide' healthy food by making it cheaper and more accessible, instead tell people to discipline themselves by watching their weight, the number of servings of fruit and vegetables they eat each day, and so on. This resonated with the emerging neoliberal ideology that sought to reduce the role of the state in New Zealand during the 1980s and 1990s especially, generally extending 'market' techniques into healthcare and other areas that worked with the grain of advanced liberal techniques (Guthman and DuPuis 2006; Prince, Kearns et al. 2006; Peet 2012; Lovell, Kearns et al. 2013; Boston and Eichbaum 2014). Durie's own argument emerged in the context of other forces for change in New Zealand society at the time: the reassertion of Māori identity through the Waitangi process, the establishment of kohanga reo (Māori language 'nests' for pre-schoolers), and the discourse of a bicultural state (Moon 2009).

The confluence of these three elements – the governmental techniques of advanced liberalism, the political ideology of neoliberalism, and the post-colonial attitude of biculturalism – produced an approach to Māori health, a biopolitics, that simultaneously

sanitised the holistic view of health held by Māori ancestry, individualised and responsibilised Māori regarding their own health, and collected them together in an aggregate fashion as a distinctive group whose comparison to the rest of the population could then be folded back onto them in a disciplinary manner. Māori get responsibilised and disciplined three times: as individuals, as a group, and systemically by being subjected to a sanitised conceptualisation of Māori health.

In terms of the consequences of this biopolitics, on the one hand, this was a productive moment: a political object – Māori health – took shape. Political and social projects could leverage off this object by linking their proposed outcomes to the goal of improving Māori health statistics. Resources could be redirected and captured for a range of purposes, so long as they could be premised on helping to ameliorate the problem of Māori health. For example, where once Māori health research was basically research done on 'Maoris' by non-Māori researchers, there are now multiple levels of health research funding dedicated and set aside by the Health Research Council of New Zealand (HRC), specifically for Māori-led and Kaupapa Māori-driven research. These include studentships, masters and doctoral scholarships, and research grants for community-based research, research development, emerging researchers, full projects, and research programs, all dedicated to Māori research and Māori researchers[4]. The question of whether this health funding has been as high as it should have been aside, much of it owed to the development and integration of Te Whare Tapa Whā and other Māori health movements into mainstream health over the last few decades. What's more, government programs such as Whānau Ora[5] as well as strategies like He Korowai Oranga (Ministry of Health 2002) that guide the government and health sector to achieve best outcomes for Māori health, are a direct result of these early Māori health models.

But on the other hand, as the vignettes with which we opened this paper show, this biopolitics has a hard edge. The individualisation of health comes together with the need of some 'measure' of health, and the measure that has emerged as dominant in this biopolitical paradigm is weight (Guthman 2009; le Besco 2011; Warin 2011; Powell and Gard 2014; Shannon 2014). In New Zealand many media and public health campaigns focus on increasing physical activity and improving diet. While initial impressions highlight the focus on enhanced lifestyle habits, rather than focusing initially on weight, public health sponsored initiatives almost always include weight loss as a primary outcome measure; the primary measure of 'success'. Thus, how does the Green Prescription[6] patient who has spent 10 weeks successfully developing a habit of regular physical activity feel when the scales suggest they haven't really achieved anything at all (according to weight standards)? In reality, the only option available to those with 'Western lifestyle' illnesses is initiatives targeted at weight loss.

Current Biopolitics: 'The Health of Māoris'

When Māori health is intractably associated with individual performance against a statistical measure like weight, much more is lost than just a bit of the latter. Despite the fact that many Māori academics and distinguished leaders have fought to have a Māori view of health recognized, in this biopolitics, the object that is 'Māori health' is really little more than 'the health of Maoris', to adapt the words of Dame Evelyn Stokes (1987), with Māori understood as nothing more than an otherwise indistinguishable subset of the population Concrete examples of this can be seen in the work of New Zealand scientists, operating with the very best of intentions they constantly perpetuate the existing biopolitics. For instance, while describing the demographics of Māori children Rush et al (2013) state that "relative poverty and Māori ethnicity compared with non-Māori ethnicity are factors associated with

rapid weight gain and a high prevalence of obesity" (p. 369). Similarly Rush, Crook and Simmons (2009) attempted to redefine the "optimal waist cutpoint" (p.786) for the Māori population subset as opposed to 'the rest'. It is easy to dismiss these examples as 'simply' banal science-speak, i.e. just the way things are done. But these routine and mundane practices are exemplars of carriers of the current problematic biopolitics, these are the words that carry through into the media reporting and become common speak in the population of Aotearoa, reinforcing and repeating 'the health of Māoris'.

So how do we move past this problematic place we find ourselves in? It is worth pointing out that the Te Whare Tapa Whā model, despite being over 30 years old, is still considered in 'mainstream' circles as the gold-standard Māori view on health. Much has happened in the 30 years since its development and one could argue that Te Whare Tapa Whā is the 'Māori 101' introductory view of health; it is important but only a beginning. For instance more than 15 years ago George Salter drew our attention to one important Māori interpretation of Te Whare Tapa Whā that is not acknowledged in current health, he quotes a kaumatua (tribal elder):

> *…the whare (house) is built on the ground… and the land is an important connection. I know there are only four sides in the picture, but I think you'd find Māori people know the floor is as important as the walls… although it's not shown, that's what gives the whole a foundation, the links to the whakapapa… with each corner post having its own mauri (life force).* (In Salter, 2000, p. 12)

Salter's analysis suggests that it would be exceptionally difficult for our current biopolitics to adequately comprehend the significance of this interpretation: "From a Pākahā perspective the notion of land as an essential element of hauora is somewhat abstract, and while this view

may focus on its commodification and economic potential, Māori interest in the land is of fundamental significance to Māori" (ibid, p. 12). In fact a Māori ancestral perspective on the land is epistemologically different from European-Pakeha conceptions. Consequently, we suggest that an entirely new epistemology is needed to advance Māori health beyond the current deficit, weight-focused approach; an epistemology based on the Māori health discourses that have developed and progressed in the last three decades of critique since the ground-breaking work of Durie and others. In other words, rather than a biopolitics of the 'health of Maoris', a biopolitics where the 'Māori' in 'Māori health' signifies much more than just a population subset, has the potential to transform how health is understood by the kinds of subjects we began this paper with, and so give them an identity that is not tethered to measures of their biomass.

Towards a New Epistemology of Māori Health

Away from popular discourse, a renaissance to reclaim pre-European environmental knowledge and its application in modern settings has highlighted opportunities to develop authentic health approaches for Māori. One of the outcomes of this renaissance has been the development of an approach that keeps the iwi-centric (tribal) nature of health related knowledge intact i.e., the development of health initiatives that can be populated with iwi specific interpretations. A number of such initiatives have popped up throughout Aotearoa, which have achieved success without being tethered to measures of biomass. Such strategies have focused on the role that particular healthy lifestyle choices have on enhancing cultural identity, social interaction, and sheer enjoyment. Others have focused on connecting individuals and whānau with culturally significant landmarks (mountains, rivers, and oceans), histories and/or significant tupuna (ancestors).

Ihi Heke employed such an approach in practice with a sedentary, 'overweight' group in Tolaga Bay on the East Coast of the North Island of New Zealand (Tahana, 2009; Heke, n.d.). Employed to improve the health in this small rural community, Heke's focus was not to 'help' people lose weight, but to connect these individuals, all of whom were Māori, to ancestral lands; their mountains, rivers, and forests. In the process, individuals and families came to know these culturally significant locations, which are an inseparable part of cultural identity and health, more intimately. The actual physical activity and subsequent changes in health and weight achieved in the process of 'reconnecting' became secondary to a far more meaningful and arguably healthier focus. Presenting physical activity as a means to enhance cultural identity or conversely, cultural identity as a means to enhance physical activity and linkages to significant aspects of ones environment by running up culturally-significant maunga (mountains), and swimming in genealogically relevant awa (rivers) has led to enhanced health and well-being, without focusing individual efforts on weight and weight loss. Similarly, healthy eating plans based on traditional diets and Atua Matua principles, have the potential to make eating healthy food a significant cultural activity and an opportunity for reconnection, rather than a perceived sacrifice or chore. What's more, the neoliberal ideal of weight as a measure of success diminishes the versatile value of healthy eating and exercise as a tool for enhanced well-being i.e. "it's only good for weight-loss", reducing exercise and healthy eating to a means to look good and avoid illness. This approach also obscures the role of other risk factors (poverty, smoking, stress etc.) in poor health while equating health and well-being with thinness.

The strength of the Atua Matua approach is in its focus from maunga to tangata (from mountain to individual), a downstream process deliberately chosen to combat the current

upstream model that begins and ends with the individual. This approach acknowledges that individuals are the result of a range of ancestral and environmental influences, suggesting that health promotion requires greater emphasis on fostering healthy environments, rather than pointing the finger of blame at the weaknesses of 'fat' individuals. An example of this from traditional forms of knowledge is the well-known proclamation from the people of the Whanganui area in the Western North Island of New Zealand

'Ko au te awa, Ko te awa ko au'

'I am the river, the river is me''

While some will struggle initially to make a connection between such a view and current models of health promotion, opportunities abound for creative connections between pre-European Māori knowledge and improved contemporary health. For instance, in the emerging field of epigenetics, many researchers acknowledge a physiological link between environment exposures and the expression of certain genes, and whether/how environmental factors in one generation can impact on subsequent generations. This field of study has become extremely popular among health scientists with studies linking environmental stresses such as maternal dietary status, early-life exposure to pollutants, and historical trauma with intergenerational health outcomes (Thayer and Kuzawa 2011, Walters, Mohammed et al. 2011). Walters et al. note that extreme environmental stress in one generation [such as that caused by colonization, disconnection from lands, and institutional racism] can "leave an imprint on the epigenome that can be carried into future generations with devastating consequences" (Walters et al., 2011, p.184). While contemporary biopolitics would separate 'scientific' epigenetics from 'non-scientific' indigenous knowledge, it is not difficult to see the theoretical link between epigenetic determinants of health and a Māori

view of health; one which locates the health of individuals within the context of whakapapa; a term concerned with the links between environment, genealogy and posterity. The separation and disconnection of people from their lands was a monumental impact of colonization; one that impacted greatly on the health and well-being of Māori on spiritual, psychological and physical levels. In essence, the introduction of colonization and more recently neoliberalism has led to a dissolving of ties between individuals, whānau, and iwi (tribes) from the environment that had sustained them, and provided the foundation of their identity as Māori (Durie 2004; Panelli and Tipa 2007). Importantly, studies in non-Māori also show a strong relationship between a population's health and their physical environment (Mitchell and Popham 2008). In fact the argument here is that any human-centered approach to Māori health is destined to fail because the 'human' simply does not exist in isolation, the environment we live in is of primary importance for Māori communities. The Atua Matua framework focuses on reconnecting ties between individuals and the environment in a way that is relevant to Māori. Although there may be differences in how 'environment' is defined in these two epistemologies, a Māori world view and the views expressed in epigenetic research provide an example of how two seemingly opposing views are in fact connected, in this case by the role of external environmental influences on the health of individuals and generations.

Another essential component of the Atua Matua approach to health promotion is tinorangatiratanga, a principle synonymous with aspirations of self-determination for Māori. Within our current biopolitical frame this principle has negative connotations of activism, extremism, and racism, primarily because it questions the sovereignty of the State. However, central to the epistemology of the Atua Matua system of thinking is recognising that each iwi

(tribe or community) must populate this health framework with information that is specific and relevant to their particular knowledge base, environment or interpretation, rather than docilely accepting mainstream prerogatives. This further ensures maintenance of self-determination while moving away from the mentality of dependence fostered by currently marketed messages from the weight loss industry.

The absolute importance of self-determination has been echoed among non-Māori as well. In a study of the fat-acceptance movement, for example, it was found that the social engagement in critical dialogue provided by their community gave a "sense of self-worth, independence, and autonomy to take control of their bodies and their lives" (Dickins, Thomas, King, Lewis, & Holland, 2011, p10). Indeed, there are few expressions of self-determination and self-empowerment within the neoliberal health paradigm where the weight loss industry benefits from the handing over of one's will to pills, supplements, diets, or products in the pursuit of 'good' health. Contrary, the self-determination expressed within the Atua Matua framework provides a shift toward empowerment, ownership, and accountability of health, allowing communities to define what health *is*, independent of moralising agendas of the state and corporate sector.

Concluding Remarks

The Atua Matua framework provides a way to re-imagine Māori health as a new epistemology, one that recognises the in-roads made over the past 30 years with the development of Te Whare Tapa Whā and other early Māori health models, but also recognises the need for a bolder epistemological shift. Might it be that the time of 'Kaupapa Māori' thinking may be at an end? Exchanged for iwi-centered whakapapa (genalogical) related information? While the 'Kaupapa Māori' approach was undoubtedly an important tool to gain

political and academic access, the Māori 'renaissance' rolls on and as such a whakapapa rationale at an iwi level may be the next step forward. We might even suggest that the Māori language is at risk if it remains human centred with no connection to the origin of communication founded in the environment, such as the sound of a crashing wave as a raw form of language that forewarns of the danger of entering the ocean.

With this in mind we conclude by explicating implications for public health policy in Aotearoa and around the world. We argue for a new epistemology that actively abandons the current biopolitics of 'the health of Maoris' in favour of a new biopolitical future for Māori health, situated at the level of iwi. We see this example of an alternative discourse to neoliberal ideals also as a signpost for non-Māori health movements that are fed-up with current health promotion and its undue focus on biomarkers such as weight. After all, Māori share a common struggle with those uncritically categorised as 'overweight' and 'obese' by body mass. Both Māori and 'the obese' experience discrimination and bias resulting in reduced employment and educational opportunities, social isolation and marginalization. Mainstream discourses on health and weight continue to stigmatise weight as caused by the 'obese' individual's poor decision making (Dickins et al, 2011). Māori too have their apparent poorer health, education, and employment blamed on some sort of chosen laziness or weakness. Such attitudes overlook the on-going struggle of negotiating socio-cultural, financial, and genetic influences upon the lives of those who are 'obese'.

Conversely, the concepts of whānaungatanga and whakapapa that are woven throughout the Atua Matua framework suggest that focusing on an individual's supposed illnesses, weaknesses and failings is ignorant. These Māori concepts acknowledge the impact of genes, family, and environment on the health (and weight) of an individual. These concepts also

highlight the importance of whānau as a source of support and influence in the achievement of health and well-being, similar to studies with non-Māori that identify family and friends as a major source of shaping attitudes toward weight (Dickins et al, 2011). Also the design of the Atua Matua framework shows a deliberate attempt to validate Māori metacognitive processes. Such an attempt to validate a previously silenced voice may pave the way for the 'obese' to have a say as to what would be best for them, strengthening alternative paradigms such as the 'Health at Every Size' movement (Bacon 2010, Bombak 2014, O'Hara and Taylor 2014), while contributing to emergent indigenous health policy movements in other countries.

We accept that recognition of this new epistemology will not come from the private sector, where impulse sales and weight anxiety (Dickson, 2011) are a corporate goal. Thus we openly challenge our current public health sector to abandon the dominant, but failing, one-size-fits-all approach. Instead we invite the sector to connect with frameworks like Atua Matua. We accept that it is no small task, particularly in the case of non-Māori who often wonder how they can be expected to operate in this domain. Nevertheless, this new epistemology is not designed to exclude interpretations but highlights the need for empathetic and open discussion to ensure messages are culturally and morally sound. The Atua Matua framework provides an entry point for health promoters to engage with a new Māori health, and an example of health in general, with a different set of concepts that do not focus *en masse*.

Notes:

1 see Dickson, 2014, for a discussion of autoethnography in public health research

2 Ihirangi Heke was featured on the show primarily as an exercise psychologist/trainer/health promoter.

3 The full framework is available from: http://toitangata.co.nz/uploads/files/Dr_Ihi_Heke_Atua_Matua_Framework.pdf

4 See The Health Research Coucil's website - http://hrc.govt.nz/funding-opportunities/maori-development

5 An approach that places whānau (family) at the centre of service delivery with a particular focus on integrating health, education, and social services

6 This is a government initiative, described as: "A Green Prescription (GRx) is a health professional's written advice to a patient to be physically active, as part of the patient's health management." Taken from: http://www.health.govt.nz/our-work/preventative-health-wellness/physical-activity/green-prescriptions

References

Aphramor, L. (2005). Is a weight-centred health framework salutogenic? Some thoughts on unhinging certain dietary ideologies. *Social Theory and Health, 3*, 315-340.

Bacon, L. (2010). *Health at every size: The surprising truth about your weight*. BenBella Books.

Bombak, A. (2014). Obesity, health at every size, and public health policy. *American journal of public health, 104(2),* e60-e67.

Boston, J., & Eichbaum, C. (2014). New Zealand's Neoliberal Reforms: Half a Revolution. *Governance, 27*, 373-376.

Burrows, L. (2009). Pedagogizing families through obesity discourse. *Biopolitics and the "obesity epidemic": Governing bodies*, 127-140.

Dean, M. (1999). *Governmentality: Power and Rule in Modern Society*. London, Sage.

Dickins, M., Thomas, S. L., King, B., Lewis, S., Holland, K. (2011). The role of the fatosphere in fat adults' responses to obesity stigma a model of empowerment without a focus on weight loss. *Qualitative health research, 21*, 1679-1691.

Dickson, A. (2011). The Jouissance of the Lard(er): Gender, desire and anxiety in the weight loss industry. *Culture & Organization, 17*(4), 313-328.

Dickson, A. (May 16, 2013). Unethical weight-loss mantra is 'Enslaving Gen-Y', NZ Herald. Retrieved from http://www.nzherald.co.nz/lifestyle/news/article.cfm?c_id=6&objectid=10884117

Dickson, A. (2014). Re: living the body mass index: How A Lacanian autoethnography can inform public health practice. *Critical Public Health*(ahead-of-print), 1-14.

Durie, M. H. (1985). A Maori perspective of health. *Social Science and Medicine, 20*, 483-486.

Durie, M. (1999). Te Pae Mahutonga: A model for Maori health promotion. Health Promotion Forum of New Zealand Newsletter.

Durie, M. (2004). Understanding health and illness: research at the interface between science and indigenous knowledge. *International Journal of Epidemiology, 33*, 1138-1143

Gluckman, P., & Hanson, M. (2012). *Fat, Fate, and Disease: Why exercise and diet are not enough*. Oxford University Press.

Guthman, J. (2009). Teaching the Politics of Obesity: Insights into Neoliberal Embodiment and Contemporary Biopolitics. *Antipode, 41*, 1110-1133.

Guthman, J., & DuPuis, M. (2006). Embodying neoliberalism: economy, culture, and the politics of fat. *Environment and Planning D-Society & Space, 24*, 427-448.

Heke, I. (n.d.). *Introducing the Atua Matua Māori Health Framework.* Unpublished Document, available from: http://toitangata.co.nz/uploads/files/Dr_Ihi_Heke_Atua_Matua_Framework.pdf

Heaton, S. (2011). The co-opting of 'hauora' into curricula. *Curriculum Matters* 7, 99-117

Hokowhitu, B. (2014). If you are not healthy, then what are you? Healthism, colonial disease and body-logic. In K. Fitzpatrick & R. Tinning (Eds.), *Health Education: Critical Perspectives*, (pp. 31-47). New York: Routledge.

Lakoff, A. (2015). Real-time biopolitics: the actuary and the sentinel in global public health. *Economy and Society, 44,* 40-59.

le Besco, K. (2011). Neoliberalism, public health, and the moral perils of fatness. *Critical Public Health, 21,* 153-164.

Lemke, T. (2011). *Biopolitics: An Advanced Introduction*. New York, New York University Press.

Lewis, S., Thomas, S. L., Hyde, J., Castle, D., Blood, R. W., Komesaroff, P. A. (2010). “I don't eat a hamburger and large chips every day!” A qualitative study of the impact of public health messages about obesity on obese adults. *BMC public health, 10,* 309.

Lovell, S. A., Kearns, R. A., & Prince, R. (2014). Neoliberalism and the contract state: exploring innovation and resistance among New Zealand Health Promoters. *Critical Public Health*, *24*(3), 308-320.

Lupton, Deborah. (2014). The pedagogy of disgust: the ethical, moral and political implications of using disgust in public health campaigns. *Critical Public Health*(ahead-of-print), 1-14.

Ministry of Health, N. Z. (2002). *He Korowai Oranga: Maori Health Strategy*. Wellington, NZ, Ministry of Health.

Mitchell, R., & F. Popham (2008). Effect of exposure to natural environment on health inequalities: an observational population study. *The Lancet, 372,* 1655-1660.

Moon, P. (2009). "A chequered renaissance: The evolution of Maori society, 1984-2004."

O'Connor, T. (2007). New Zealand's Biculturalism and the Development of Publicly funded Rongoa (Traditional Maori Healing) Services. *SITES: New Series, 4*(1), 70-94

O'Hara, L., & J. Taylor (2014). Health at Every Size: a Weight-neutral Approach for Empowerment, Resilience and Peace. *International Journal of Social Work and Human Services Practice, 2,* 272-282.

Panelli, R., & Tipa, G. (2007). Placing well-being: A Maori case study of cultural and environmental specificity. *EcoHealth, 4*, 445-460.

Powell, D., & Gard, M. (2014). The governmentality of childhood obesity: Coca-Cola, public health and primary schools. *Discourse: Studies in the Cultural Politics of Education*, (ahead-of-print), 1-14.

Prince, R., Kearns, R., & Craig, D. (2006). Governmentality, discourse and space in the New Zealand health care system, 1991–2003. *Health & Place*, *12*(3), 253-266.

Rose, N. (1999). *Powers of Freedom: Reframing Political Thought*. Cambridge, Cambridge University Press.

Rose, N., O'Malley, P., & Valverde, M. (2006). Governmentality. *Annual review of law and social science*, *2*, 83-104.

Rush, E. C., Crook, N., & Simmons, D. (2009). Optimal waist cutpoint for screening for dysglycaemia and metabolic risk: evidence from a Maori cohort.*British journal of nutrition*, *102*(05), 786-791.

Rush, E., Reed, P. W., Simmons, D., Coppinger, T., McLennan, S., & Graham, D. (2013). Baseline measures for a school-based obesity control programme: Project Energize: Differences by ethnicity, rurality, age and school socio-economic status. *Journal of paediatrics and child health*, *49*(4), E324-E331.

Salter, G. (2000). Marginalising Indigenous Knowledge in Teaching Physical Education: The Sanitising of Hauora (well-being) in the new HPE curriculum. *Journal of Physical Education New Zealand, 33*(1), 5-16

Shannon, J. (2014). Food deserts: Governing obesity in the neoliberal city. *Progress in Human Geography, 38,* 248-266.

Sinkinson, M. (2011). Back to the future: Reoccurring issues and discourses in health education in New Zealand schools. *Policy Futures in Education, 9*(3), 315-327

Stokes, E. (1987). Maori Geography or Geography of Maoris. *New Zealand Geographer, 43*(3), 118–123

Tahana, Y. (2009, Mar 21). *Welcome to the 100kg club, just don't get too fit.* NZ Herald. Retrieved from: http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10562716

Taylor, R. W., Brooking, L., Williams, S. M., Manning, P. J., Sutherland, W. H., Coppell, K. J., … Mann, J. I. (2010). Body mass index and waist circumference cutoffs to define obesity in indigenous New Zealanders. *The American journal of clinical nutrition, 92,* 390-397.

Thayer, Z. M., & C. W. Kuzawa. (2011). Biological memories of past environments: epigenetic pathways to health disparities. *Epigenetics, 6,* 798-803.

Foucault, M. (2008). The Birth of Biopolitics: Lectures at the College De France 1978-1979. New York, Palgrave Macmillan.

Peet, J. R. (2012). Comparative policy analysis: Neoliberalising New Zealand. *New Zealand Geographer* 68(3): 151-167.

Villadsen, K., & Wahlberg, A. (2015). The government of life: managing populations, health and scarcity. *Economy and Society, 44,* 1-17.

Wahlberg, A., & Rose, N. (2015). The governmentalization of living: calculating global health. *Economy and Society, 44*, 60-90.

Walters, K. L., Mohammed, S. A., Evans-Campbell, T., Beltran, R. E., Chae, D. H., Duran, B. (2011). Bodies don't just tell stories, they tell histories. *Du Bois Review: Social Science Research on Race, 8*, 179-189.

Warin, M. (2011). Foucault's progeny: Jamie Oliver and the art of governing obesity. *Social Theory and Health, 9*, 24-40.

Winnard, D., Wright, C., Jackson, G., Gow, P., Kerr, A., McLachlan, A., ...Dalbeth, N. (2013). Gout, diabetes and cardiovascular disease in the Aotearoa New Zealand adult population: co-prevalence and implications for clinical practice. *NZ Med J, 126,* 53-64.