‘Obesity is killing our people’

Social constructions of obesity and the impact on the health and well-being of Maori and Pacific Island migrants in Australia.

L. Rodriguez
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Social constructions of obesity and the impact on the health and well-being of Maori and Pacific Island migrants in Australia.

by
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Masters of Arts

A thesis submitted in fulfilment of the requirements for the award of the degree of Doctor of Philosophy
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This work is dedicated to the memory of Ina, Mateira, Aunty Lydia and Mihi George who always gave their time and energy to help others. To the extended Bondi whanau – Arohanui!
ABSTRACT

This thesis examines the dual roles of social class and cultural practice in understanding obesity–related disease and the personal experiences of chronic illness in the Polynesian migrant community in Australia, using social constructionist concepts and addressing issues of Cultural Safety in health practice. New Zealand Maori and other Polynesians from Samoa, Tonga, the Cook Islands and Niue (Pacific Islanders), comprise one of Australia’s fastest growing migrant groups. People from these communities are in the highest percentiles of obesity–related illnesses such as heart disease, type 2 diabetes, renal failure and respiratory problems in the world. Despite the public health messages regarding the implications of obesity, Polynesians appear not to be responding to recommendations of health care providers as intended. This thesis explores the socio–centric nature of Polynesian families and kinship structures that are enacted within a network of reciprocities and understandings that do not privilege the individual. It examines how the cultural identities created and re–iterated by these practices inform relational notions of belonging and well–being. It is argued that without addressing such cultural understandings, health promotion messages derived from the biomedical position that regards obesity as the result of poor individual choices, are unlikely to be adopted by Polynesians. As Polynesian migration to Australia is steadily rising, this issue will be of increasing significance as it impacts on Australian mainstream health services.

The research employs qualitative methods and epistemologies based on Kaupapa Maori, a theoretical model designed by Maori scholars, to elucidate participants’ discursive constructions of their bodies, health and wellness. Kaupapa Maori encompasses an examination of the cultural dynamics that are influential in how health and ill–health are conceived and experienced in this population group. This also allows for an exploration of socio–economic factors that exacerbate the likelihood of poor health outcomes in Polynesian communities. Qualitative interviews were conducted with sixty–seven interview participants from Sydney and the Hunter region of New South Wales. This included extended interviews with three key informants who are Polynesian nurses practising in Australia. For an Australian or non–Polynesian readership, this thesis is intended to bring a broader cultural understanding of the Maori/Pacific Islander communities, and the strengths and the challenges it faces in relation to obesity–related illness. It is also intended to have resonance for Maori and Pacific Islanders in Australia in regard to their perceptions of health, well–being and identity in their adopted country.

Key words: Maori/Pacific Islander/Polynesian/obesity/health/migration/identity
Preface: My interest and involvement in this topic

_Mahia te mahi, mena he panga mo te iwi_
Do what needs to be done if there is a benefit in it for the people

My ties to the Maori/Pacific Islander community go back to the mid 1980s and include my partner, a New Zealand–born Cook Islander. We were both politically active in this extended community, especially focusing in the areas of education, social justice, health and sport. While not Polynesian of descent, my own involvement, therefore, was both deeply personal and political as I became part of an extended Polynesian family. Over this period I became aware of the problem of obesity-related disease amongst Maori and Pacific Islanders and witnessed how the repercussions of these preventable illnesses, particularly disability and premature deaths, have impacted upon families and the broader community. The web of cultural and socio-economic contributors to this situation is complex, and has motivated this thesis.

In order to conduct this research into these communities in Australia, it was evident to me that the only culturally appropriate methodology would be and continues to be that of _Kaupapa Maori_. This theoretical model was introduced to me in the late 1990s by Gary Foley, Aboriginal activist and academic, who celebrated the fact that at last there was a methodology that had the intellectual flexibility and cultural respect necessary to do justice to Indigenous research. _Kaupapa Maori_ is the theoretical and methodological model I used for my Masters thesis in 2003, hence I have already established my status of ‘adopted’ researcher in the Sydney Maori/Pacific Island community. This position reflects my ongoing commitment to this community, and the family ties that connect me to this community after the completion of this project.
# TABLE OF CONTENTS

**ACKNOWLEDGEMENTS** iv  
**ABSTRACT** v  
**Preface: My interest and involvement in this topic** vi  
**Introduction** 5  
  - Research aims and questions 6  
  - The importance of Australian research on Polynesians 6  
  - Rationale for this configuration of participants 8  
  - Cultural and linguistic considerations for this thesis 9  
  - Why Australia is becoming the destination of choice for Polynesian migrants 10  
  - Notions of ‘community’ and associated obligations 12  
  - Scale of the problem: evidence of obesity and related illness among Polynesians 15  
  - Discourses of crisis 17  
  - The cost of obesity 18  
  - The implications of this issue for Australians and the Australian government 19  
  - Thesis overview 20  

**Chapter One** 24  
Introducing *Kaupapa Maori* and Cultural Safety: A southern view 24  
  - Introduction 24  
  - Southern Theory: A challenge to the global North 25  
  - The problem with ‘post–colonialism’ 27  
  - *Kaupapa Maori* and Cultural Safety: A shared history, common goals 29  
  - *Kaupapa Maori* as theory 32  
  - Emergent status of Cultural Safety 35  
  - Conclusion 36  

**Chapter Two:** 38  
Contours of empire: The impact of colonialism on Pacific peoples 38  
  - Introduction 38  
  - Brief history of colonialism in Polynesia 38  
  - Fatal contact: The arrival of the Europeans and the introduction of disease 40  
  - Post–colonial adjustments to social order: *mana*, *tapu* and *noa* 40  
  - Gendered positions: The moral discourse by church and state 41  
  - The Treaty of Waitangi 1840 44  
  - Disillusionment with the Treaty and the implications for health 45  
  - Post–colonial lifestyle changes 46  
  - Conclusion 48  

**Chapter Three:** 49  
Social and cultural understandings of food, health and the body in the South Pacific 49  
  - Introduction 49  
  - Divergent notions of health and illness: Biomedical and bio–psycho–social models of health understandings 50  
  - Paradigms of well–being 54  
  - The role of social and cultural capital in achieving well–being 55  
  - *Kaupapa Maori* and Cultural Safety: Working towards a Polynesian concept of well–being 56  
  - The role of *whanau* (family) 58
<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contested aetiologies of obesity and related illness</td>
</tr>
<tr>
<td>Genes and obesity: Is there a genetic explanation for the high rate of obesity in Polynesians?</td>
</tr>
<tr>
<td>Genetic attempts to explain the disease burden of diabetes</td>
</tr>
<tr>
<td>Post–colonial and socio–cultural explanations of obesity</td>
</tr>
<tr>
<td>Health promotion to alleviate obesity: A middle class discourse?</td>
</tr>
<tr>
<td>Maori and Pacific Islander health and lifestyle</td>
</tr>
<tr>
<td>Globalisation, nutrition transitions and the impact on health</td>
</tr>
<tr>
<td>Gastro–politics in the South Pacific: The tale of the mutton flaps</td>
</tr>
<tr>
<td>Perspectives on the self and the body</td>
</tr>
<tr>
<td>The relational or consocial self</td>
</tr>
<tr>
<td>The body as social agent</td>
</tr>
<tr>
<td>The body as subjective entity in the social domain</td>
</tr>
<tr>
<td>The body and relations of power: The ‘colonised body’</td>
</tr>
<tr>
<td>Puritanism and discipline: A moral imperative</td>
</tr>
<tr>
<td>The ‘civilised body’</td>
</tr>
<tr>
<td>Counter–positioning: The logic of ‘fat admiration’</td>
</tr>
<tr>
<td>Reflections on the social meanings of food and eating for Polynesians</td>
</tr>
<tr>
<td>Perspectives on food, eating and the body</td>
</tr>
<tr>
<td>Eating and social order</td>
</tr>
<tr>
<td>Food (kai) as ritual and facilitator of social networking</td>
</tr>
<tr>
<td>Contemporary Polynesian foodscapes: Gastro–identity in a globalised world</td>
</tr>
<tr>
<td>The socio–political context of economic marginalisation</td>
</tr>
<tr>
<td>Employment and unemployment</td>
</tr>
<tr>
<td>Educating Maori: Why education takes a back seat to sport</td>
</tr>
<tr>
<td>Household population densities</td>
</tr>
<tr>
<td>Social class and mobility</td>
</tr>
<tr>
<td>Failure of the ‘Third Way’: New Zealand social policies and trans–Tasman lessons</td>
</tr>
<tr>
<td>Neo–liberalism and public health policy in New Zealand and Australia</td>
</tr>
<tr>
<td>Cultural and structural barriers to optimum health delivery: An argument for Cultural Safety</td>
</tr>
<tr>
<td>Limitations of Cultural Safety in health practice</td>
</tr>
<tr>
<td>Socio–economic disadvantage and the Australian health system</td>
</tr>
<tr>
<td>Identity, belonging and well–being</td>
</tr>
<tr>
<td>The post–colonial experience: Ascribing a national identity</td>
</tr>
<tr>
<td>Polynesian women and the Western gaze</td>
</tr>
<tr>
<td>Navigating hybrid, bicultural and migrant identities</td>
</tr>
<tr>
<td>Consocial identity, belonging and well–being</td>
</tr>
<tr>
<td>Living – and dying – away from home: Implications for well–being</td>
</tr>
<tr>
<td>Conclusion</td>
</tr>
</tbody>
</table>

**Chapter Four**

**Methodology**

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
</tr>
<tr>
<td>Research context: The influence of Western colonialist methodologies</td>
</tr>
<tr>
<td>Kaupapa Maori methodology</td>
</tr>
<tr>
<td>The non–Indigenous researcher</td>
</tr>
<tr>
<td>Participants</td>
</tr>
</tbody>
</table>
Method 127
Family groups 129
Individual and focus group interviews 130
Data Analysis 131
Reflections on methodological practice 134
Limitations of qualitative data 135
Communication of results 136
Conclusion 136
Chapter Five 138
Introducing the participants in their socio–economic and cultural context 138
  Introduction 138
  Education and employment: Realities, aspirations and limitations 138
  Household over–crowding: Is it a problem? 143
  Housing status, household income and distribution 145
  Disposable income: Where does the money go? 146
  Conclusion 149
Chapter Six 150
Food and lifestyle: The habitus of Polynesian migrant households 150
  Introduction 150
  Eating as a legitimate pleasure 150
  Traditional food, its processes and practices 152
  Changes and distortions in cultural practice: The impact of modernisation and
globalisation on Polynesian alimentary trends and behaviours 157
  How cultural associations and practices around food are retained in the migrant context
  Impact of socio–economic disadvantage on food choices 162
  ‘Just eat less’ advice is ineffective for Polynesians 164
  Trifecta of risk: Eating, smoking and a sedentary lifestyle 165
  Conclusion 171
Chapter Seven 173
Polynesian embodied experience 173
  Introduction 173
  ‘Traditional’ view of the Polynesian body: Body as sacred continuum 173
  The sensual body: Post–colonial policing of the ‘Native’ body 174
  The somatically felt body 176
  Disciplining the body and the justification of corporal punishment 179
  Big bodies: The cultural validation of a ‘large’ body 182
  Negative associations with thinness 184
  Physical habitus: The embodiment of class and culture in work and sport 184
  The problematic body: Obesity 188
  Changing perceptions and the Australian experience 190
  Conclusion 192
Chapter Eight 193
The Polynesian experience of healthcare in Australia and reflections of Cultural
Safety 193
  Introduction 193
  Reluctance to engage with health services 193
Western paradigms of health care delivery and the subjective Polynesian experience 196
Cultural reflexivity of doctors and allied nursing staff 199
Stress on carers 201
Cultural safety and increased engagement 204
Conclusion 207

Cultural identity, adaptation and belonging: Keys to well–being 208
Introduction 208
Polynesian socialities in an individualised world 209
Relational values of health and happiness 212
‘Polycultural capital’: How forms of social and cultural networking are employed in this migrant community 215
Inter–generational tensions: Between two worlds 218
Offshore identity: Sites of identity formation for young Maori and Pacific Islanders in Australia 221
Cousin peer relationships 225
Social engagement and perceptions of well–being in Australia 227
Conclusion 232

Conclusion 234
The importance of this research and its findings 234
Discussion of findings 235
Implications for government social and health policies 239
Limitations of this research 241
Implications and suggestions for further research 242

References 245

GLOSSARY MAORI/PACIFIC ISLANDER TERMINOLOGY 276
APPENDIX A 278
Summary of family participants’ household densitites and migration histories 278
APPENDIX B 280
Summary of individual and focus group participants 280
APPENDIX C 282
Education and employment histories of individual and focus group participants 282
APPENDIX D 284
APPENDIX E 288
Consent Form 288
TABLE 1 290
Summary of family household economic profiles 290
Introduction

This thesis examines how the convergence of cultural practices and socio-economic positioning affects health understandings and outcomes in the Polynesian diasporic community in Australia. Maori and Pacific Islanders face many of the challenges of being a culturally and visibly distinctive minority migrant population. They are also experiencing the constraints of being part of a low socio-economic group with associated implications for their health. Collectively, as Polynesians, they present with extremely high rates of obesity–related illness and the incidence of co–morbidity and premature mortality are significantly higher than their Anglo counterparts in New Zealand and Australia (van Driel et al. 2009).

While issues surrounding low socio–economic status are significant to this discussion, cultural constructions of family and community relationships are also integral to understanding how health and well–being are conceived in this community. The role of food and food practices is examined in relation to how Polynesians perceive their cultural identity, their bodies and themselves. Food has a prominent place in the Polynesian social order, with traditional and ‘neo–traditional’ practices enacted around food exchange, obligations and gifts. This thesis will explore the historical associations of food with status, power, ceremony and reciprocity and how these associations are maintained and reflected in cultural notions around a collective, or ‘consocial’, identity. It will examine how this cultural orientation acts to shape standards and notions of well–being and belonging that are relational in contrast to the individualistic focus of bio–medical perspectives. In this undertaking I have used the theoretical model of Kaupapa Maori (simply translated as ‘the Maori way’) as it best reflects these culturally specific concepts, privileges localised/cultural knowledge, and utilises frameworks familiar to participants while also engaging in dialogue with more conventional models of ‘risk’ and health.

In this introductory section I outline the demographic trends relating to Maori and Pacific Island migration to Australia in recent decades. I also provide an overview of the rates of ill–health and mortality associated with obesity that are prevalent in this extended community. These are of concern, not only because of the physical health and well–being of this population group, but also because the cost of obesity in clinical, social and economic terms is rising. This is the starting point for a more qualitative investigation of the meanings of food, the body, and well–being for Polynesians. This section concludes with an overview of the thesis structure and a brief description
of cultural and linguistic considerations that have informed how the thesis has been conceived and presented.

**Research aims and questions**

The over-riding research aim of this thesis is to explore the dual roles of cultural practices and socio-economic disadvantage in contributing to obesity, and the specific implications this has for the health and well-being of Maori and Pacific Island migrants in Australia. These two elements – cultural behaviours and socio-economic status – therefore, create two sub-aims. In the first instance, there are cultural dynamics that reference how health and well-being are constructed and experienced in this population group. An enquiry into such practices requires conducting appropriate qualitative research around local understandings of the ways in which Polynesians consider their bodies, their health and their lifestyle. This research aim is designed to draw out perceived and actual impacts of daily habits, including food choices and eating patterns, on individual and community health outcomes. It also allows an exploration of the history of the Polynesian relationship to food and its complex role in relation to identity formation and the maintenance of cultural practice in a migrant context. The second aspect, or research aim, involves an exploration of the socio-economic factors that exacerbate the likelihood of poor health in Polynesian communities. This will be informed by a discussion of the theoretical and practical correlations between low income status and poor health. The relevant data will be used to illustrate how these socio-economic factors intersect with cultural practices in the Maori and Pacific Island communities.

These aims will be achieved by pursuing the following research questions:

1. To what extent do the cultural practices around food inform the Polynesian view of the (obese) body, and how does this relate to Polynesian perceptions of health and well-being?
2. What role do food-centred rituals play in the preservation of cultural identity for Polynesians in the migrant context?
3. How does social disadvantage compound the incidence and severity of obesity-related illness in this community?

**The importance of Australian research on Polynesians**

During the century from 1850 to approximately 1950, the colonial powers of Europe divided the South Pacific into strategic zones of influence. In the aftermath of these excisions and alliances
Australia was charged with responsibility for much of Melanesia, and New Zealand was allocated responsibility for the small Polynesian island states of Tonga, Western Samoa, the Cook Islands and Niue\(^1\). This post–colonial configuration may explain why Australian scholarship is so limited regarding ethnographic, political, or cultural understandings of Polynesia, and instead concentrates, almost exclusively, on Melanesia. Brown (1998, p.112) is critical of the lack of Australian scholarly literature and expertise on Polynesia: ‘It is surprising how relatively little is known about the Pacific Island migrant community in Australia and elsewhere’. Fifteen years later, this situation has not changed, and may be deteriorating. According to Cooney (2009, p.15): ‘Pacific studies have either completely disappeared from the courses being offered, or are so low in prominence, many students no longer want to take part in them’. As a consequence of this neglect, Australia is, in terms of scholarship, largely unprepared for the rapid escalation of Polynesian migration.

As the statistics around Polynesian obesity and related illness continue to rise, there is a need for culturally informed research to be undertaken. This has been recognized in New Zealand by both qualitative and quantitative researchers (Bramley et al. 2004; Cram 2001; Spoonley 1999). For example, in order to reconcile the various determinants acting on Polynesian obesity, empirical researchers Bramley and colleagues (2004) have argued that there should be more \textit{Kaupapa Maori} (Maori–centred) qualitative research, in order to better understand the health discrepancies between Maori and non–Maori:

Kaupapa Maori research is needed. When research is undertaken from this perspective, Maori health concerns and needs become self–determined, as well as the research response needed to address them. Kaupapa Maori research also advocates for the use of Maori/non–Maori comparisons and produces results that have ‘equal’ meaning and relevance to Maori as non–Maori (Bramley et al. 2004, p.1).

One of the reasons \textit{Kaupapa Maori} research has been taken up by New Zealand medical researchers, particularly those concerned with primary health care, is that it encompasses both cultural considerations and economic positioning as integral aspects to overall community health. Hence, \textit{Kaupapa Maori} is the theoretical and methodological model used in this thesis and is discussed in detail in Chapter One.

\(^1\) In this thesis, Samoans, Tongans, Cook Islanders and Niueans are referred to collectively as Pacific Islanders. Also, for the remainder of this thesis, Western Samoa (now known as Independent Samoa) will be referred to simply as ‘Samoa’.
Another culturally related framework for understanding Polynesian health centres around Cultural Safety. Cultural safety emerged in New Zealand in the late 1980s in the context of best practice in the service of Polynesian patients (Wepa 2005; Williams 1999; Polaschek 1998), and since the 1990s, has become a model for health care that has been adapted by health care workers in Indigenous communities in several countries including Australia (Browne and Fiske 2001; Williams, 1999). Cultural safety sets out to enhance the health of the whole person, their family and their community. It is, therefore, essentially a community model wherein health and well-being are regarded as a collective concern, not an exclusively individual problem (Ramsden 2000;1992; Wood and Schwass 1993). It also contains an understanding of the stress of long term dislocation and marginalization issues that are discussed throughout this thesis. The paradigms of Kaupapa and Cultural Safety, therefore, allow an examination of the historical, political, structural and social forces that are specifically relevant to this experience (Browne et al. 2009; Cram 2001). The large numbers of Polynesians in Australia who are now presenting in the health system with long term complications of preventable illness, reinforces the need for a greater understanding and utilisation of the theory and practice of Kaupapa Maori and Cultural Safety in this country. This thesis will help redress the lack of qualitative Australian research regarding the cultural protocols, behaviours and broad health concerns of this population group.

Unsurprisingly New Zealand is at the forefront of research not only for Maori, but also for first and second generation Polynesian migrants. New Zealand scholars generate a significant amount of medical, social and other academic data regarding correlations between social disadvantage and health, in addition to exploring issues of cultural identity and well-being for Polynesians. Australia needs to invest in a considerably more substantial way to research in regard to this growing population group, therefore, this thesis provides a basis for future researchers in a range of areas related to social issues and health. It has relevance for health practitioners, teachers, community workers and policy makers.

Rationale for this configuration of participants

In this thesis I follow the New Zealand model of referring to ‘Maori and Pacific Islanders’ – a description that has specific understandings in political, civic and research domains. In this context, ‘Pacific Islanders’ refers quite specifically to Tongans, Samoans, Cook Islanders and Niueans. As a result of the colonial relationship described above, these groups are entitled to New Zealand citizenship and those who remain in the home islands continue to be administered from New Zealand.
Zealand. For those Islanders living in New Zealand, with the expansion of Pacific Islander community activism and increased numbers of Islander academics, it is also the accepted term used by Pacific Islanders themselves\(^2\). In the New Zealand research context, these groups are continually disaggregated into their culturally specific ‘Island’ profiles (Samoan, Tongan etc), and reconstituted collectively as ‘Pacific Islanders’.

In regard to this thesis, there are other reasons for combining these cultural groups as a single research demographic. In Australia, these are all relatively small population groups in themselves who share similar post-colonial health profiles, and have in common a range of issues around housing, education, employment, dietary patterns and childbearing statistics. Each of these groups continue to enact a great number of Polynesian cultural practices, particularly surrounding food, that are relevant to this thesis. For example, signature events are celebrated with a ‘feast’. This entails both traditional foods and cooking methods, such as the Maori *hangi*, or Island *umu*, where the food is cooked underground, with the addition of processed foods. Also, the high rate of intermarriage between these groups effectively precludes a focus on just one strand of the Polynesian community. Because of these layered notions of community and identity, I primarily use the term ‘Maori and Pacific Island community’ as a broad collective construction. This is modified where necessary to better examine the ideas and behaviours of specific sub–groups.

**Cultural and linguistic considerations for this thesis**

Because this thesis involves five participant groups, each with a different language other than English, I will briefly outline several methodological elements here to aid clarification for a readership not familiar with Polynesian languages and colloquial references. For consistency, I will primarily use Maori language terms, with specific exceptions for Pacific Island dialogue. There are several reasons for this. Most New Zealand researchers, government instrumentalities and mainstream media use Maori terms in the context of their research and public statements. For example, words such as *whanau* for family, *hauora oranga* referring to health and well–being, along with *Pakeha*, meaning an Anglo–New Zealander, are no longer translated. The majority of participants for this thesis come from New Zealand and are familiar with the use of Maori language and concepts that reflect their broader Polynesian cultural reality. It is also the Polynesian language with which I am most familiar.

\(^2\) The term Pacific Island Nationals is also used in New Zealand, however, in this thesis I have used Pacific Islander only.
For a non–Polynesian readership, Polynesian words are italicised, except for the names of people and places, and have English translations in brackets, rather than a glossary. However, for purposes of familiarity with oft–repeated terms there are three rudimentary rules of Maori language for the English–speaking reader. In Maori, there is no ‘s’; consequently the plural of Maori remains Maori and the collective is referred to as Maoridom. Also, ‘wh’ is pronounced as ‘f’, for example, ‘whanau’ is pronounced ‘far–no’. Finally, the term Pakeha, an Anglo–European in the New Zealand context, is now used commonly to refer to Anglo– Australians. In some instances, Pakeha may be used in this way and is not italicised.

**Why Australia is becoming the destination of choice for Polynesian migrants**

New Zealand is home to the largest Polynesian population in the world (New Zealand Census 2006). Statistics New Zealand, the equivalent of the Australian Bureau of Statistics (ABS), estimates the population of Maori in New Zealand to be 652,900, or fifteen percent of the total population. Between 1991 and 2006 this population rose by thirty percent and is still increasing at a rate significantly faster than Anglo–New Zealanders (Statistics New Zealand 2009). According to the Ministry of Pacific Island Affairs (2009) there were 226,000 Pacific Islanders of Polynesian origin in New Zealand, making up almost seven percent of the population. Projections of government statistics (Te Tari Tatau 2000) indicate this figure is expected to double by 2031. The scale of out–migration, from the home islands³ to New Zealand is accelerating. Six out of ten Samoans and Tongans are now born in New Zealand, not their country of ‘ethnic origin’, and in the case of Cook Islanders and Niueans, it is seven out of ten (Callister and Didham 2007).

Most Maori and Pacific Islanders hold New Zealand passports and arrive in Australia under the generic category of ‘New Zealanders’ whether coming from New Zealand or the home islands, and according to the last census (ABS 2006), ‘New Zealanders’ continue to comprise Australia’s leading migrant group. One of the more challenging aspects of gathering demographic data on these population groups is to separate the figures referring to Polynesians from Anglo–New Zealanders. Complexities surrounding inter–ethnic identity, ‘mobile’ or transitory identities, and varying methodologies involved with ethnicity issues, have also played a role in this complex picture. Paul Hamer, independent researcher and senior policy advisor to the New Zealand government, has produced a body of work outlining the issues that affect the calculation of Maori migration figures

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³ When talking about the ‘Islands’, or ‘home islands’ I am referring to Tonga, Samoa, Niue and the Cook Islands collectively, unless otherwise stated.
(Hamer 2009a, 2009b, 2008a; 2007). He suggests that there are a range of systemic and informal factors that have previously hindered accurate assessment of these numbers. For example, at the time the question of ‘ethnic origin’ was dropped from arrival and departure cards, Australia also dispensed with the question of ‘ancestry’ in the census. Consequently, at a time when Maori were coming to Australia in their greatest numbers – in the 1980s and 1990s – there is not a clear indicative record. Upon reinstatement of the ‘ancestry’ question in 2006, the ABS figures for Maori jumped twenty–seven percent to 93,000, almost a quarter of all ‘New Zealand’ migrants. Hamer’s large qualitative study of Maori in Australia (2007), also identified that nearly a quarter of participants admitted they had not, or ‘did not know’ if they had completed a census form. Others were unclear on the distinction between ‘ancestry’ and ‘nationality’, with many simply putting ‘New Zealander’ to indicate their ancestry.

As a result of revised statistical analysis combined with his qualitative work, Hamer (2009a) has concluded that a realistic estimate is that 126,000 – one in six of all Maori – are now permanently resident in Australia. This is almost a third higher again than the official ABS figures. Considerably less work has been done to break down the statistics concerning Pacific Island migration. Available figures (ABS 2006) give a total of 72,082 Polynesian Pacific Islanders, however, it would be reasonable to assume that this may also be an under–estimate as many of the same methodological problems exist in relation to these calculations. It is evident that Polynesians constitute a significant component of these migrants. The variables influencing migration patterns fall into two main groups. First, there is the economic motivation represented by greater employment opportunities in a larger country. As John Connell’s work on Pacific migration indicates: ‘Migration is largely a response to real and perceived inequalities in socio–economic opportunities, within and between states’ (2006, p.60). The deteriorating New Zealand economy in the aftermath of decades of neo–liberal fiscal ‘belt tightening’ has meant many Maori who intended to work in Australia for some years and then return home, are now reluctant to return to New Zealand with fewer employment options and lower pay (George and Rodriguez 2009; Hamer 2008a). It is evident that the desire of first generation migrants to return to New Zealand once their working lives are over is not becoming a reality:

We love and miss our country, our land, our water, our people, our culture, our Maoritanga [culture] our friends and whanau [family], but we’ve all had a taste of the good life here, and success, and we don’t want to come home to New Zealand only to end up struggling and broke again (Hamer 2008a, p.3).
In addition, Pacific Islanders who, prior to the 1990s would have migrated directly from the islands to New Zealand, are now seeking the perceived economic advantages of Australia, another development that is central to this thesis. Combined, this leads to a more permanent Polynesian presence here than would have been expected even ten years ago (Singh 2005).

While access to improved employment opportunities is a common motivation for migration to Australia, there are cultural and social factors that have served to make Australia an attractive destination. Some of these include family reunions, the availability of better, more affordable health care, greater educational opportunities and significantly, the growth of Pacific Island churches that act as de facto community centres for newly arrived migrants. This emerging pattern of intensifying migration follows what has been described as the ‘beaten path’ effect, whereby the prior migration of extended family leads to increasing numbers in the migration flow (Appleyard and Stahl 1995). Hamer (2008a) also identifies this as a particularly strong phenomenon amongst Maori and describes it as ‘chain migration’. He calculates between thirty and fifty whanau, or family members, may migrate in order to support the original migrant and maximise employment opportunities for other family members. Many of the participants for this thesis had been prompted to make the move to Australia to join other family members and, in turn, sponsor the arrival of more relatives from New Zealand and the home islands.

With the average age of Maori and Pacific Islanders now twenty–three and twenty–one respectively (New Zealand Census 2006), it is young people who have borne the brunt of failed policies driven by the economic rationalism of the last two decades in New Zealand (Stevenson 2004). The unemployment rate is disproportionately high for Polynesians, and the appeal of relatively highly paid, unskilled work in Australia is a strong lure. As approximately two–thirds of the Polynesian population in New Zealand is under thirty years of age, the scale and excitement of Australian cities is also attractive. Another factor influencing the overall numbers of Polynesians in Australia is a high fertility rate in this community. In New Zealand, Maori and Pacific Islanders have a fertility rate double the national average (Bellamy 2009). Consequently, with such a young, fertile population, it is inevitable the numbers of Maori and Pacific Islanders born in Australia is likely to rise at a rate significantly higher than the Anglo–Australian population. There is also considerable anecdotal evidence to suggest the number of older Polynesians is increasing as more migrate to be near their Australian–born grandchildren (Hamer 2007; Rodriguez 2003).

**Notions of ‘community’ and associated obligations**
The ‘Maori and Pacific Islander community’ is not a single, homogenous entity. Nor is the term simply a descriptive device to collectively refer to ethnically and culturally related groups. For this thesis, multiple definitions of ‘community’ are required to clarify the descriptions of participants and their positioning in relation to the dominant Anglo–Australian presence, other migrant groups, and each other. In New Zealand many Maori and Pacific Islanders identify primarily in terms of their own culturally specific ethnicity, however, there is a growing need for a ‘working’ identity in Australia where the general public, teachers and health workers have difficulty distinguishing between these groups (George and Rodriguez 2009).

Most Maori and Pacific Islanders operate within and between a number of community fields. These community identifications may shift depending upon the social situation and a range of ethnographic understandings of participants. For example, for Maori, tribal affiliations that are commonly used in New Zealand as a signature identity become subordinate to ‘being Maori’ once in Australia (Hamer 2007). Maori continue to exchange tribal identities when introducing themselves to other Maori and, often, Pacific Islanders. However, when engaging with Anglo–Australians, or other non–Polynesian migrants in Australia who do not share the same cultural references, it is common to simply use ‘Maori’ (George and Rodriguez 2009). It is the same with historic inter–island rivalries and ethnic distinctions. Samoans and Tongans who work together, or play football together in Australia, more readily identify as ‘Islanders’ in this context. This does not mean that specific cultural identities are no longer valued, but that they may co–exist with a broader Pan–Pacific cultural identity in the migrant context of Australia.

A related aspect of community is being accepted and recognised by others of the same or related ethnicity. Specific cultural indicators such as the wearing of a Maori greenstone, or bearing a Samoan tattoo, are able to affirm discrete cultural identities, thus reiterating membership of that community. Such culturally specific statements are then re–worked for those who describe themselves as part of the overall Maori and Pacific Islander community. For example, a tattooed Samoan may relate to other Samoans who can ‘read’ that tattoo locating the wearer in terms of land, lineage and family positioning, and simultaneously affiliate with other Maori and Pacific Islanders by virtue of sharing physical and cultural characteristics.

Another reflection of community is discussed in the work of Ife (2002). Ife uses the concept of ‘Gemeinschaft’ to describe ties to family and those in your immediate world who constitute your ‘community’. This is an ‘insider’, or emic perspective whereby the familial and cultural roles of
community members are defined by that community. Within this understanding, people’s social, civic and cultural roles may vary considerably inside and outside that community. For example, in the Maori and Pacific Island community, while a person may be a ‘chambermaid’ or ‘steel fixer’ in their working lives, they can be an esteemed elder and cultural ambassador in their community life. Concepts of community also operate around geographic delineations such as the ‘Sydney Samoan community’. This becomes a point of reference, or etic perspective, for ‘outsiders’ to this community, both Anglo–Australians and other Samoan communities elsewhere. Another distinction that is common in Pacific Islander communities is that of church denomination. For instance, the ‘Wesleyan Tongan community’ has extensive networks that reach out to their related religious communities as well as the wider communities of ethnic origin. In addition, the majority of participants for this thesis have an overarching identity as ‘New Zealanders’ or ‘Kiwis’, that is used in conjunction with their specific ethnic backgrounds under the mantle of the ‘Kiwi’ ex–pat community in Australia.

As Ife (2002) points out, survival and continuity of a discrete group relies on active membership and participation by those in the group. This expectation contains elements of both rights and responsibilities. For example, if a community member should ‘pass away’, there is an expectation that all members of the related extended community should participate in the associated funeral events. Attendance at the actual funeral is preferred, particularly if the person is known to you, however, donations of cash and foodgoods are expected and usually forthcoming. This is a cultural recognition of a community need. In the modern world, it takes considerable amounts of money to feed the hundreds of people who attend these ceremonies, as well as to house and transport them to various events that take place over several days, or weeks. Financially, this would not be possible without the generosity of members of the extended community. Other cultural expectations and obligations revolve around the housing of relatives and caring for the ill and disabled. A further financial expectation, particularly in Islander communities, is that remittances are sent to family members still living on the home islands, and each family is expected to contribute the to their local Island church. These and similar cultural practices reinforce cultural ties with the country of ‘ethnic’ origin and act to maintain identity in the migrant context. This continuity and associated notions of ‘belonging’ to a community are essential to overall well–being (Derne 2009; Heil 2009). As with many non–Anglo peoples, cultural identity and well–being are more socially and relationally anchored than is common in Western societies: ‘Well–being is the result of an on–going dynamic process that constitutes and reconstitutes the social person and the socialities of which they are part and to which they contribute’ (Heil 2009 p.104). In this thesis I will discuss how these
obligations are reciprocally constituted and are thus dynamic, acting to affirm well–being, but also how, arguably, they may constitute a disincentive to class mobility.

Alongside the elements of community described above, Maori and Pacific Islanders also constitute a ‘culturally and linguistically diverse’ (CALD) community. Since 1996 Commonwealth agencies have used the term CALD to describe populations from outside the host country, where a language other than English is spoken at home and where there is an issue of limited English language proficiency. In Australia this term also includes cultural or linguistic affiliation with another country by birth, ancestry, ethnic origin, religion, preferred language or because of parental identification with these (ABS 1999a). In the Australian health services, Maori and Pacific Islanders are described as a CALD group (see van Driel et al. 2009; Bedford et al. 2009).

**Scale of the problem: evidence of obesity and related illness among Polynesians**

The rise in obesity–related illness is both a globalised and localised phenomenon (Zimmet 2005). A report by the World Health Organisation (2005) tabled statistics that preventable diseases, mainly type 2 diabetes and other obesity–related illnesses, are responsible for twice as many deaths as infectious diseases, maternal/perinatal complications and malnutrition combined. The report warns that if no adequate action is taken, 388 million people may potentially die from chronic diseases such as type 2 diabetes and heart disease in the decade to 2015. The consequences of obesity are particularly marked in poor and marginalised communities. Polynesians are most usually in the lowest socio–economic percentiles and present similar patterns of poor health literacy, late diagnosis, inadequate treatment and high rates of premature death.

Approximately one in four Maori and Pacific Islander adults are obese by the accepted biometric measures (Ministry of Health 2008a). Detailed analysis of New Zealand statistics also indicates a disturbing trend: that prevalence of obesity is increasing in these communities (Obesity Task Force 2008. When adjusted for age, Goulding and colleagues (2007) estimate two thirds of Polynesian children, aged five to fourteen, are already obese. These obesity rates have led to a concomitant rise in type 2 diabetes – or ‘lifestyle’ induced diabetes. New Zealand Health Ministry figures show type 2 diabetes is accountable for twenty per cent of all deaths among Maori, compared with four per cent for Anglo–New Zealanders (Cunningham 2006).

Obesity, as an agent of co–morbidity, is a critical issue in the overall discussion of Polynesian incidence of illness and mortality rates. In general usage, ‘co–morbidity’ refers to one or more
health issues being present in addition to the original ailment being treated. Obesity therefore, not only engenders health problems, it also complicates the diagnosis and treatment of other conditions (King, Aubert and Herman 1998). The results of the extensive 2008 New Zealand Health Survey confirm the findings of researchers in the areas of cardiovascular disease, diabetes and respiratory dysfunction, in relation to the disparity between Polynesian and non–Polynesian health statistics. These comparative statistics enable an overview of the scale of the problem of co–morbidity and premature mortality related to obesity–related illness for Maori and Pacific Islanders.

The New Zealand Health Survey (2008) revealed that Maori male mortality due to ischaemic heart disease was three times higher than for non–Maori and the Maori female mortality rates were just over four times higher than for non–Maori (see also Ajwani et al. 1999). One in twenty Maori adults (five percent) had doctor–diagnosed diabetes (excluding diabetes during pregnancy). Nine out of every ten adults with diabetes were diagnosed when they were twenty–five years or older, and almost all will have type 2 diabetes. After adjusting for age, Pacific men and women were over–represented in the above groups, and had three times the prevalence of diagnosed diabetes than men and women in the total population. Premature mortality from type 2 diabetes, a preventable condition, is of concern. The study found that Maori males are six and a half times more likely, and Maori females ten times more likely, to die from diabetes than non–Polynesians, while Pacific peoples are five times more likely to die from diabetes than non–Pacific peoples.

The largest Maori/Pacific Islander community health needs assessment in Australia was conducted by the Ethnic Communities Council of Queensland (ECCQ 2009). Health researchers used the figures cited above as a baseline comparison with the health of Polynesian migrants presenting in the Queensland hospital system. The authors concluded that, proportionally, these figures are mirrored in the migrant population in Australia. Both the quantitative report (van Driel et al. 2009) and qualitative study (Bedford et al. 2009) accompanying this assessment, identified the common precursors of these conditions to be a combination of obesity and sedentary lifestyles.

The steep rise in obesity–related figures over the last two decades is of concern and has been indicative of a rapidly escalating public health challenge. The literature identifies access to

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4 Characterised by reduced blood flow to the heart induced by diabetes, high cholesterol, lack of exercise, obesity and smoking.
processed foods, sedentary lifestyle, socio–economic factors and ethnicity, as the most likely predictors of obesity and associated ill–health. Indigenous Australians, Native Americans, and Polynesians are amongst the highest risk groups (Scheder 2006; Bramley et al. 2004). A significant voice in this debate is that of Professor Paul Zimmet who describes these increased risks as resultant from a process of ‘Coca–colonisation’ (Zimmet 2005; 2000), whereby a traditional diet has been replaced by poor quality, highly processed foods and is accompanied by a progressively more sedentary lifestyle. The cultural and socio–economic determinants of food choices and practices are explored through the model of ‘foodescapes’ or ‘food landscapes’ (Pollock 2009; Cummins and Macintyre 2002). The notion of a foodescape enables a layered understanding of how food choices and practices adopted by a particular community may simultaneously reflect socio–economic positioning and enhance cultural identity. Foodescapes, therefore, offer an insight into the interaction of socio–economic and cultural factors in the selection of certain food types rather than these simply being the result individual food preferences.

Discourses of crisis

The health issues to be explored in this thesis have attracted progressively dramatic language to convey the scale and urgency of medical concerns around Polynesian obesity. Helen Clark, when New Zealand Prime Minister, opened her address to a WHO regional meeting by stating ‘Obesity is a time bomb for New Zealand and the Pacific’ (Clark 2007). Medical researchers Anand and Yusuf (2011) use the term ‘tsunami of obesity’. However, when these words and phrases are used as headlines in the public domain, they are capable of creating unease, distress and even depression amongst those communities who are most affected by the range of illnesses being described. The statistics surrounding type 2 diabetes in the Polynesian community have also evoked the use of apocalyptic language: ‘Maori diabetes fear – threat of extinction’ (Williams 2006), and ‘Diabetes could wipe out Maori by end of century’ (New Zealand Herald 2006) are typical of many headlines that have been used in relation to this issue. Both these headlines referred to the release of conference data wherein Professor Paul Zimmet, whose work is cited above, had said:

Without urgent action there certainly is a real risk of a major wipeout of indigenous communities, if not total extinction, within this century (Zimmet in Williams 2006, p.1).

Zimmet has demonstrated a particular commitment to the control of type 2 diabetes in disadvantaged, Indigenous communities and migrant populations. Within the context of a conference of his peers, he was attempting to galvanise action on behalf of health professionals and academics in related fields. However, when his comments were co–opted by tabloid newspapers
and radio commentators, as with similar claims of genetic determinism concerning Maori, the result was a ‘moral panic’ (see Turia 2006). Such language and imagery without an equivalent emphasis on the preventable nature of this disease, cannot be helpful. It is obviously important, with the health statistics briefly outlined above, that these issues be addressed urgently, however it is patently distressing to members of a particular ethnic community to have themselves described as being on the point of ‘extinction’ – a term usually reserved for plants and animals. It has colonial resonance for Maori old enough to remember being told at school that they would ‘die out’ (McDougall 1998).

Further, it has been argued that these ‘doomsday’ scenarios may unintentionally lead to a certain resignation about contracting these diseases, and dying as a result (Liburd 2010). For many participants in this thesis, there has been a feeling of inevitability accompanying the likelihood of losing family members to one or other of the major obesity–related illnesses. As Durie (2003), Foliaki and Pearce (2003) and others have pointed out, obesity and associated ill–health was uncommon in these population groups fifty years ago, therefore, there is a compelling argument for more detailed sociological explanations of the associations between ‘lifestyle’, health and well–being for Polynesians. For the majority of Maori and Pacific Islanders who do not follow the socio–cultural debate that critiques the biomedical construction of obesity–related illness, they are left with the shadow of such irresponsible headlines. As with Australian Aboriginal people who have been exposed to similarly frightening statistics, there is risk of people internalising the notion that their life expectancy is pre–determined.

Sensationalising statistics on premature mortality in these communities may be intended to motivate complacent bureaucracies of federal and state governments and health authorities into action, and prompt these communities to adopt ‘healthier’ lifestyles. Instead, according to Scheper–Hughes (2006) this process may be considered responsible for a residual fatalism, effectively becoming a disincentive to early testing and seeking treatment.

**The cost of obesity**

Alongside predictions that government inaction and insufficient resourcing will result in dire consequences for the world’s Indigenous communities, Zimmet has also suggested that this is extremely short–sighted, and failure to act may in itself lead to inordinate stress on health care systems:
Despite the warning signs, national governments have been slow to act on diabetes which is now a global epidemic with devastating humanitarian, social and economic consequences (Zimmet 2006)

For the New Zealand government that has responsibility for the health of Maori and Pacific Island migrants there, as well as the home islands of Tonga, Samoa, Cook Islands and Niue, the outlay on obesity–related illness has become a matter of significant economic concern. Signal (2011) has estimated that the cost of obesity–related illness has risen from approximately two percent of the New Zealand health budget to seven percent. This represents an enormous outlay for a country that has the equivalent population of the city of Sydney. Additionally, the extreme obesity rates for Polynesian teenagers has serious financial and, as a consequence, social implications. Scragg (2003) is concerned that if obesity remains unaddressed, it will not only consume vast amounts of health funding, it may also force health professionals to make decisions on who can, and cannot, be treated in order to meet budget constraints.

The financial calculations to assess the ‘cost of obesity’ vary considerably in an attempt to provide a broader picture of the expenses incurred by having a progressively obese population. While the cost of treating obesity–related illness may be considerable, the cost of not doing so may be greater. The cyclical nature of socio–economic disadvantage is compounded by this issue. Obesity is demonstrably greater in low socio–economic groups, and in itself, obesity contributes to further social disadvantage in terms of reduced employment opportunities, increased likelihood of disability and poor health (Khang and Wang 2004). Given that the majority of health funding is for medical treatment, it is the preventable nature of obesity–related illness that presents the biggest challenge to conventional notions of how health care should be funded.

The implications of this issue for Australians and the Australian government

The high rates of preventable chronic disease, co–morbidities, disability and premature mortality reported by New Zealand researchers investigating obesity, are also being seen in the Australian context (van Driel et al. 2009). The profile of obesity in Australia reflects ‘class clusters’ whereby poorly serviced, working class suburbs contain a disproportionate number of overweight and obese children and adults (Page et al. 2007). As most Polynesian families have both a large number of biological children and an established cultural practice of housing relatives for extended periods of time, these communities will tend to congregate in the more affordable regions that comprise this low socio–economic cluster (Rodriguez 2003).
As combined Maori and Pacific Islander immigration to Australia is steadily increasing, this issue will be of growing significance as it impacts on Australian health services. Already, chronic obesity–related illness constitutes the majority of the total disease burden in Australia (National Health Priority Action Council 2006) and costs over two billion dollars a year in hospital admissions alone (van Driel et al. 2009; Page et al. 2007). Indirect costs such as absenteeism from work through obesity–related illness, and reduced productivity at work are estimated to cost a further nine billion dollars annually (Lavelle 2006). Despite the Australian government being advised that the correlations between socio–economic status and health underlie the budget ‘blow outs’ experienced in the state hospital systems, there appears to be resistance to shifting focus towards prevention (Doggett 2007). In terms of ‘frontline’ health delivery, comparative findings of health economists reveal CALD populations account for a relatively high proportion of the consumption of health services for chronic ailments (van Driel et al. 2009). As an immigrant population with a statistical tendency towards obesity–related disease is added to a health system already over–burdened with inadequate resourcing for chronic disease, this has implications for the Australian health budget.

The trans–disciplinary nature of the study of obesity–related illness in a non–Anglo migrant group does not readily fit into any one body of literature within the Australian scholarship context. In order to explore the many factors that combine to influence the health status of the Polynesian and Pacific Islander diaspora in Australia, it is necessary to examine contributions from various academic disciplines such as health sociology, medical anthropology and Indigenous studies. To address the complexity that multi–disciplinarity involves, the theoretical components of this thesis have been addressed by an over–arching Southern paradigm of Kaupapa Maori, though specific Western, or Northern, theoretical considerations are drawn upon when appropriate.

Thesis overview

Following this introduction the thesis is organised into nine chapters and a concluding chapter. Chapter one is a discussion of Connell’s Southern Theory and Kaupapa Maori as theoretical models relevant to this thesis. Both models refer to the post–colonial condition in the southern hemisphere in general, and in the case of Kaupapa Maori to the Polynesian experience in particular. I have included the framework of Cultural Safety in this discussion, as it was originally conceived and calibrated for Maori and later, Pacific Islanders and references Kaupapa Maori principles. While
each of these models contributes to specific Pacific–oriented understandings, they do not preclude the use of other more familiar Western concepts employed throughout this work, for example, Bourdieu’s notion of *habitus*.

The second chapter, ‘sets the scene’ for this research in an historical context. It offers a brief account of colonial expansion in the region and its impact on the lives and health of Indigenous Pacific peoples. As the colonial experience underlies many aspects of this thesis, this chapter will identify the ways in which current marginalisation of this community, and their associated health status, could be viewed as a legacy of these processes.

Chapter Three comprises the literature review encompassing an exploration of contributing factors that influence the choice and use of foods by Polynesians that result in extremely high rates of obesity and associated illness. This requires an overview of the inter–related issues from a range of disciplines including health sociology, medical anthropology, ethnographic and cultural studies. Each of these elements requires its own theoretical lens to some degree, and these are embedded in the discussion.

Sociological understandings of health and wellbeing includes alternative readings to the conventional biomedical view of health and illness, and elucidates Pacific perspectives on the nature of health and well–being. A core issue for this thesis is the contested aetiologies of obesity. This section will compare biomedical and bio–psycho–social explanations of obesity–related illness, as well as socio–cultural views that promote a more layered understanding of contemporary Maori and Pacific Islander health and lifestyle. This includes the debate on whether Polynesians have a genetic propensity to obesity and type 2 diabetes. This section will also explore the contradictory roles of Australia and New Zealand in regard to their stated health goals in the Pacific and their commitment to arguably damaging trade practices around large scale export of products associated with burgeoning obesity in the region.

The site where these contested positions are played out is ‘the body’. Western concepts of the ‘civilised body’, symbolising restraint and personal discipline, are contrasted with Polynesian views of what constitutes physical beauty and strength and accompanying nuanced social values associated with a large body. This section, therefore, will employ both Western and Pacific theories of identity formation and attitudes to the self and the body. Crucial to the discussion of the obese body, is the role of food and eating practices in this community. Reflections on the social meanings of food and eating for Polynesians are explored through both sociological and anthropological
concepts and is framed within the notion of ‘foodscapes’ to draw out both traditional and contemporary food practices and their symbolism for Polynesians. It will also discuss the impact of globalisation and migration on food choices made by this population group.

The research question regarding socio-economic positioning contributing to obesity–related illness in this community is discussed in relation to economic marginalisation and structural barriers to class mobility. This information serves to help understand the extremely low rates of health literacy in this migrant group, and highlights the interaction of social positioning and cultural practice in the overall thesis. Also, how cultural practices and migrant status interrelate with social disadvantage to impact on access to healthcare for this population group is discussed within the framework of public health policy generated in a climate of neo–liberal economic rationalism.

The themes of identity, belonging and well–being offer an explanation of how the consocial Polynesian identity underlies relational notions of well–being. At the centre of this thesis is how Polynesians integrate traditional practices in a post–colonial, globalised world. This section encompasses a discussion of shifting, or mobile identities of young Polynesians living in Australia. As more Maori and Pacific Islanders present with obesity–related diseases that are debilitating over long periods of time, these understandings assume greater importance for this CALD community.

In chapter four the methodology of Kaupapa Maori is described as the unifying factor that brings these divergent academic strands together and relates them to the Polynesian experience. It underpins the way the qualitative research component of this thesis is explored in ways that reflect Polynesian cultural perspectives. There is also a detailed discussion of my role as an ‘Insider/Outsider’ researcher for this thesis. The methodology chapter describes the cultural protocols expected of a non–Indigenous researcher in this community and introduces some of the complexities regarding how the participants were recruited and interviewed.

The findings are discussed and analysed in chapters five to nine encompassing qualitative interviews with participants, and therefore, have been presented in a way that bridges Western academic explanations of obesity–related illness and a non–Western, lived experience. These chapters are structured to reflect the main themes addressed in the literature review. Participants will discuss their own views on the extent to which traditional food practices have been transformed through colonisation and globalisation and the measures they have employed to counteract this trend. Polynesian perceptions of being a ‘gastro–identified’ group whereby cultural associations with food are maintained and re–invigorated to secure identity in a migrant context are discussed.
As Maori and Pacific Islanders do not seem to be responding to the health messages regarding obesity–related illness, both socio–economic positioning and cultural explanations are examined to explore this apparent resistance to adopting different eating and lifestyle habits. The socio–economic positioning of Maori and Pacific Islanders in Australia is fundamental to an appreciation of participants’ accounts and understanding levels of obesity–related illness in this community. The transitioning of identities for second and third generation Maori and Pacific Islanders are explored, both in relation to their extended community and the broader Anglo–Australian population, and the ways in which cultural identity and notions of ‘belonging’ inform notions of well–being.

In the conclusion section, I discuss the implications of these findings and explore ways in which the issues identified could be addressed in the Australian context. This includes the potential for partnerships between community members and health professionals to improve the health outcomes for this population group in ways that are culturally conceived and targeted, as well as exploring the wider theoretical and practical applications of health sociology through the framework of Cultural Safety.