‘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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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!
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>Chapter Four</th>
<th>122</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methodology</td>
<td>122</td>
</tr>
<tr>
<td>Introduction</td>
<td>122</td>
</tr>
<tr>
<td>Research context: The influence of Western colonialist methodologies</td>
<td>122</td>
</tr>
<tr>
<td><em>Kaupapa Maori</em> methodology</td>
<td>123</td>
</tr>
<tr>
<td>The non–Indigenous researcher</td>
<td>125</td>
</tr>
<tr>
<td>Participants</td>
<td>126</td>
</tr>
</tbody>
</table>
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. 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 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 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, Kaupapa Maori is the theoretical and methodological model used in this thesis and is discussed in detail in Chapter One.

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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. 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 islands 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 over–arching 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

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 ‘foodscape’ or ‘food landscapes’ (Pollock 2009; Cummins and Macintyre 2002). The notion of a foodscape 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. Foodscape, 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 uniting 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.
Chapter One

Introducing *Kaupapa Maori* and Cultural Safety: A southern view

Introduction

This chapter will provide an overview of why the theoretical concepts of *Kaupapa Maori* and the framework of Cultural Safety are useful in discussing the implications for both health and well-being in the extended Maori and Pacific Island community. Underpinning both models is the premise that people are entitled to good physical health, a sense of self-worth, job and housing security, and other basic rights essential to overall well-being. They also examine and critique notions of power through interactions of historical factors, resultant loss of autonomy and associated ill-health in relation to the post-colonial economic marginalisation of Maori and Pacific Islanders.

The theoretical model of *Kaupapa Maori*, often referred to simply as *Kaupapa*, reflects Maori ways of learning and sharing of knowledge, and has emerged from a southern, localised experience, specifically surrounding Maori and later adapted by Pacific Islander researchers (Carter 2011; Baba et al. 2004). Initially in the late 1980s, Cultural Safety in nursing practice had attempted to redress the discrepancies in health between Maori and Pakeha New Zealanders (Papps and Ramsden 1996). Subsequently *Kaupapa Maori* developed during the 1990s. As *Kaupapa Maori* gained strength and cohesion, many medical researchers and Cultural Safety advocates began to adopt this framework. Cultural Safety continues to question the dominant biomedical framework of health, and has sought to promote a more holistic bio-psycho-social approach that is often advanced by health sociologists and advocates of culturally targeted health services for Indigenous communities. This understanding contains notions of relational belonging integral to well-being in these communities. Both conceptual frameworks value cultural integrity and share the belief that the colonial legacy in the Pacific means Polynesians are currently being denied access to ‘cultural democracy’. (Burnett 2009; Thaman 2009; 2002; Smith 1999).
Southern Theory: A challenge to the global North

In the nineteenth century, countries such as New Zealand and Australia were regarded as the frontier of the empire; in themselves the poor relation to the ‘civilised entity’ of Britain (Salmond 1997). In the colonies, civic and cultural institutions, particularly the production of literature and art, were conceived and enacted in relation to the metropole (Britain) many thousands of miles away. In cultural terms, Anglo–New Zealanders and Australians looked to the global North for identity, affirmation and direction. In relation to academic notions of critical theory, the argument has been made by Connell (2007), Slater (2004) and others that those of us who live in the global South, are still compelled to relate to the North as the place where ideas of importance are born, and debates of consequence are conducted.

Southern Theory as proposed by Connell (2007) is not conceived as a single, contained theory, but, rather, is constituted as a broader challenge to the hegemonic constructions of the global North. Connell uses ‘Southern’ not simply to locate and delineate geographical boundaries, but to ‘…emphasise relations – authority, exclusion and inclusion, hegemony, partnership, sponsorship, appropriation – between intellectuals and institutions in the metropole and those in the world periphery’ (p.ix). Connell also uses the term ‘majority world’ as a sharp reminder that most of the world’s people do not live in the designated metropoles of Europe and North America. A premise of Connell’s Southern Theory is that the majority world is also predominantly a colonised world, and as such, is not represented on an equal intellectual footing with the established colonial powers that remain the bastions of academic thought and engagement. This raises a critical discussion on the broader historical and political contexts in which knowledges and meanings are produced and transmitted.

In exploring Connell’s discussion of North/South relations, there are four major characteristics emergent from our geo–political location that reflect the relationship of the metropole (or ‘core’) to the periphery. Connell uses these elements to demonstrate the continuing domination of post–colonial and Eurocentric constructions of knowledge. First, Southern Theory questions claims of universality purported in the work of Northern theorists. Referring to Giddens’ (1984) book, Constitution of Society, Connell highlights this assumption of universality:

The relationship that Constitution does not theorise is colonisation; the structuring principle it does not explicitly name is imperialism; and the type of society that never enters its classifications is the colony (Connell 2007, p.37).
The lack of reflexivity in the global North regarding the residual impact of colonialism on transmission of knowledge underlies the dismissal of contributions, experiences and understandings of those who live in previously dependent nation states, the colonies (Slater 2004). Largely unquestioned, the myth of universal application of Northern theories remains intact, albeit tacit. According to Connell, should the Eurocentric dominance of academia become explicit, its own relevance may be challenged. Hence, ideas from the ‘colonies’ are geographically or ethnically branded to keep them distinct from the metropole. For example, ‘Latin American dependency theory’, or ‘West African philosophy’ are names and descriptions reserved for thoughts and contributions from the global South; by definition lacking in universality and peripheral to the greater undertakings of the North.

Central to this discussion is the role of the ‘Other’ as defined by Said in his seminal work (1978). This is both in regard to visibility, ethnicity and skin colour as a marker of differentiation from Anglo colonising populations, and also in cultural terms, being part of a non–Western culture targeted for compromise and assimilation in the post–colonial aftermath. Historically this has allowed the coloniser to operate from a position of relative superiority emerging from familiarity and understanding of the dominant cultural paradigms, while those who have been colonised struggle with resultant feelings of difference, inferiority and always trying ‘to catch up’ (Hereniko and Wilson 1999).

This illustrates another contention of Southern Theory which is that the North, or ‘core’, continues ‘reading from the centre’, that is, from their own worldview of Anglo–European normativity:

For colonised cultures, conquest is not evolution, rationalisation or transformation, but catastrophe. Colonisation introduces fundamental disjunctures into social experience that simply cannot be represented in metropolitan theory’s models of change through time (Connell 2007, p.45–46).

As Franz Fanon (1990) and Gandhi (1998) have pointed out, if the ‘post–colonial’ scholar wishes to criticise or challenge these tacit assumptions of peoples and societies, they are required to do so using the language and concepts of the global North, preferably within the domain (and confines) of post–colonial theory. However, for the non–Anglo colonised person in particular, this is accompanied by the risk of exclusion, or marginalisation, the third element of Southern theory. The ethnographic re/construction of Indigenous peoples as neither ‘purely native’, nor entirely ‘modern’, is instrumental in what Connell calls ‘grand ethnography’. This conundrum relates to the
fourth premise of Southern Theory. The social structure of the colonial state is not discussed or questioned because the role of critical thought in colonised cultures is effectively silenced from the perspective of the North, culminating in what Connell refers to as the ‘grand erasure’.

Connell’s deconstruction of the assumption of universality by the global North highlights the colonial relationship. In supporting the argument for a ‘southern’ voice, the elements that comprise Southern Theory are also of paramount importance in regard to the precepts of both Kaupapa Maori theory and Cultural Safety. In the sense of emerging from localised conditions and perspectives, these two Maori–inspired models may be described as exemplars of Southern Theory. In the following discussion, I will endeavour to demonstrate how these theoretical models contribute to a more detailed understanding of the issues facing Maori and Pacific Islanders in the post–colonial context.

The problem with ‘post–colonialism’

A great deal of academic work on Indigenous peoples centres around theoretical notions of post–colonialism. Given the scale of socio–economic marginalisation and outstanding issues of social justice in relation to the sovereignty of Maori and Pacific Islanders both in New Zealand and the home islands, the term ‘post–colonial’ is problematic. Many scholars struggle with this language. Even influential academics such as Linda Smith (2000; 1999) who is regarded as a leading theorist in the post–colonial discourse in the Pacific (see Denzin and Lincoln 2005; Baba et al. 2004), are uncomfortable with the term. The implication of ‘post’ is that colonialism is a thing of the past. While I have used the term in this thesis, I have done so primarily to differentiate between historical periods, to suggest a distinction between that which occurred before colonisation and after. I have also on occasion used the term ‘neo–colonial’ when illustrating a colonial or post–colonial influence that is active. It is difficult to avoid, or replace, the term ‘post–colonial’ completely. Arguably, the pervasiveness of colonising practices of bodies and minds has been so extensive, that the term can still be applied to the experience lived directly, or indirectly, by so many. Therefore, rather than the term being ‘phased out’, there is instead reason to breathe new life into what ‘post–colonialism’ means.

According to Gandhi (1998, p.4) post–colonialism is: ‘…a disciplinary project devoted to the task of revisiting, remembering and, crucially, interrogating the colonial past’. Gandhi maintains that a critique of globalisation provides a platform for a re–examination of the post–colonial discourse:
For a time this postcolonial scholarship thrived but now it must rearm … itself to combat, comprehend, or cop out of the contemporary globalized, deterritorialized, and denationalized world that is under the thrall of a mega nation state, the single arbiter of its Empire (Gandhi 1998, p.27).

For Nandy (2003) this ideology of global modernisation, underpins the post–colonial state and its language of ‘developmentalism’. According to Nandy this has an extremely negative impact on pre–existing cultures in that the development agenda co–opts aspects of cultures that are conducive to modernity, and in this process relegates Indigenous knowledges to ‘transient counter–systems’. An implication of this position is that the non–Anglo experience of Otherness is confirmed and capacity for cultural transmission diminished, thereby contributing to biographical disruption and notions of what Goffman (1963) described as a ‘spoiled identity’.

It is argued by many Indigenous Pacific scholars, including Baba and colleagues (2004), Thaman (2009; 2002) and Graham Smith (1992) that these residual and contemporised colonial practices are reinforced by imposing Westernised educational practices, standards and goals at all levels of the educational system. This has implications for knowledge transmission in general, and also for health literacy and security of identity intrinsic to well–being. In the Pacific Island context, Thaman (2009) argues that teaching and/or learning environments of most formal educational institutions are not culturally democratic. This is both in relation to curriculum content and pedagogical methods. In other words they do not incorporate Pacific languages, or have regard for how most Pacific people think, learn and communicate. According to Hau’ofa (1999) this places the Indigenous student in an unacceptable cultural compromise whereby the values of their parents and extended communities are not valued or recognised. In relation to health, ‘traditional’ views on the body and illness are devalued while Western concepts regarding the body and illness are not readily understood or embraced.

A further consideration is the ideological and historical structure of separate disciplines underpinning Western tertiary education. This is fundamentally divisive, in that all aspects of life for Indigenous peoples, their societies, their philosophies, their education and their health are examined independently, in isolation from other interactive cultural contexts. Cultural behaviours are examined in anthropology, language in linguistics, physical remains are conserved by museums and so on. Linda Smith (1999) contends that this is a consequence and extension of imperialism: ‘It was a process of systematic fragmentation which can still be seen in the disciplinary carve–up of the indigenous world…’ (Smith 1999, p.32). Two decades ago, New Zealand researchers Novitz and
Willmott (1990) denounced the organisation of universities into exclusive departments and disciplines, and described this structure in itself as a major hindrance to more complete understandings of Indigenous issues. These authors argue that service to Indigenous studies cannot be undertaken without cultivating a genuine transdisciplinary discourse:

In looking at something as pervasive as culture or as complicated as identity, no discipline alone can shed adequate light, so our enterprise must be interdisciplinary (Novitz and Willmott 1990, p.xvii).

This segregation of disciplines has also impacted on understandings of health that involve an appreciation of the interrelatedness of socio–economic positioning, education, identity and perceptions of well–being. It is evident that unless this is addressed, and if only the values and language of the dominant (colonising) culture are promoted, the critical theorising of Pacific issues becomes, in the words of Burnett (2009), just another ‘Western metanarrative’. In other words, transmission of knowledge – education – will continue to only be described and interpreted through the Northern Eurocentric gaze. Alternatively, by embracing a Pacific–centric framework of understanding, emergent voices are able to contest this view and cultivate a more locally referenced position from which these same issues may be explored.

**Kaupapa Maori and Cultural Safety: A shared history, common goals**

Kaupapa Maori is the philosophy and practice of ‘being Maori’. It assumes the taken for granted social, political, historical, intellectual and cultural legitimacy of Maori people (Smith 1992, p.1).

*Kaupapa Maori* theory (*Kaupapa*) emerged from genuine community processes in the 1980s and 1990s in New Zealand, including *te kohanga reo*, Maori language kindergartens, usually referred to as *kohanga*, and *kura kaupapa Maori* or Maori immersion schools (Hohepa 1993; Ka’ai 1990). These Maori–driven initiatives in language restitution had been inspired by earlier activism around Land Rights and issues of sovereignty that had radicalised many Maori. According to Pihama (2001), *Kaupapa* represents a theoretical process that reflects the struggles inherent in the birth of these grassroots Maori institutions and acknowledges these same struggles as a ‘conscious part of our analysis’ (Pihama 2001, p.100).

The banning of Maori language in New Zealand schools from the 1870s was clearly a repressive act of state control on a colonised people in an attempt to replace tribal, or regional identity, with an
attributed national identity and perspective. However, it also represented a severance of language and associated spiritual and conceptual knowledge from educational institutions. It was not until a century later that *te kohanga reo*, or language ‘nests’, were established. The success and popularity of *kohanga* secured the future uptake and expansion of Maori language that had been under severe threat (Te Puna Matauranga 2010). It also paved the way for demands by ordinary Maori, as well as motivated activists, to demand a more Maori–centred way of learning. Since the 1980s, the *kohanga* model has been extended to primary and secondary schools and was also instrumental in the *wananga*, or Maori higher education movement (Moorfield 2005).

In a circulatory fashion, these developments emerged from and contributed to a resurgence of pride for Maoridom collectively. By reinvigorating inter–generational learning practices, it became evident that there was an existing (although previously repressed) Maori pedagogy to build upon in relation to modern critical theory (Smith 1990a; b). Similarly, around the same time (late 1980s, early–mid 1990s), as the health statistics of Maori were deteriorating when compared with Pakeha, Maori health workers, nurses and academics began to question the association between deculturation and poor health (Durie 1997; 1995; Papps and Ramsden 1996). It was in this climate of resistance to assimilationist, colonial models of education and health that *Kaupapa Maori* and Cultural Safety were conceived. Both value the role of the whanau or family, and embrace local knowledges, languages and spiritual concepts. They also both share an exploration of the nature of power relations in regard to the colonial experience.

Smith (1999) situates *Kaupapa Maori*, in relation to western critical theory, as a post–colonial model for research with an emphasis on the ideas of criticism, resistance, struggle and emancipation. *Kaupapa* is, therefore, a localised theoretical position wherein these pillars of critical theory may be formulated and realised. As illustrated throughout this thesis, individual and public health are also influenced and defined by relations of power. Traditional biomedicine has been constructed under the aegis of objective scientific knowledge, and as such, promotes the notion that it is unsullied by questions of power. However, as Lupton (1996) suggests, power itself ‘should not necessarily be considered a ‘repressive’ force, but as a property that runs through and permeates all dimensions of social life, and therefore cannot be ‘removed’…’ (Lupton:1996, p.14).

According to Freund and McGuire (1999), medical scientists as a professional elite, are able to utilise their common experience and shared values to perpetuate their own monopoly of power:
Scientific paradigms are frameworks of formal knowledge that members of a given scientific community share, mainly due to having undergone similar educations and professional initiations; to sharing a common professional language, rules of evidence, and conceptual schemes; and to relying on the same professional literature and communication of the same scientific community (Freund and McGuire 1999, p.189).

Therefore, the premise that biomedicine is a strictly a–political, scientific undertaking is misleading (Clayton 2002). For instance, Canadian researchers Browne and Friske (2001) also agree that health research is not simply a benign aspect of ‘pure’ science, particularly in relation to indigenous peoples:

Health research, particularly epidemiological research has played a role in constructing colonizing images of …communities as sick, disorganized and dependent, reinforcing unequal power relationships and justifying ongoing paternalism and dependency in health care (Browne and Friske 2001, p.129).

Cultural safety also questions the nature of relationships of power and requires an understanding of the colonial and post–colonial experience, socio–economic disadvantage, and social constructions of health and illness. It further explores issues of identity and belonging that are essential for well–being. Within the paradigm of Cultural Safety, it is not conducive to overall health and well–being if one is experiencing feelings of dislocation, lack of belonging, frustration, anger or resentment. Consequently, Cultural Safety also advocates that culturally targeted education is not only the key to health literacy and therefore better individual and family health, but is also necessary for better employment opportunities and maximising life opportunities that increase resilience and capacity to redress broader social inequity. In this way, Cultural Safety is not simply a health initiative, but rather a broader intervention to circumvent disempowerment in other areas of people’s lives:

Cultural Safety … is useful because it extends analyses well beyond culturalist notions of cultural sensitivity to power imbalances, individual and institutional discrimination, and the nature of health care relations between the colonized and colonizers at the micro, meso, and macro levels (Browne and Fiske 2001, p.127).

Kaupapa Maori and Cultural Safety both reference the Treaty of Waitangi as a foundational document in regard to the New Zealand government’s legal and moral responsibility to endorse the terms of the Treaty that were promised to Maori on its signing. Pihama (2001) identified the Treaty of Waitangi as integral to defining the relationship between Maori and the Crown – the nation state of New Zealand. It affirms the status of Maori as tangata whenua (indigenous people of the land) and thereby provides a structural, legal lens through which Maori and Pakeha New Zealanders may constitute their relationship and notions of citizenhood. It is the baseline for the recognition of rights and entitlements of Maori. It is the Treaty, with its alleged promise of recognition of Maori
soverignty, that has provided the basis for Maori to argue entitlement to an education system that reflects Maori philosophy, history and ways of conducting the learning process itself. Unlike Aboriginal people in Australia who were not party to a treaty, and many First Nation tribes in the United States and Canada who signed treaties that were never intended or proved not to be honoured, the nation state of New Zealand is continually held to account over every aspect of the Treaty of Waitangi.

**Kaupapa Maori as theory**

In the early 1990s, Graham Hingangaroa Smith formulated a series of principles to introduce the theoretical concept of *Kaupapa Maori* in relation to education (Smith 1992; 1990). Smith’s early writings emanated from a primary tenet of Maori identity being central to maintaining and reinvigorating Maori ontologies and ways of learning.

As Smith’s ideas evolved (1997; 1992; 1990a; b), and gained exposure and momentum with other Maori writers and academics, it became clear that *Kaupapa Maori* operated both as an academic construct and as a practical, culturally–endorsed platform with which to equip Maori to perform their own research and describe their own experiences:

> Kaupapa Maori as an intervention strategy, [and] in the western theoretical sense, critiques and re–constitutes the resistance notions of conscientisation, resistance and transformative praxis in different configurations (Smith 1997, p.65).

Other Maori scholars who have contributed to *Kaupapa* as theory and methodological practice include Linda Smith (2004; 2000; 1999), Bishop (2008; 1994), Pihama (2001) and Pohatu (2005) amongst others. However, it was Linda Smith’s 1999 work that prompted *Kaupapa’s* rise to prominence internationally. Although deeply centred in the struggle for Maori rights and legitimacy, Smith’s work struck a chord with Indigenous researchers, particularly in the Pacific. As Cook Island sociologist, James George, points out:

> Kaupapa Maori is a watershed for indigenous research, most specifically Maori, but also for Islanders. No more ideologically flawed research/information about indigenous people. A few more doors have opened up for Maori and other Polynesian faces in the Social Sciences – this time not as subjects, but as researchers and theorists (2009, personal communication, 15 July).

While *Kaupapa’s* approach and perspective was picked up very quickly by Pacific researchers it has also continued to expand in popularity in Australia, the United States and Canada. According to Denzin and Lincoln (2005), this is because its foundational principles have resonance for Indigenous peoples who share common conceptions and values surrounding the role of family and extended family and who further share the cultural dislocation of colonialism.
The concepts and elements comprising *Kaupapa* are described as ‘principles’ and in keeping with the New Zealand literature I employ this term. In relation to *Kaupapa* theory and research, the primary principle is that of *whanau* (pronounced far–no). While ‘*whanau*’ is usually translated as ‘family’, it has much wider associations within Maoridom than the English translation suggests (Durie 2003). This is central to *Kaupapa* as the individual is perceived to exist in relation to family and *iwi* (tribe), that in turn, act in relationship to the broader Maori and non–Maori community. The related term, ‘*whakawhanaungatanga*’ is used to explore and describe these relationships that extend beyond notional nuclear boundaries, or even ‘extended’ family. This term contains notions of belonging and continuity exemplified by a shared biographical history and assuming extended family obligations. It also concerns the relationships which are formed during the research process and the community or ‘family’ that is created by such an interactive research model. *Whakawhanaungatanga* acknowledges the care that is taken to cultivate these relationships.

*Tino rangatiratanga* reflects concepts of sovereignty, self–determination and the right to independence for Maori, thus reiterating the core of *Kaupapa Maori* that is for Maoridom to be able to debate, conceive, shape and create its own aspirations and goals. This is closely associated with *taonga tuku iho*, or the principle of cultural aspiration. This places emphasis and value on *te reo Maori* (Maori language), *tikanga* (historically informed cultural practices) and *matauranga Maori* which refers to knowledge and understandings of both the visible and invisible that exist and interact in the Maori worldview. According to Meduna and Preistly (2006) it is *matauranga Maori* which encapsulates and transverses many cultural precepts, including language and cultural practices, as well as traditional environmental knowledge, and the conceptualisation and practical information on healing and medicines, fishing and food cultivation. Under this model, Western concepts can therefore be understood as comparative paradigms, rather than the only way in which ideas can be generated and exchanged. This enables the *Kaupapa* student or researcher to accept, reject or modify these concepts.

As with Southern Theory, *Kaupapa* encompasses local histories and events, and ways of transmitting knowledge that provide context for the Southern/or colonised researcher. This premise is closely aligned with *ako Maori* – the principle of culturally preferred pedagogy. This includes both those understandings and pedagogic techniques unique to Maori and also those, which may not be traditional, but are conducive to Maori learning. As alluded to in the history of *Kaupapa* above, the teaching methods employed in *te kohanga reo* kindergartens proved popular both with children,
their parents and extended family members (Hohepa 1993). The success of this early linguistic and cultural immersion led to the foundation of *wananga* or higher learning institutions. This resulted not only in parents being willing to ‘return to school’, but also meant the children instructed in this way improved in other areas of Western education with enhanced life skills (see also Ka’ai 2008). As a consequence of validating cultural pedagogical methods and thought systems, *Kaupapa* has the capacity to be transformative for both individuals and communities who may not be succeeding under more conventional Western, post–colonial models:

Transformation is one of the driving elements of *Kaupapa Māori*. How that transformation is defined and brought is determined by how the issues are understood, theorised and engaged (Pihama 2001, p.102).

Another illustration of *Kaupapa Māori* being able to move between the altruistic and the practical, the past and the future, is reflected in the remaining two elements comprising *Kaupapa* theory. Firstly, there is the principle of socio–economic mediation, *kia piki ake i nga raruraru o te kainga*. This principle requires a dual approach. One aspect is designed to mediate the experience, understandings and causalities of socio–economic disadvantage in Maori communities. The second is to provide a political overview of social justice issues and review the dominant language employed to describe and exclude Maori from many of the most basic social processes of civic engagement. Through this dialogue, Maoridom is able to make positive gains through culturally inspired initiatives and interventions rather than be described continually in terms of a ‘deficit discourse’. This puts an emphasis on *Kaupapa Māori* research to be relevant, accessible, and translate into positive benefits for Maori, rather than conventional ‘Pakeha’ research detailing a litany of areas where Maori are not achieving. This locates low socio–economic positioning as something that can and must be addressed in order for Maori to maximise potential and well–being. It is, therefore, the ‘insider’ (or emic) nature of *Kaupapa* that allows examination of social disadvantage and class in a way that is not offensive or demeaning for those being studied, and facilitates the examination of pre–existing power relationships:

Intrinsic to Kaupapa Maori theory is an analysis of existing power structures and societal inequalities … [and] therefore aligns with critical theory in the act of exposing underlying assumptions that serve to conceal the power relations that exist within society… (Smith 1999, p.189).

As an extension of this mediation, it is necessary to consider *ata* – the principle of nurturing respectful relationships. Developed by Pohatu (2005), *ata* refers to the cultivation of better, stronger relationships between government agencies, such as social services, and Maori. This requires a transformative approach in regard to how representatives of such instrumentalities engage and behave with Maori. *Ata* provides a focus on negotiating boundaries and working towards creating
‘safe’ places for Maori people to engage (Maori and Indigenous Research Institute 2009). This incorporates notions of time (wa) and space (wahi), respect and reciprocity. Ata encompasses ideas of effort, discipline and the ability to plan. It also requires reflection, a precursor to critical analysis. Kaupapa itself is an expression of collective philosophy. Conceptually, Kaupapa has broader connotations and applications than generally understood in regard to academic research. It incorporates self–defined direction and aspirations of Maori communities, and contains a commitment to empowerment and belonging, in relation to the research being undertaken. Kaupapa is not detached from the topic being researched and Kaupapa researchers are not separate from the people being studied. This is further discussed in Chapter Four of this thesis.

Emergent status of Cultural Safety

The extent to which perceptions of health and well–being are culturally defined is critical in understanding the issue of impact of illness for a minority, non–Anglo population group. A social constructionist approach to health knowledges is useful to reflect on how ideas of ‘culture’, concepts of families, and the power relationships demonstrated by the medical ‘establishment’ are all influenced by social processes and historical developments. As described by Talbot and Verrinder (2005), ‘culture’ emerges from the historical, social and political experience of any group of people and provides an expression for the group’s preferred way of making sense of the world. Eckermann (in Talbot and Verrinder 2005, p.51) warns of the consequences of ignoring or invalidating cultural practices and identity: ‘… when indigenous worth is not recognised, when one cultural system restricts the level of choice of health care facilities, health values and attitudes, clients find themselves in a position of ‘cultural danger’. Therefore, Cultural Safety represents a shift in power at all stages of health engagement and requires reflexivity on behalf of individual health practitioners which allows both the health consumer and the professional provider some mutuality in achieving their stated aim or outcome.

Although not generally regarded as a theoretical model in its own right, Cultural Safety has gained credibility as a transformational framework for understanding Indigenous health issues (Wepa 2005; Polaschek 1998). As a Cultural Safety combines elements of sociological debates around the biomedical versus bio–psycho–social aetiologies of illness, and the social construction of the ‘patient’. It also seeks to explore and validate the ontologies of Maori and other non–Anglo cultures which have otherwise been ignored in relation to the health of these populations. Although relatively undeveloped in theoretical terms, Cultural Safety has acquired an international profile
very quickly and is being adapted and used by health professionals in many countries overseas with both Indigenous and migrant populations (Browne and Fiske 2001; Eckermann et al. 1995).

In the last twenty years, there have been many definitions and approaches to Cultural Safety, however I have drawn on the original New Zealand model as it was conceived directly in relation to this population group. In New Zealand, medical researchers for large-scale institutions such as Massey university and Middlemore teaching hospital in Auckland have recognised the correlations between cultural approaches to health and improved health outcomes for Maori and Pacific Islanders that have led to a demand for more Kaupapa research to be undertaken in relation to health (Edwards, McManus and McCreanor 2005; Cram 2001). In this way Kaupapa Maori and Cultural Safety intersect as complementary agents for transformative research and practice.

In both theory and practice, Cultural Safety was designed to afford acknowledgement of colonialism and resultant social disadvantage in addressing issues of health (Wepa 2005; Papps and Ramsden 1996). As a working model, it fits within the broader theoretical orientation provided by cultural health sociology and critical medical anthropology, and allows a focus on the interplay between social, economic, political, cultural and historical determinants of health and health care. Cultural Safety, by acknowledging the importance of the post–colonial experience, socio–economic disadvantage, and security of identity in determining health status, challenges the prevailing biomedical model of illness. This does not mean, however, that culturally aware health workers and researchers are opposed to all biomedical contributions towards identifying and treating poor health in the Polynesian populations. Many New Zealand health researchers maintain that smaller scale community interventions and qualitative research initiatives need to be ‘nested’ within larger epidemiological studies. The argument by many senior Maori and non–Maori health professionals is that these larger studies should also be premised on Kaupapa Maori principles (Williams et al. 2003).

**Conclusion**

Connell’s Southern Theory is a direct challenge to assumptions of universality by Northern theorists. It does not oppose, or stand in isolation to the breadth of the Western (in this sense Northern) canon, but rather seeks a redistribution of power and recognition. Kaupapa Maori and Cultural Safety were developed prior to Connell’s (2007) work on Southern Theory. In their own right they are both successful examples of Indigenous theoretical models conceived in response to localised conditions of post/neo–colonialism in the Pacific. Kaupapa Maori offers an alternative to
other theories and research models that are informed by individualised, Westernised ideologies. Maori academics who have worked very hard to formulate Kaupapa Maori wish to address the disillusion and struggle of many Indigenous students seeking resonance in Western critical theory wherein they are invisible and largely unrepresented within ‘self-serving’ colonial discourses. This model also provides ethical and cultural guidelines for the non-Indigenous researcher. Kaupapa affirms the centrality and legitimacy of Maori language, history, lifestyle, relationships and ways of learning.

Similarly, Cultural Safety embeds the inclusive roles of cultural identity, language and local understandings that, in turn, underlie perceptions of health in Indigenous communities. The principles of Cultural Safety involve respect, reflexivity and awareness by health practitioners. As outlined by Papps and Ramsden (1996) amongst others, the key concepts of Cultural Safety require respect for cultural difference and non-Western ontologies and are intended to act on transforming attitudes, policies and practices in health care. Cultural safety requires a reflexive approach by health providers to examine their own values and preconceptions that they bring to their professional lives. In addition, by gaining an awareness of the political and historical forces shaping the health of Indigenous peoples, Cultural Safety challenges fundamental assumptions surrounding relations of power. Understanding issues of disempowerment resultant from colonial processes and subsequent socio-economic marginalisation is a foundation for addressing the health of this population group.
Chapter Two:

Contours of empire: The impact of colonialism on Pacific peoples

Introduction

As with other Indigenous peoples, the relative health status of Maori and Pacific Islanders reflects their historical, political and social realities. Current health issues cannot be separated from these instrumental factors that have each played a part in the trauma of family dislocation, land loss and cultural upheaval. The burden of socioeconomic disadvantage emanating from post–colonial marginalisation compounds the likelihood of ill–health, and reinforces the international pattern that those colonised seldom reach the health standards of the coloniser (Ellison–Loschmann and Pearce 2006). This chapter contains a brief history of the colonising process as it was experienced in both New Zealand and the Islands, and its immediate impact on the health of Polynesians. It will also explore the shift in social relations that accompanied colonisation.

New Zealand promotes itself as representing a successful model of post–colonial biculturalism. In this chapter, however, I explore the underside of New Zealand as a colonial power and examine the role of the Treaty of Waitangi, in relation to issues of social justice for Maori. This chapter will also include a discussion of how post–colonial lifestyle change has affected the health and well–being of Maori and Pacific Islanders, and how these changes may be experienced by the Polynesian diaspora in Australia.

Brief history of colonialism in Polynesia

It is extraordinary that the same Nation [Polynesia] should have spread themselves over all the isles in this vast Ocean from New Zealand to this Island which is almost a fourth part of the circumference of the Globe (Captain James Cook at Easter Island, March 1774 in Bellwood 1987).

Polynesia, derived from the Greek term for ‘many islands’, includes all the islands in a triangle stretching from Hawaii in the north, Rapanui (Easter Island) to the east and New Zealand in the southwest. While there are sporadic accounts of Spanish and Portuguese contact from the mid–16th century, the major colonising powers of Europe began their annexation of Polynesian territories in earnest during the 19th century. The battles and negotiations for territory in the Pacific were largely contested between Germany, France, Britain and the United States. This colonial expansion resulted in the excision of large tracts of Polynesia without regard for sovereignty, land tenure systems, or
cultural and linguistic affiliations. The creation of the French protectorates of Tahiti, Society Islands and the Marquesas in 1842, divided a previously culturally homogenous archipelago into the French speaking territories and the English speaking Cook Islands. ‘French Polynesia’ therefore is not an Indigenous or cultural subdivision, but rather it constitutes a purely political entity imposed by the colonising powers (Bolin 1997). Despite nearly two hundred years of colonial separation, Cook Islanders and Tahitians still share ancient genealogies and acknowledge each other as ‘one’ people. Apart from the obvious barriers of language instituted by shifting colonial rulers, French Polynesians (the most well known being Tahitians), share the Maori language with New Zealand Maori, Cook Islanders and Hawaiians.

Tonga and Samoa were German outposts, with Britain maintaining a distant interest. For Tonga, the 1876 ‘Friendship Treaty’ with Germany and Britain, allowed it to remain a nominally independent monarchy. The physical position of Samoa made it desirable to the United States which wanted more strategic footholds in the Pacific at the end of the 19th century. Consequently, a deal was struck in 1889, the Tripartite Convention, whereby Britain and Germany waived their interest in the country allowing the United States greater access (Ryden 1975). Samoa was subsequently divided into American Samoa, under the auspices of the United States, and Western (now Independent) Samoa being ‘given’ to New Zealand. This effectively divided families and villages from each other, and continues to affect Samoan citizenship in several countries. The tiny atolls of Niue were less contested and were allocated to New Zealand after World War II.

The Polynesian islands relevant to this study – Tonga, Samoa, Cook Islands and Niue – have retained majority populations in their own country. For mainland New Zealand, there was a different colonial path. Regarded by the colonial authorities in Britain as more substantial than a trading port, New Zealand was quickly assessed as a suitable strategic outpost of empire. According to historian Claudia Orange (1987) and historian and anthropologist Anne Salmond (1991; 1997), the prevailing view was that once the Maori were subdued, assimilated, or had ‘died out’, the extensive fertile land, so reminiscent of Britain, would be a settler’s paradise. New Zealand, therefore, was to undergo a much more gruelling and vicious process of military invasion and long term, large scale guerrilla campaigns in a three way battle for supremacy between the Maori, the settlers, and the colonial government. Critical elements of this process are outlined below.
Fatal contact: The arrival of the Europeans and the introduction of disease

It is widely recognised that European colonisers brought with them infectious diseases that decimated indigenous populations (Martin and Combes 1996; Kunitz 1994; Tomkins 1992). Diseases brought by James Cook’s 1778 voyage alone, led to widespread and immediate deaths (Bushnell 1993). The ailing and distraught people were then beset by further infectious and fatal illnesses brought by subsequent sailors, slave traders, merchant and settlers. Syphilis and other venereal diseases were prevalent, but four major epidemic diseases were particularly destructive: tuberculosis, typhoid, influenza and smallpox. These were rampant in French Polynesia during the 1860s, when approximately eighty percent of the population of the Marquesas died (Martin and Combes 1996). During that period, exchange of populations between the Marquesas and other islands increased as a consequence of trading, and the diseases quickly spread to the rest of Polynesia and New Zealand. It has been noted that mortality from these infectious diseases was not as extensive in Samoa and Tonga at this time, however, according to Tomkins (1992), Samoa lost twenty–two percent of its population within weeks during this period, eventually losing thirty percent of adult men, twenty–two percent of women and ten percent of all children. The ravages of introduced disease were also disastrous for the Maori of New Zealand, and were exacerbated by the deprivations of a protracted campaign of land theft and armed conflict.

Post–colonial adjustments to social order: mana, tapu and noa

Not only did introduced diseases radically reduce population numbers in the Pacific, the arrival of the colonising powers heralded a traumatic and unprecedented upheaval in social relations. It is useful, therefore, to have some understanding of the pre–colonial social order to help gain a sense of what has been lost, as well as appreciate what has been retained, or in some cases, reclaimed, in the aftermath of such widescale cultural destruction. For this reason, I will discuss the three most significant concepts at the traditional spiritual core of Polynesian values: mana, tapu and noa. These concepts not only underpinned spiritual life in ancient Polynesia, they governed all social interactions and broader power relationships (Irwin 1984; Howard and Kirkpatrick 1989). Mana, throughout Polynesia, denotes a sacred power. It also has connotations of integrity, decency, courage and leadership. Tapu, via its Melanesian pronunciation of ‘tabu’ became ‘taboo’ in English. For Polynesians it means ‘sacred’ rather than the English meaning of being banned. The opposite is noa, meaning mundane, ordinary or not sacred (Irwin 1984). In the Polynesian worldview, everything exists within the realm of mana, tapu and noa.
Pre-colonial Polynesia was ordered by a system of genealogical ranking which was universally comprised of chiefly family lines, which in turn, shared assets and resources with the rest of the community. The status and recognition of mana, automatically bestowed on chiefs, carried with it the laws of tapu governing the intricate web of behavioral rules, restrictions and duties. All social, familial and gendered behaviour were delineated by the rules of tapu which prescribed daily life for individuals, families, and villages (Howard and Kirkpatrick 1989). Maori society, as in other Polynesian societies prior to colonisation, was organised around whanau (immediate family), hapu (extended family) and iwi (tribal) kinship groups identified as emanating from a common ancestor (Bellwood 1987; Irwin 1984). Chiefs were assigned along hereditary lines, from within this superstructure. Genealogical connections (whakapapa) identified these relationships allowing for descent lines from both men and women (Metge 1995).

The process of colonialisation, and the duty of missionisation, was to dismantle the hierarchical aspects of this social system and erode the chiefly structure, along with the system of tapu and mana that had for so long sustained it. Despite threats and coercion, this battle for the ‘hearts and minds’ of Polynesians clearly has not been won. It is virtually impossible, even today, to have a conversation about anything of importance with Polynesians without mana and tapu being mentioned. Along with the associations of dignity and sacredness, there is also a tacit implication in these terms of mutual care and respect. In relation to an understanding of mana and leadership, it is insufficient for a community or tribal leader to rely solely on birth ranking for prestige. Many distinguishing elements of mana such as courage, generosity, and prioritising others, act as a counter–balance to the power invested in hereditary leaders. Generosity and reciprocity are the touchstones of Polynesian culture, and a leader is expected to demonstrate these qualities. By birthright, a chief or chieftainness is considered to inherently embody mana and be deserving of tribute, and indeed may be feted. However, generosity to those less well off, and the ability to share are expected of a good leader, thus earning the right of mana. In other words, great leaders are to be looked after, but they are also responsible to ensure their people do not do without (Irwin 1984).

**Gendered positions: The moral discourse by church and state**

Puritanism demands that happiness and frivolity are subordinated to the work ethic, monogamous reproduction and commitment to law and order (Marcuse 1956, p.3)

Traditional Polynesian societies operated under a system of gender complementarity. The contribution of both men and women was valued, as status was determined by birth ranking rather
than on the basis of gender (Howard and Kirkpatrick 1989; Levy 1973). Women, particularly high ranking women, were influential as tribal leaders, and were entitled to have a series of lovers, more than one husband, and leave the marriage if they wished (Bolin 1997). This elevated position of power and freedom was reported with a mixture of incredulity, and frequently disapproval, by early missionaries and government officials (Bentley 1999).

In an era when European women could not hold land in their own right, nor were enfranchised to vote, explorers venturing into the Pacific encountered matrilineal land holders – women who were physically strong, often tattooed, and outspoken. On Captain Cook’s voyage to New Zealand in 1769, Sir Joseph Banks described Maori women as being like ‘unbroke fillies’ (Banks in Smith 1999, p.9). This is also borne out in Lockwood’s observation of traditional Polynesian women being ‘anything but a passive, deferential, submissive lot; certainly not in domestic matters and often not in public affairs either’ (Lockwood 1989, p.207). Therefore, for both Maori and Pacific Islander women, colonisation (and missionisation) represented a diminution of their legal and social position.

The ideological defense of empire in the century from 1850–1950 was underpinned by ideas of progress and enlightenment which were central to the colonial discourse. The ‘natives’ were constructed as backward, and the colonial powers regarded themselves as the rational agents of ‘progress’ (Said 1978, p.40). While economic gain remained a central motive for conquest, colonial rule of the nineteenth and twentieth centuries was also engaged in a moral crusade. Implementation of colonial laws and church sanctions meant a total change in local society. European education, Christianity, and preferred political and bureaucratic systems were to replace the old ‘pagan ways’. Bound up with this, was the notion of moral duty as pre–eminent in the ‘civilising’ process.

Rapid competitive expansion of empire occurred at a time in Europe when an individual or family’s destiny was largely determined by class. The deprivations of the poor meant hunger and disease were rife, housing inadequate and sanitation legendarily poor. It was also an era when the church sought to punish those who indulged in ‘sins of the flesh’.

For those Europeans who arrived in tropical Polynesia, the country left an indelible imprint – appearing as a veritable Eden. Tahiti, because of its role as a port to many nations, was the site where many sailors, whalers, and traders first encountered Polynesians. Tahiti specifically, and
Polynesia generally, became known all over the maritime world as a Bacchanalian paradise. The following is typical of many of those early accounts:

The great plenty of good and nourishing food, together with fine climate, the beauty and unreserved behavior of their females, invite them powerfully to the enjoyments and pleasures of love. They begin early to abandon themselves to the most libidinous scenes (Forster 1778 in Bolin 1997, p 8).

However, the traditional social systems, regulations and sanctions that governed this behaviour by certain Polynesian women and not others, were not apparent to early Europeans. To the colonial gaze, emanating from tight–laced Victorian/Edwardian England and puritan Europe, such ‘libidinous scenes’ could only be of the most depraved and licentious nature: ‘While the sailors took advantage of the sexual liberation of these young girls, they experienced some ambiguity because their own Western sexual paradigm had no comparable framework or referent’ (Misa 2004, p8).

Colonisation also led to inevitable changes to the political economies of Polynesia. Traditional landholdings and collective systems of re–distribution, were replaced with private tenure of ‘crown’ land, or no title to land at all. Accompanying this rapid stripping of sovereignty, was the establishment and propagation of Protestant Christian values, which underscored the end of ‘pagan ways’ and introduced the Christian concept of marriage. This ‘new’ way of being married, meant a re–ordering of family life along distinct gender lines. Men had access to the outside world, while retaining domain over the interior of the home as well. Women were expected to confine themselves to approved tasks, preferably within the home, and be answerable to their husbands. This physical restriction was advocated by missionaries who regarded the traditional practices of women gardening and seafood–gathering as inappropriate to their sex (Bolin 1997).

The missionary and colonial emphasis on women as homemakers was absorbed by Polynesians to the extent it entered the language: women’s work came to be described as *haka ha’e propa* which translates as ‘keeping the house clean’ (Howard and Kirkpatrick 1989). This description included various domestic tasks such as child care, the washing of clothes and cooking, while men were expected to do the ‘outdoor’ tasks such as agriculture and horticulture, gathering of coconuts, fishing and paid manual work. According to Thomas (1987) and Levy (1973) this is directly at odds with pre–colonial models of task sharing, which were more flexible and prone to gender cross–over.

Despite the systematic erosion of the status of women, through both colonisation and missionisation, Maori women, in particular, continued to play an active (if markedly more prescribed) role in the evolution of the new colony. For European men such as the shore whalers in
the early 1800s, deals were struck whereby they would be offered protection by local chiefs and were allowed to marry Maori women. Haines (2006) examines how the nature of sexual contact developed during this period, from fleeting encounters with ‘native hospitality’, to one of companionship and domesticity (Haines 2006, p.3). Haines maintains that the role played by the women, many of whom bore a great number of children, was one of cultural mediators in these early social contracts, and their contribution remains largely unexplored.

**The Treaty of Waitangi 1840**

Throughout the early nineteenth century, the Maori had proved to be excellent strategists and guerrilla fighters, and had continued to resist the British takeover of their country (Orange 1987). The British army, despite sending for reinforcements, including some from Australia, had failed to accomplish a clear cut victory, and made the decision to enter into a pact with the Maori chiefs in the form of the Treaty of Waitangi. The Treaty was ‘signed’ in 1840 between representatives of the British Crown and approximately five hundred Maori chiefs – and has been contested ever since. The Treaty was designed from a British perspective, to allow migrants to come to New Zealand in safety and establish a settler government. Walker (1990) and other historians have agreed the Treaty was seen by the chiefs as an agreement which did not diminish their ultimate sovereignty, or rangatiratanga, or they would not have signed. The chiefs were assured by negotiators that they would retain sovereignty over their land, forests, and waterways and that they could authorise or veto the lease and use of these assets by settlers. Elements of the Treaty have been disputed at all levels of the court system in New Zealand since the signing, primarily because the ‘Maori version’ and the ‘English version’ are not remotely similar. In other words, the chiefs, and descendants of the chiefs, have argued they would not have agreed to a proposition whereby an unseen head of state in another country, now owned their ancestral lands. The Treaty, therefore, did not reflect either in the letter, or spirit of the law, what the British government had promised the chiefs on the act of signing (see Orange 1987; Walker 1990).

Dissatisfaction with the Treaty meant the fledgling colony of New Zealand descended into decades of civil war. In his meticulously documented work, William Main (1976) traces, in photographs and text, what he describes as the three broad movements of Maori people and culture – before, during

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5 Most chiefs ‘signed’ with a thumb print
and after the disaster of the Land Wars. He begins with the early years of white contact in New Zealand with a healthy, passionate, artistic, warrior race, and visually documents the decades of the Land Wars as the Maori population suffered the protracted trauma of land loss, war, and introduced diseases.

In 1840, there were estimates of 80,000 Maori and approximately 2000 ‘settlers’. The signing itself prompted a rush of British migrants and in the next eighteen years, the number of settlers grew to nearly 60,000, which was roughly equivalent to the depleted number of Maori who had survived exposure to infectious disease, land dislocation and firearms. By 1901, the population of 770,313 settlers outnumbered Maori by more than sixteen to one (Pool 1991). This saturation of white settlers and colonial administrators managed to achieve what decades of armed conflict could not; the dispossession and subjugation of Maori in their own country. Weaver (2000) refers to this process as ‘internal colonialism’:

‘Internal colonialism is different from classic colonialism … in colonialism’s classic form a small group of colonists occupy a land far from the colonial metropolis (metropole) and remain a minority, exercising control over a larger indigenous population. By contrast, (with) internal colonialism, the native population is swamped by a large mass of colonial settlers who, after generations, no longer have a metropole to which to return. Metropole and colony thus become geographically coexistent’ (p.223)

**Disillusionment with the Treaty and the implications for health**

After the signing of the Treaty of Waitangi, not only was land confiscation legal for the settlers, but also the way was paved for other Maori rights to be infringed, such as the banning of Maori language in schools. The goal and tone of the Treaty of Waitangi was allegedly to protect and maintain the rights of all citizens, including their health. Indigenous health practice has acknowledged the importance of social justice and civic participation as integral to the sense of well-being that underpins good health. Maori have continued to assert their rights as negotiated under the Treaty, and point to continuing disparities in health between Maori and non-Maori as evidence that the Treaty is not being honoured (Ratima 2001; Pomare 2000).

By the early twentieth century colonial practice had evolved to include a more planned civic infrastructure with a welfare component. In 1939 the British government changed its Law of

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6 In the colonial education system, this period was referred to as the ‘Maori Wars’ and has only recently been amended, now being described as the ‘New Zealand Wars’. In this thesis I use the term ‘Land Wars’ which is used by many scholars, and Maori themselves, as it more accurately reflects the motivation for the conflict.
Development of the Colonies to the Law of Development and Welfare of the Colonies, making issues of health, education and nutrition, as well as economic development, a responsibility for the colonisers. Kunitz (1994) commends colonial policies aimed at improving Maori health during this period, coupled with the employment of Maori physicians in the nascent Department of Health. However, these policies have since been criticised and diminished as they were simply targeted at correcting immediate health issues such as malnutrition in Maori children, and arresting the spread of infectious diseases; conditions which were created in the direct aftermath of broader colonial practices (see Durie 2003; Pool:1991). These critics argue that as soon as the immediate health threats were addressed, little more was done to encourage Maori participation in the health services. For example, the New Zealand colonial government provided funding for Maori nurses as early as the 1890s, but as Holdaway (1993) points out in the title of her research: ‘Where are the Maori nurses who were to become those efficient preachers of the gospel of health?’

Despite the Treaty being regarded as the basic component of the relationship between Maori people and the government of New Zealand, the redress of contentious issues has not been included as a priority in social policy legislation. This failure continues to fuel resentment and the lack of social justice represented arguably undermines the capacity for Maoridom to ‘move on’, and for New Zealand to emerge as a truly bicultural nation. In the light of the inequality surrounding Maori health and well-being, it is evident that the post–colonial legacy is impacting through the generations.

**Post–colonial lifestyle changes**

Obesity, the biggest health crisis facing Maori and Pacific Islanders today, has only been a significant problem for Polynesians in the last fifty years. For example, in the 1930s, medical officers in New Zealand were concerned that bread and potatoes had become the mainstay for many Maori families and this often led to severe malnutrition. It has been suggested that memories of this time, being hungry, may also have played a part in the eating habits of modern Maori. Regardless of the emotional or psychological underlay, with subsequent urbanisation, the problem has become one of over–eating. For Polynesians, as with other colonised indigenous peoples, historical processes combine with contemporary socio–economic deprivation to create a health profile, as noted in the Introductory section of this thesis, that reveals a decline in health over the period of colonisation (Ellison–Loschmann and Pearce 2006). Transitions in eating practices from pre–colonial times up to the present, and how the Polynesian body has changed since colonisation, have been explored by Durie (2003) and McCarty and Zimmet (2001) amongst others. In New Zealand,
dispossession of land and population displacement impacted on the ability of Maori families, who were previously self–sufficient, to grow their own food. It also resulted in a more complex erosion of autonomy and identity, contributing to a decline in health and wellbeing generally. The population movement towards urban centres in search of work, and the modern sedentary lifestyle, has led many Maori and Pacific Islanders to experience a deterioration in health status and a commensurate rise in obesity rates (Durie 2003).

The history of capitalism and colonialism are closely related (Connell 2007; Wallerstein 1974). Maoridom was collectively brought under the aegis of the New Zealand ‘welfare state’, and despite being consistently at the bottom of socio–economic ladder, have nonetheless been able to earn money in the context of a first world economy. For Pacific Islanders, their lands have been deemed too remote and small to be of on–going commercial value. Outside commercial logging and tourism, there has been little opportunity to earn the equivalent of a Western wage, and there are not the usual welfare ‘safety nets’ available in Australia or New Zealand. In economic terms they have been abandoned and remain reliant on subsistence agriculture (Yari 2003). In less than a century of colonial rule, the tribal lifestyle of Islanders was eroded by power plays, land grabs, inducements and threats, including the fining of those who did not attend church. For a poor population virtually devoid of currency, this was a particularly cynical manoeuvre (Tangatapoto 1984).

Cook Island and Niuean men were co–opted to work in mines in Chile, many of whom died of smallpox and other infectious diseases. Others were forced to leave their families for many years to work in Tahiti and other countries. There is little to indicate any improvement in the financial lives of Pacific Islanders. The per capita income of Islanders places the Islands firmly in the realm of ‘developing countries’, markedly below the poverty line in Western countries, and below the income of countries such as Bolivia and Chad. According to the World Bank (2008), the state of Independent Samoa occupies an area of 434 square miles, has a population of 170,000 people, and a per capita income of US$2,780. Tonga has an even smaller land mass of 124 square miles, housing 106,000 people, and a per capita income of US$2,560. The statistics are similar for the Cook Islands and Niue. These incomes are heavily subsidised by remittances from relatives abroad, mainly in New Zealand, Australia and the United States. When combined, these remittances constitute up to a third of the Gross Domestic Product of these countries (Singh 2005). These figures help explain why first generation Island migrants are so committed to the sending of remittances as they are aware that without these contributions, immediate family members will struggle. It is further evident that the current migration rates from the Islands are unlikely to diminish, and are far more likely to increase.
Conclusion

As a country, New Zealand prides itself on its status as a bicultural nation. Romanticised images of Maori are employed to promote the view of New Zealand as a modern country which also has a rich cultural tradition. The national mythology centres on the premise that the Treaty of Waitangi was signed allegedly giving rights to both parties, and from this point, Maori and Pakeha have coexisted on equal terms. Unfortunately, by every economic measure, Maori and now the large New Zealand–born Pacific Island population, are in deficit when compared to Pakeha New Zealanders. According to New Zealand government statistics, household incomes, educational achievement and consequent employment prospects are significantly below those of their Anglo counterparts (Poata–Smith 2007). Given the associations between good housing, secure employment and health, it would appear that Polynesians are not sharing a level playing field with Pakeha. These socio-economic statistics demonstrate that the policies of the early colony still have residual impact today.

In relation to Pacific Islanders in the home islands, their situation is complex. On the one hand, these populations are perceived to live in ‘paradise’, and indeed, most Islanders think and talk fondly of ‘home’. The daily realities are harsh, and poverty levels are unacceptably high. The exodus from the home islands is continuing, as work is progressively difficult to find. The colonial legacy of belittlement, inferiority and invisibility – not allowing these cultures their own history – has, arguably, not helped these countries to determine issues of sovereignty or cultivate strong leadership. Having been made dependent on the larger countries of Australia and New Zealand for their economic survival, migrants from the islands continue to come to these countries for a better life.
Chapter Three:
Social and cultural understandings of food, health and the body in the South Pacific

Introduction

This literature review undertakes an exploration of the relevant sociological understandings of health and well-being in relation to issues of health and identity in the Polynesian diaspora. It will cover comparative understandings of Indigenous health with particular reference to cultural notions of the body and subjective understandings of health in a consocial, or socio-centric migrant community. Who gets ill, which ailments they experience, the treatment they receive, and their likelihood of premature mortality, are not random factors. According to Freund and McGuire (1999), a baby’s social environment can provide potent indicators of childhood health, and the ability to acquire the skills necessary to maintain a healthy life, and their chances of achieving full wellness. These are significantly shaped and constructed by the social world into which the baby is born and is reared.

Certain social practices contribute to the production of a healthy body; others lead to its destruction. The very condition of our bodies – whether we are healthy or sick, whether we live or die – depends not on luck but on social circumstances (Freund and McGuire 1999, p.39).

Perceptions of health and illness, wellness and well-being are highly variable reflecting not only the biological status of the body, but also psychological, social and cultural referents. The nature and complexity of these issues are also subject to historical and contemporary relationships of power within and between the medical service providers and those they are charged to serve.

Competing views of disease causation and what constitutes ‘good practice’ in medicine, has meant the more conventional, reductionist biomedical model has been subject to challenge by various alternative approaches, most particularly, the bio-psycho-social (BPS) model of health. The BPS framework, pioneered by George Engel (1977), has been instrumental in introducing the concept of well-being as a state that is more far-reaching than ‘not being sick’, and which is influenced by a range of psychological and social factors. In a climate of post-structuralism, this model has been
expanded to include the impact of social disadvantage, lifestyle possibilities and choices, cultural beliefs, equity of health care access, and other non–medical issues that may affect a person’s health and perceived well–being (Lupton 2003; Petersen and Lupton 1997). In this discussion I will explore these processes of challenge and change.

In addition, since the 1990s, further research has been forthcoming on how concepts of both health and well–being have been socially constructed (for instance, Eckersley, Dixon and Douglas 2001) and how the differences of each of these concepts are experienced in Indigenous, or other highly consocial communities (Mathews and Izquierdo 2009; Heil 2003; Anderson 1999). I will, therefore, examine how new ways of understanding health and well–being have been conceived and enacted in the Polynesian community in New Zealand, and the role that has been played by the introduction of the principles of Cultural Safety.

**Divergent notions of health and illness: Biomedical and bio–psycho–social models of health understandings**

The conventional biomedical view reflects belief in the Cartesian premise of mind–body dualism, with illness being the exclusive domain of the physical body. Within this paradigm, the ill individual comes to be regarded as an adjunct to the diseased body (Lupton 2003). In this regard, biomedicine is unable to explain, or adequately address the escalating problem of long term, chronic disease. As Clayton (2002, p.844) explains:

> Adherence to strict binary distinctions can no longer provide a sufficient framework to explain social phenomena, particularly disease. If the ‘nature’ of disease cannot be understood in terms of immutable characteristics, then the concepts of disease and health cannot be confined to biomedical explanations.

In any assessment of a person’s health and well–being, their individualised biological, or physiological, state is a primary marker that needs to be evaluated in comparison with assessments of both health and well–being of the general population. It is evident, therefore, that epidemiological studies are extremely useful to calculate the incidence and distribution of illness and mortality rates, and analyse these in relation to non–biological structural factors such as gender, class, ethnicity, as well as geographical location. However, it is in the area of social epidemiology, exploring patterns of illness and the social influences that created them, that is most relevant to this thesis in providing an insight into the intricate web of causal factors of ill–health (Anderson 2007; Saggers and Gray 2007).
According to Clayton (2002) Western medicine examines the body in terms of divisible (and largely replaceable) parts. Epistemological knowledge that prioritises physiological understandings of the body as a composite of these body parts forms the basis for the biomedical model of health (see also Lupton 2003). In the biomedical view, a person’s health status is essentially a static condition whereby the person is either ill or healthy, or something in between. Within this framework, ‘disease’ is commonly considered as the sole agent of ill health, and accordingly, the ‘cure’ lies in treating the disease. Aligned with this model is the pursuit of the single agent of disease that presumably can be identified, targeted and eliminated. This has remained the core goal of various strands of medical enquiry which Dubos called the ‘doctrine of specific etiology’ (Dubos in Freund and McGuire 1999, p.6).

In recent times, the quest for the ‘offending germ’ has arguably been replaced by the search for the ‘rogue gene’, responsible for a particular illness. The broad study of genetics has continued to receive generous research funding from governments, teaching institutions, large pharmaceutical companies, and investment banks, despite its limited predictive capacity and inability to address the nature and trajectory of chronic illness (Petryna 2009; Petryna, Lakoff and Kleinman 2006; Pearce et al. 2004; Clayton 2002). These authors have expressed concerns, not only regarding the efficacy and appropriateness of genetic technology in relation to the treatment of chronic illness, but also in regard to the ethics of the ‘corporate research’ that is producing it.

Another criticism of conventional biomedical frameworks is that they are limited in their understandings of the complex interplay of indirect or external factors that may influence the onset or distribution of illness (Lupton 2003; Freund and McGuire 1999). The Western biomedical model of health considers that environmental factors may be relevant in relation to public health policy, for example, infection control, or assessing the health impacts of over-exposure to toxic chemicals. However, this model is not effective in dealing with long–term chronic conditions and disorders, or syndromes, that have a variety of intersecting causalities. In arguing for a review of health care delivery in Australia, Foster and Fleming (2008a, p.60) point out that, ‘the rise in chronic and complex conditions has exposed the limitations of biomedical frameworks in primary care …’. In Australia and overseas, the strictly physiologically–based biomedical model has been further criticised as inadequate to explain multi–faceted, cultural reflections of disease. The contemporary literature on health psychology, sociology of health and illness, medical anthropology and the
precepts of the bio–psycho–social models of health, are engaged in a much more complex discourse:

Disease is not an isolated entity, unanchored until confronted. It is the construction of a concept that has meaning by virtue of its interrelationship with the subject’s social reality (Clayton 2002, p.840).

George Engel’s (1977) challenge to the American biomedical establishment, is often cited as the beginning of the modern concept of the bio–psycho–social model of health (BPS). Engel’s work queried the efficacy of the strictly biomedical approach in being able to successfully treat many conditions. The three components of the BPS model begin with the biological or physiological. In common with the biomedical standpoint, this seeks to understand the cause of the illness in regard to the functioning of an individual’s body. The psychological element addresses thoughts, emotions and behaviours that may be having an adverse impact on an individual’s health and well-being, and the ‘social’ refers to a range of factors, such as socio–economic status, cultural issues, poverty, and feelings of isolation that may influence health status. Using the BPS model, it is the interaction of these criteria that holds the key to an individual achieving and maintaining good health. Further, there is an acknowledgement that satisfaction with one’s state in life is relevant to this perception (Eckersley, Dixon and Douglas 2001).

A premise of the bio–psycho–social approach is that many ailments have multiple causes and effects, and the ‘whole’ person needs to be treated. The existence of these complexities and detailed interactive factors have certainly not been agreed and accepted by all, and have met resistance by researchers and health practitioners persevering with the straightforward biomedical model (Duckett 2008). However, as chronic disease is now responsible for the majority of avoidable hospital admissions in Australia (Page et al. 2007), the demand has increased for a change in health care delivery that incorporates a more holistic view. Advocates of advanced primary health care in Australia, such as Duckett (2008) and Foster and Fleming (2008a;b) argue that everyone, regardless of their physical state, has a right to maximise their opportunity for well–being.

When looking at the health of non–Anglo populations in particular, it is necessary to explore not only the bio–psycho–social paradigm, but also to further examine the role of cultural beliefs and practice in relation to behaviours that may impede or promote overall health and well–being. From a medical perspective, Kunitz (1994) describes the sequential and overlapping nature of disease causation in Indigenous peoples:
Once disease ecology has been held roughly constant, one can see more clearly the ways in which colonial policy and political institutions have shaped the affairs of indigenous peoples. And once policy has been held constant, one can see more clearly how culture can make a difference (Kunitz 1994, p.177).

Kunitz argues that biomedical understandings of disease causation, and a more culturally aware (anthropological) approach should work together. However, different professional interest–groups continue to dispute and contest their areas of expertise, via what he refers to as their ‘ideological weapons’. A significant part of this ideological weaponry is the culturally derived language used to describe an individual’s state of health. It is, therefore, important here to distinguish between ‘disease’, a condition that the clinician is charged to treat, and ‘illness’, which is more descriptive of how the patient and family members experience the manifestations of that disease. The domain of the medical anthropologist is ‘illness’ or ‘sickness’, which contains a subjective understanding of how the person experiences this state, implying a social context. Kleinman, Eisenberg and Good (2006, p.3) make this distinction in the following terms:

Disease in the Western medical paradigm is malfunctioning or maladaptation of biologic and psychophysiologic processes in the individual; whereas illness represents personal, interpersonal, and cultural reactions to disease or discomfort. Illness is shaped by cultural factors governing perception, labeling, explanation, and valuation of the discomforting experience, processes embedded in a complex family, social, and cultural nexus.

How people are taught to perceive, relate to, prioritise and understand their bodies profoundly affects how they regard bodily deportments such as eating, sex, birth, illness, transitions of ageing, and death, and are resonant of other cultural and spiritual values (Lupton 2003). In cultural and sociological terms, the use of particular language to describe a person’s health status may, in itself, affect their ability to engage with preventative strategies, or comply with the treatment offered (Baxter 2002; Eckermann et al. 1995). In other words, how health problems are described and communicated affects responses to that knowledge. According to Schepers–Hughes (2006) and Parsons (1975) the experience of illness, and what strategies are employed to cope with that experience, are culturally shaped by understandings of the body, health and ill–health. These authors argue that the ability to evaluate one’s own health status and care, is influenced by the systems of meanings with which we are familiar, and are specific to the social positions we occupy.
It therefore becomes necessary to reinterpret ill health, and/or deterioration of well–being, in terms that reflect the reality of the person or population group concerned. As Young (1982) points out, descriptions of illness are fundamentally semantic, yet the illness itself is culturally experienced and dependent on the interpretive nature of clinical practice. Arguably, this creates an impasse, whereby dominant scientific language serves to reinforce the hegemony of the medical discourse, while more particular culturally specific understandings of health may lead to better outcomes and a more comprehensive uptake of primary health services (Baxter 2002).

Paradigms of well–being

Integral to this thesis is the concept of ‘well–being’. Engel’s work in the 1970s introduced the idea that the ‘patient’ is not simply a biomedical entity, but a complex psychological and social being who is affected by their environment. The influence of both social and physical notions of environment continued to be explored by subsequent researchers as attempts were made to theorise and/or quantify something as subjective as ‘well–being’. For those researchers committed to defining and clarifying cultural difference in perceptions of well–being, the challenge was arguably more complex. Narolls (1983) sought to identify common ground, across cultural boundaries. Narolls found that how people coped with stressful situations, such as family breakdown, or long term illness, was determined by a variety of factors, reflecting cultural ontologies, but were also affected by a range of personal, social, political and institutional influences and religious affiliations.

This reflects the earlier work of Martin Orans (1978) who asserted that an individual’s relationship to economic institutions and overall social positioning influenced their perception of well–being. Orans also introduced the concept of ‘self–reported’ happiness. The subsequent direction of studies of ‘well–being’, while still being described and critiqued within specific disciplines, came to include these two key features: that the state of ‘happiness’ or ‘well–being’ is affected by influences other than the purely biological, and is therefore dynamic and relational.

In 1986, the WHO issued a statement on the need for broader social and cultural understandings for health, which became known as the Ottawa Charter for Health Promotion. Even earlier in 1946, the WHO defined health broadly as “a state of complete physical, mental and social well–being and not merely the absence of disease or infirmity”. While this holistic definitions has been criticised for its vagueness it does highlight the importance of the social context of health. Heil (2003) points out
that it is so broad as to be virtually meaningless as a guideline to action. Heil’s argument, using the example of Aboriginal people in central New South Wales, is that for most Indigenous people, their own health status is not the measure of their happiness. Rather, the successful negotiation of the community’s interrelatedness takes precedence and is the ‘yardstick’ of perceived well-being of the individuals within that community. The National Aboriginal Health Strategy working paper (NAHSWP 1989 in Heil 2003), confirms this position. Health for Indigenous people is rarely considered in isolation from their broader family and clan groups. It is ‘… not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole–of–life view and it also includes the cyclical concept of life–death–life’ (Heil 2003, p.25).

This position echoes that of Anderson (1999; 1994) who also explored the elements that constitute ‘well–being’ for Aboriginal people. Anderson’s work acknowledges the multiplicity of social relations that underpin an Aboriginal sense of well–being, and challenges Western notions of an individual’s health being bounded by their own embodiment as an isolated entity. Heil (2009) critically examines this theme, as well as the meanings comprising the concepts of health, and, in comparison to that, well–being. Deriving from her comparative analyses of the two concepts from scholarly perspectives in the social sciences, she demonstrates that the meanings applied to the concept of well–being have primarily been equated with those meanings applied to the concept of health; however, Heil argues that those equations are neither correct nor useful. Further, she examines the prioritising of individual health over social health, whereby the individual is abstracted from cultural and spiritual beliefs, post–colonial realities and their current and ongoing engagements in socialities. Heil (2009, p.101) suggests that the Aboriginal experience of well–being encompasses understandings:

…which move away from the conventional medical focus on individuals as embodied selves, to instead include the social positioning of individuals, their historical experiences, and their being members and participants in a matrix of relationships and social practices.

**The role of social and cultural capital in achieving well–being**

In the broader Australian context, Manderson (2005) locates well–being within a discourse of social inclusion and community. In Manderson’s view, the primacy of a specific body being ‘healthy’ or ‘unhealthy’, is insufficient in understanding the interactive spaces that people inhabit. Manderson is concerned with the role of social justice and its impact on perceptions of well–being. A significant element of the ‘social inclusion’ agenda is predicated on a degree of civic engagement. Manderson argues that this is more likely to be achieved when social injustice, or ‘exclusion’, are addressed. In
this work, Manderson (2005) also returns to the methodological challenges of such research. She urges caution in regard to the ways in which social capital in different communities is assessed and compared. A straightforward economic model may not accurately reflect the social capital of a community in which other strengths such as extended social support and cohesion are not measured.

Bourdieu (1986) describes social capital in the following terms: ‘…the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition’ (Bourdieu 1986, p.248). These sources may be both material and/or symbolic. For Bourdieu, cultural capital refers to non–material, or non–financial contributions, such as educational and intellectual assets that may promote the likelihood of social mobility beyond the current economic status of the subject (Bourdieu 1984;1973).

In 2010 a significant article was published in New Zealand by Mila–Schaaf and Robinson. In their work, Bourdieu’s concepts of social and cultural capital have been adapted to theorise the Polynesian experience of exposure to more than one culture. The authors coined the term ‘Polycultural capital’ in relation to the acquisition of both Polynesian and non–Polynesian social and cultural capital for New Zealand–born Pacific Island youth. Mila–Schaaf and Robinson (2010) examine the high educational outcomes of students who successfully bridge the two worlds of their ethnic backgrounds and the dominant Anglo–European school system. They regard these students and young professionals as a resource for the growth of social and cultural capital for their ethno–specific and wider communities. The concept of ‘Polycultural capital’ is therefore useful in understanding both socio–economic positioning and cultural behaviours. In this view, the accumulation of cultural knowledge is able to confer confidence and improve educational outcomes and social engagement. This engagement and its relationship to overall well–being is especially important in the context of a minority ethnic group in a Western country.

**Kaupapa Maori and Cultural Safety: Working towards a Polynesian concept of well–being**

_Hauora ora nga_ is the Maori term for health and wellbeing. The meanings contained within _oranga_ (well–being), however, are far broader than implied by the English translation. The Maori use of _oranga_ shares with English the somewhat abstract notions of ‘well–being’, such as an absence of illness, intellectual alertness and physical fitness (see Ministry of Health report 1998). However, it is far more descriptive in that it contains a sense of identity, confidence and pride, control of one’s destiny, spiritual awareness and being ‘heard’. There
are further dimensions to the concept of *oranga* including the more active and interactive roles of personal responsibility, cooperative action, respect for others, and to offer and receive family support (*awhi*). Mason Durie, whose work is at the forefront of a transformational approach to Maori health, suggests *oranga* will only be experienced when the person has economic security and a knowledge of *te reo* (language) and *tikanga Maori* – the Maori way of doing things (Durie 2003; 1997). Durie and other authors such as Robson and Harris (2007), further argue that true *oranga* requires social justice, land rights, and language restitution, to pave the way for greater social inclusion in the aftermath of colonial marginalisation. In this view, self–respect, autonomy, and sovereignty (in the sense of belonging to ‘place’ and having control over that place), are implicit in notions of optimum well–being, and cannot be divorced from broader political issues.

The political and theoretical basis of *Kaupapa Maori* and the practical contributions of Cultural Safety, come together around notions of health and well–being as subjectively experienced by Polynesians in the post–colonial context. As both have emerged from a Maori–centred perspective, they share the position that it is the relational nature of Polynesian socialities which is the key to true well–being. For someone to flourish, and not just survive, a sense of ‘belonging’ is required. Further to this, there is a need that their culture is regarded as worthy of respect and inclusion, in order for people to fully engage with their life situation (Mathews and Izquierdo 2009).

In 2009, the New Zealand government issued a report outlining the role of ‘culture’ in securing overall health and well–being:

New Zealanders share a strong national identity, have a sense of belonging and value cultural diversity. Everybody is able to pass their cultural traditions on to future generations. Maori culture is valued and protected… A strong cultural identity can contribute to people’s overall wellbeing (Ministry of Social Development 2009, p.1–2).

This statement represents a departure from the assimilationist goals of previous decades. The ministry is acknowledging the assertion of *Kaupapa Maori* researchers that a strong *cultural* identity, as well as national identity, is vital for people’s sense of self, and influences how they relate to others in their family and community, and that this, in turn, informs their
perception of their own state of well-being. Over many decades, this argument has been successful to the extent New Zealand medical research institutes and government departments have adopted the concept of oranga, or well-being, as integral to Maori achieving improved health outcomes.

The role of whanau (family)

As discussed earlier, it is impossible to discuss Cultural Safety, health and well-being, or indeed any issue of significance regarding Maoridom, without an understanding of whanau. It is now so embedded in medical, social and cultural literature from New Zealand that it is no longer translated. For the Western reader it is important to appreciate that the ‘immediate’ family in a Polynesian sense is commonly twenty to fifty people, and the hapu, or extended family, also referred to as whanau, can readily encompass several hundred relations with whom there is a great deal of interaction. Durie (1994a) offers a succinct definition of whanau: ‘A whanau is a diffuse unit, based on a common whakapapa [descent from a shared ancestor] and within which certain responsibilities and obligations are maintained’ (Durie in Ministry of Health 1998, p.2). In the Australian migrant context, the term ‘whanau’ has been broadened in more recent times, to include a number of non-traditional situations where Maori, who do not directly share a blood relationship, form a cohesive group. For example, it is not unusual to hear people say ‘There will be lots of whanau there’ – meaning, lots of other Maori.

The Research Review produced by the New Zealand Ministry of Health in 1998 documented and merged the analysis and recommendations of thirty-seven other reports on Maori health, and has become a landmark in this field. The consensus of contributing authors concluded that to overcome the multiplicity of socio-economic and cultural barriers identified in relation to Maori health, a family-based approach is essential. It recommended that the whanau based approach, alongside promotion of cultural well-being and culturally sensitive services, was the most effective way to ensure participation and lasting results. Having agreed on this, the challenge remains a far from straightforward process:

Determining the criteria which accurately measure the cultural wellbeing of whanau is fraught with difficulty. Such criteria will be dependent on the diverse realities of individuals within whanau and whanau as a collective, and will inevitably involve both objective and subjective measures (Ministry of Health 1998, p.35).
Difficult as it may be, there is considerable evidence that without whanau involvement, the prospects for individual health improvement are diminished. As described by Durie (1997), the principles of Whare Tapa Wha (a metaphor for the four cornerstones of a house), when applied to whanau policy, reflect both the health of the individual and also the family. These four elements recognise the mental well–being of the family (as well as individuals within it), physical aspects of health (also symptoms of ill health), the effect of the physical environment of the family, and spiritual nourishment. Durie (1997; 1994a; b) maintains that the world of ancient Maori was divided between the physical and spiritual world, both of which impacted on the well–being of family. Thus, argues Durie, protecting the family from spiritual neglect, or contravening of spirit laws (tapu), should be recognised and form part of public health strategies. According to Durie, the collectivity of the whanau lifestyle was a successful form of social organisation that acted to ensure personal and communal well–being: ‘A public health system evolved which was based on a set of values that reflected the close and intimate relationship between people and the natural environment’ (Durie 1997, p.5).

The role of whanau as being infinitely more important than the individuals who comprise it, is a central tenet of the Polynesian psyche that cannot be overstated, and is fundamental to Kaupapa Maori understandings. The traditional functions of whanau have been acknowledged in New Zealand, and as defined in the Ministry of Health report cited above (1998, p.3) include:

- manaakitanga – the roles of protection and nurturing
- tohatohatia – the capacity of the whanau to share resources
- pupuri taonga – the role of guardianship in relation to whanau physical and human resources and knowledge
- whakamana – the ability of the whanau to enable members
- whakatakato tikanga – the ability of whanau to plan for future necessities

In agreement with Durie’s work, a New Zealand Public Health Commission report (1995) suggested that the most effective strategies for changing whanau health practices and behaviours are also in the best interests of Maori development aspirations: ‘Maori development is synonymous with whanau development’ (Public Health Commission 1995, p.35). This acknowledgement of the role of family has been incorporated into the New Zealand model of Cultural Safety in nursing practice since the late 1990s. However, in this twenty year period, other areas of social policy have been subject to a movement away from culturally distinct and targeted interventions that arguably have thwarted broader attempts at whanau based Maori development (Durie 2003).

The long term nature of chronic illness, or sickness, defies the biomedical strategy of simply treating the presenting ailment. The strict biomedical framework for understanding disease causality
and treatment is no longer satisfactory to reflect the subjective experience of ill–health in marginalised, low socio–economic groups, or a non–Anglo migrant population. The more reflexive biopsychosocial model is an attempt to redress many of the issues surrounding overt disadvantage, and encompasses ideas of multiple causalities, and the confluence of stress factors. However, while this model acknowledges the ‘person in environment’ and other social influences, it has also received criticism for being Anglo–centric and essentially middle class in its goals and outlook.

As with many other Indigenous peoples, for Polynesians a concept of well–being is not generated in isolation from other family and community members. Without an understanding of the inter–twined consociality of Polynesians it is difficult to apply individually based Western medical solutions to health issues such as obesity.

Contested aetiologies of obesity and related illness

The health of Maori and Pacific Islanders in Australia is tightly bound up with obesity and its role as a co–morbidity factor in the leading diseases afflicting Polynesians. An understanding of the empirical data, allows an appreciation of the urgency and severity of the situation confronting Polynesian communities and those responsible for their care. Central to this discussion are Western notions of obesity, its causes and its impacts. In the Western health context, being overweight is in itself a medical problem: ‘Obesity is a biomedical disease state resulting from a judgement that there is an excess of adipose tissue in the body’ (Cassidy 1991, p191). The state of being overweight, or obese, is commonly assessed by using the body mass index (BMI)\(^7\). The debate about whether there should be another less Euro–centric BMI for Polynesians has already been discussed, however, as the BMI index is the standard measurement for weight used by health professionals in Western countries, it is these results which are reported here. It is evident, however,

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\(^7\) The BMI is derived by dividing an individual’s weight in kilograms (kg) divided by his or her height in metres squared. (WHO 1995)

<table>
<thead>
<tr>
<th>BMI</th>
<th>Definition</th>
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<tr>
<td>&lt;18.5</td>
<td>Underweight</td>
</tr>
<tr>
<td>18.5–24.99</td>
<td>Normal range</td>
</tr>
<tr>
<td>25–29.99</td>
<td>Grade I overweight</td>
</tr>
<tr>
<td>30–34.99</td>
<td>Grade IIa overweight</td>
</tr>
<tr>
<td>35–39.99</td>
<td>Grade IIb overweight</td>
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<tr>
<td>40+</td>
<td>Grade III overweight</td>
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( WHO 1995)  
Formerly a BMI over 25kg/m2 is defined as overweight, and a BMI of over 30kg/m2 constitutes obesity (WHO 1995).
from these statistics that even if baseline allowances were to be made for a larger Polynesian build, the degree of obesity in these communities would still be problematic.

While obesity does have a medical, and arguably, a psychological dimension, it is the sociological exploration into the multi-faceted factors behind this escalating phenomenon which are of significance here. The social aetiology of obesity is explored through a discussion of three main areas of debate: the genetic explanation of obesity and associated illness (primarily diabetes), the post-colonial legacy of radical shifts in lifestyle, and the discussion encompassing the dimension of class and socio-economic disadvantage in being able to implement health policy recommendations.

**Genes and obesity: Is there a genetic explanation for the high rate of obesity in Polynesians?**

Pacific Islanders repeatedly appear in the highest percentiles of international studies regarding obesity and diabetes (see American Diabetes Association 2005; WHO 2003). Consequently, the physical make-up of Polynesians is under scrutiny. The evidence suggests that obesity, a compromised health status due to being excessively overweight, results from a tapestry of issues and circumstances which coalesce around social and economic disadvantage, cultural impoverishment and possible genetic propensity. It is important to address the persistent debate surrounding the genetics of Polynesians. The ‘genetic argument’ suggests that Polynesians are host to two genetic markers relevant to this thesis: firstly the ‘obesity’ or ‘thrifty’ gene, and secondly, a genetic predisposition to diabetes. This section briefly outlines the issues surrounding this debate in which the Polynesian genetic profile has a central role.

The impressive sea-faring feats of ancient Polynesians who traversed the Pacific over a thousand years ago, form the background to the ‘obesity/thrifty’ gene theory. Oppenheimer (2003) and Diamond (1997) suggest that Polynesians must have the ‘thrifty’ gene, in order to have accomplished these long voyages while confined to meagre rations. The premise of the ‘thrifty’ or ‘obesity’ gene, as posited originally by Neel (1962; 1982), is that peoples who could sustain long periods of time without food were utilising an underlying gene that enabled them to eat large amounts, and then effectively ‘live off their fat’ until more food could be found. In this view, modern obesity is a result of the gene lying dormant and being reactivated in a manner that contributes to ill health.

This theory is contested by Dr Tom Davis, US Surgeon General for the NASA space programme, historian and long distance sailor – and himself a Cook Islander – who argues against this premise,
based on Pacific Islanders’ oral traditions and archaeological reconstructions (Davis 1992; Bellwood 1987). These demonstrate that voyaging canoes were large double hulled vessels with the capacity to carry large amounts of taro (yam), coconuts and even live animals on board. This was supplemented by fishing and the netting of birds. Davis argues that Polynesians ate very well during long voyages. Bellwood (1987) also points out that the physically demanding nature of these trans-ocean excursions required both endurance for long distance rowing, and skilful manipulation of rigged sails. It was therefore necessary that the crew should be agile and in good physical condition. Despite such ethnographic input, and persistent critiques of the ‘thrifty’ gene hypothesis itself, this view has been widely circulated in both scientific and popular culture domains.

A major concern with the ‘thrifty/obesity’ gene hypothesis is the time frame in which this gene is assumed to manifest or adapt. For example, early European accounts of contact with Polynesians detail a physicality which is healthy and sound, and even described in admiring terms (Collingridge 2008). Health statistics from fifty years ago also do not suggest a problem with obesity, yet it is suggested that the genetics of Polynesians are responsible for widespread obesity in this population. Wendorf and Goldfine (1991) argue that the ideas behind the ‘thrifty gene’ should not be described as an hypothesis at all. They point out, that the argument has no scientific basis, and despite forty years of research, the ‘thrifty gene’ is unlikely to be found. These authors are also concerned that the concept retains credence in health circles, and are critical of the waste of resources looking for a genetic ‘holy grail’ for obesity that is founded on a faulty, positivist paradigm. Further, Scheper-Hughes (2006) suggests that the ‘thrifty’ gene hypothesis is not only unproved, it serves to re-direct the attention of health workers and policy makers from other socio-economic and cultural triggers of obesity. What this suggests is that more complex interactive factors contributing to obesity in certain populations remain unaddressed, while significant research money is allocated to pursuing the genetic explanation.

Other researchers in the debate surrounding genetics, ethnicity and health agree that genetics alone cannot explain the current phenomenon of obesity trends in Polynesians (Foliaki and Pearce 2003; Pearce et al. 2004). The latter authors observe that approximately eighty five percent of genetic variation occurs randomly, and is not determined by race or ethnicity. Therefore, the specific and limited time-frame in which Maori and Pacific Island obesity rates have soared, indicates other social and environmental factors must play a significant part. The known factors that do contribute to obesity, such as a high fat diet and sedentary lifestyle practices, are clearly not as attractive as explanations. Long term support and interventions for chronic ‘lifestyle’ conditions are expensive
and, by definition, time consuming rendering them unpopular in political terms (Duckett 2008; Crawford 1980). The political preference for ‘blaming the victim’ via genetically ascribed predispositions and poor lifestyle choices, allows macro policies for complex conditions to be ignored, and prevents tackling the issue in an integrated way (Goulding et al. 2007). At most, genetic makeup may be a determinant of an individual’s propensity to gain weight, if consuming a high–fat diet, and be a predictor of where it is distributed on the body. However, as summarised by the World Health Organisation, it is the combination and nature of food (calorie) intake, quality of food consumed and physical energy outlaid, assessed in conjunction with other socio–economic indicators which will determine resultant patterns of weight gain and health status: ‘Thus societal changes and worldwide nutrition transition are driving the obesity epidemic’ (WHO 2003, p.3). In other words, this gene, even if isolated, would indicate a Polynesian predisposition for weight gain rather than be a sufficient cause in itself.

**Genetic attempts to explain the disease burden of diabetes**

As repeatedly demonstrated, the statistics concerning obesity and diabetes rates run parallel – when obesity rates soar, so does the accompanying incidence of type 2 diabetes (WHO 2003). The link between obesity and type 2 diabetes is so marked, that the term ‘diabesity’ is now being frequently used to better describe this association (Zimmet 2005). Diabetes rates are rising in both developed and developing nations worldwide. There are epidemiological studies including that of King, Aubert and Herman (1998) that have predicted a global increase of 170% in preventable type 2 diabetes by 2025. The social geography of these trends is that the greatest concentrations are in working class, non–Anglo migrant and marginalised post–colonial communities, with Polynesians heavily represented in this pattern (McCarty and Zimmet 2001). Diabetes afflicts one in four adults and accounts for twenty percent of all Maori deaths compared with only four percent of the general population (Maori Health 2010). As these figures continue to rise at a rate faster for Maori and Pacific peoples than for Europeans, this further contributes to the health inequality between these ethnic groups.

As indigenous and migrant peoples lead the rates for increased incidence of type 2 diabetes, notions of genetic susceptibility in these populations have been used to explain their disproportionate presentation with the illness. Such genetic reductionism is premised on the idea that as there are such great numbers of people from certain ethnic groups presenting with diabetes, *ergo*, there must be a genetic cause. While there is evidence to suggest Polynesians may have a tendency towards poor insulin absorption and possible glucose intolerance (see Silink 2006; Sundborn et al. 2002),
other researchers have argued that these conditions may not necessarily be genetic. Rather, the corresponding increase in obesity in these same populations would indicate that the pre–conditions for diabetes and associated conditions may well be triggered and exacerbated by obesity rather than genetic causes (Montoya 2007; Foliaki and Pearce 2003). Support for this position can be seen in the statistics of Native American and Alaskan populations, where type 2 diabetes was virtually non–existent fifty to sixty years ago. Prevalence increased 106% in the fifteen to nineteen year old populations in the ten years from 1990–2000 (American Diabetes Association 2005). Given that genetic changes are immeasurably slow, often occurring over thousands of years, these and similar figures from other Indigenous and colonised populations would indicate that there is not a genetic profile common to these groups, but rather a comparable concentration of socio–economic disadvantage, cultural marginalisation and poor health (Rodriguez 2009; Pearce et al. 2004).

Scheper–Hughes (2006) regards the reluctance of government officials and health professionals to engage with complex underlying causes of illness in Indigenous communities as: ‘…the tendency to ‘normalize’ suffering, disease, and premature death among certain excluded or marginalized classes and populations’ (p.xviii). According to Scheper–Hughes, as with the ‘thrifty/obesity’ gene argument, the dominance of the ‘faulty genes’ explanation for otherwise preventable illnesses, serves to justify political complacency, and medical failure in regard to such communities:

To date, the prevailing medical model of diabetes etiology focuses on the ‘faulty genes’ of Indigenous Peoples combined with their faulty diets and other unhealthy behaviors. [These are] victim–blaming hypotheses that only serve to trap the sick person inside a cage of disease that is seemingly of their own making (p.xviii).

Scheper–Hughes is also concerned that the idea of genetic susceptibility to obesity and type 2 diabetes, is responsible for an insidious distrust of their own bodies for Indigenous peoples facing disproportionate rates of obesity–related illness. This, in turn, translates into feelings of inevitability and hopelessness implied by not being able to ‘outrun’ one’s genetic makeup:

The notion of the ‘thrifty gene’ [and the way it has been interpreted by health workers] suggests that “Indigenous blood” carries a taint—the threat of passing on an inherited risk of diabetes for which the only solution, paradoxically, is the dilution of Indigenous blood through racial intermarriage, another form of invisible genocide. Thus, bad genetics combines with bad anthropology to produce a theory that puts Indigenous People in their place – that is, on the margins as bio–evolutionary holdovers (Scheper–Hughes 2006, p.xviii).
The adoption of genetic explanations for obesity and type 2 diabetes has constructed certain ‘high-risk’ Indigenous populations that are identified repeatedly in international studies. Public health initiatives that single out certain ethnic groups may serve to increase anxiety in these groups. For example, a warning given by the American Diabetes Association, in relation to the need for testing for diabetes, is quite clear:

Diabetes is more common in African Americans, Latinos, Native Americans, Asian Americans and Pacific Islanders. If you are a member of one of these ethnic groups, you need to pay special attention to this test (ADA 2005).

Such well–intentioned focus on specific ethnic groups may, in fact, be contributing to a certain ‘fatalism’ experienced within these groups, as outlined in the Introduction to this thesis, and borne out in the qualitative data. Accordingly, the perception by indigenous people themselves, that they are ‘destined’ to experience certain illnesses, can lead to a distortion of what behaviours actually influence the likelihood of risk. Therefore, the resigned attitude of certain population groups to their ‘fate’, and unwillingness to engage with the medical system, may mean fewer people are being tested rather than more (Tomlin et al. 2006).

**Post–colonial and socio–cultural explanations of obesity**

As discussed, the genetic argument falls short of being able to explain the rapid rise in obesity and related illness globally. It fails to take into account health implications of post–colonial marginalisation, socio–economic disadvantage, or the impact of globalisation on food intake and lifestyle habits. As Polynesians are affected by each of these phenomena, it is necessary briefly to examine the literature surrounding the incidence and interaction of these factors.

Professor Mason Durie directly attributes obesity rates amongst Maori to the post–colonial condition. Durie (2003; 2001;1997) identifies several waves of disjuncture in dietary and lifestyle habits that follow the colonial patterns of many dispossessed Indigenous people. He points out that now infectious diseases are under control, ‘lifestyle’ illnesses are the biggest killers of Polynesians, and argues that the post–colonial experience underpins the dramatic rise in illness and mortality. This was illustrated by a study of 700 Maori households conducted by Massey University (*Te Hoe Nuku Roa* 1999 in Durie 2003), which confirmed that access to customary sources of food was severely limited, and there was almost exclusive reliance on foods purchased from supermarkets.
and fast-food outlets. The report further implicated deculturalisation and poverty as major contributors to the decline in Maori health over the second half of the twentieth century.

Comparative data on escalating obesity rates confirms concentrations of obesity in marginalised groups, including the Anglo working class in developed countries. The convergence of figures around obesity and co-morbidity between minority populations and the working class poor, suggest that socio-economic positioning is a major factor, not only for the likelihood of becoming obese, but also in predicting the complications of the condition, including significantly higher morbidity for diseases which are not, in other socio-economic groups, fatal. This conclusion has been summed up by American researchers, Drewnowski and Specter (2004 p.6): There is no question that the rates of obesity and Type 2 Diabetes …follow a socioeconomic gradient, such that the burden of disease falls disproportionally on people with limited resources, racial–ethnic minorities, and the poor.

In the Australian context, thirty percent of the Australian population have no wealth – only debt (Marks, Headdey and Wooden 2005). Many who fall into this sector, will suffer the predictable ill health associated with their economic status. In common with the bottom third of Australians experiencing health problems from preventable illnesses, such as diabetes and cardiovascular disease, Polynesians are highly represented (ECCQ 2009).

**Health promotion to alleviate obesity: A middle class discourse?**

In the Western health paradigm, obesity is regarded as a personal problem; the result of an inability to control oneself. This is combined with an emphasis on ‘healthism’, the nexus of food and lifestyle, whereby the individual is expected to take responsibility for their own health status (Crawford 1980; Petersen and Lupton 1997). Disease prevention and health promotion are both heavily marketed to the general public, resulting in a myriad of fields of expertise available to help the individual achieve an improvement in their health: from personal trainers, nutritionists and complementary therapists to diet consultants. This emphasis on individual responsibility for health has been accompanied by an escalation of language exhorting these services, such as ‘Lose weight today’, or ‘Get healthy now!’. Policy around public health often couches this position in the rhetoric of ‘giving back control’. However, as outlined in the Foucauldian discourse on personal surveillance, and as Petersen and Lupton have also commented, the individual is expected to absorb this information, take it on board and incorporate it into their lives, or risk being labelled as recalcitrant.
The idea that the individual is responsible for their own health, has now been extrapolated out to include ‘sick communities’ (Sutton 2005). Health practitioners and promoters of public health policy are influenced by the statistical findings of epidemiology (van Driel et al. 2009). By all available measures, Polynesians collectively are ‘at risk’. Within this paradigm, the Polynesian community is seen to have a serious problem with obesity, and is now expected to acknowledge the problem and seek professional help to change this. This new model for ‘community development of health strategies’ has built–in assumptions of shared understandings and priorities (Foster and Fleming 2008b). Health practitioners and policy makers, pursuing the ‘information deficit’ discourse, perceive the issue in terms of ‘getting the message across’. Implicit in this notion, is the expectation that communities should change their intrinsic behaviours in relation to what others have deemed problematic (Bedford et al. 2009).

The general public has been exposed to the same health messages, yet the most ‘at risk’ groups, including working class Australians, do not appear to be responding in a way that will significantly reduce that risk. Thirty years ago, Crawford (1980) argued that there was an issue of conflicting understandings and priorities circulating around class, in relation to resistance to ‘one size fits all’ health directives: ‘The current preoccupation with personal health, displays a distinctive – although not exclusive – middle–class stamp’(p.366). The on–going disparities in health statistics would suggest the question should perhaps change from ‘Do people have access to this information?’ to ‘Does it have relevance to the cohort to whom it is addressed?’

Higginbotham and colleagues (2010) and Pont (1997) discuss heart health promotions in a mining communities in the Hunter region of New South Wales. These authors have explored the reasons behind such communities’ reluctance to engage with widely publicised health initiatives. Pont found that common suggestions, such as highlighting healthy foods in local supermarkets, offering cooking classes and nutrition programmes at a local level and appointing canteen ‘managers’, assumed that people simply needed access to this type of information and education and their health problems, as a community, would be solved. Instead, Pont concluded these strategies were met by a form of class and cultural resistance. Many of the practices deemed ‘unhealthy’, for example, drinking alcohol every day after work and the heavy consumption of red meat, were deeply important to the community and the result of many generations of preference and custom. The majority of Polynesians are also working class, and may share this view. Consequently, what health professionals see as problematic may be the very things that bring families and community together.
Pont offers a further critique of the use of ‘community’ in this context (health promotion) as naive. She maintains the term ‘community’ infers there will be a smooth, cohesive response to targeted campaigns. In her study, such campaigns generated fragmented and limited results. Pont regards this, not as a failure of the ‘community’ to meet the task, but a ‘failure of the term community to accurately describe the relationships between the people who live in a ‘community’ (Pont 1997, p.103). This is also an issue within and between Polynesian families, as well as in the broader community. Individual family members may be convinced of the worth of the public health message and attempt lifestyle change, but this can be perceived as useless, selfish or even a betrayal of culture. These are the complications and contradictions explored in the data chapters of this thesis.

**Maori and Pacific Islander health and lifestyle**

In general terms, what is meant by ‘lifestyle’ issues in relation to obesity and associated illness, can be summed up by a combination of factors which Raymer (2006) refers to as the ‘sedan and screen’ lifestyle. A report from the American Institute of Medicine (Thomas 1995) highlighted the view that it is these behaviours that underlie the global obesity crisis, rather than genetic predisposition:

> There has been no real change in the gene pool during this period of increasing obesity. The root problem, therefore must lie in the powerful social and cultural forces that promote an energy–rich diet and a sedentary lifestyle (Thomas 1995, p.152).

As Polynesians progressively adopt a Western lifestyle, they exhibit the signs and symptoms of the negative impacts of this way of living. One of the ways that the experience of colonisation of Maori in New Zealand differed from that of Pacific Islanders is that Islanders have been exposed to an industrial and post–industrial lifestyle for a much shorter period of time. Anecdotal evidence from Islanders who live in New Zealand and Australia and visit the home islands, has suggested a marked decline in traditional food practices and a corresponding increase in the consumption of commercially produced food, particularly in the last decade. This has been borne out in research that analyses rates of imported foods to the Islands by Evans et al. (2003) and Errington and Gewertz (2008) amongst others. There has also been an increase in the number of vehicles on each of the main islands, resulting in Islanders driving to places where they would customarily walk. This means the gap between Pacific Islanders living ‘traditionally’, who previously had lower rates of cardiovascular disease and diabetes than those in urban environments, is now narrowing. In
relation to diabetes, the work of Foliaki and Pearce (2003) confirms that not only is this the case, but also that the rates of co–morbidity are almost in line with urban Polynesian rates, and also higher than for their Anglo counterparts:

Epidemiological evidence indicates that prevalence is generally lowest in traditional Pacific environments, and is higher in both urban Pacific and adopted metropolitan environments; in the latter environments, prevalence is markedly higher in Pacific people than in white people. Prevalence has been increasing rapidly in all three environments, and Pacific people experience greater morbidity and more complications than white people with diabetes (Foliaki and Pearce 2003, p.437).

This, and similar studies, provide evidence that lifestyle is a key component in a person’s overall health and potential for wellness. It also demonstrates that a significant decline in individual and communal health can manifest over a comparatively short time frame. Conversely, the work of Knowler et al.(2002) demonstrated that even small lifestyle interventions can make a difference. In their study, relatively modest weight loss and increased aerobic activity acted to prevent or forestall the onset of type 2 diabetes. Again, this would point away from a genetic determinant and illustrate that these conditions can be managed better in the future, providing culturally specific and well–targeted strategies, inclusive of community, are formulated.

Globalisation, nutrition transitions and the impact on health

The rising [obesity] epidemic reflects the profound changes in society and in behavioural patterns of communities over recent decades….Economic growth, modernization, urbanization and globalization of food markets are just some of the forces thought to underlie the epidemic (WHO 2003).

Globalisation has had a profound effect on the patterns of working life. Despite exhortations to ‘work smarter not harder’, most people, are working longer hours in an increasingly insecure working environment (Ovortrup 2008; Giddens 2004). The nature of work has also changed, with workers increasingly undertaking ‘white collar’ or service sector jobs requiring them to sit for extended periods of time (Dalton 2004). Dalton also points out that with increasingly flexible working hours, individuals are eating at different times, alone, and in a hurry, thereby making them more likely to consume fast–food with little opportunity to work off the extra calories they consume.

Ovortrup (2008) takes this further and argues that labour market deregulation goes hand in hand with obesity. It is not simply that working longer hours leads to less time for exercise, greater
exhaustion, and more dependence on convenience foods. Also diminished job security in the form of short term working contracts, in turn, leads to a depressed state of well–being which in itself is associated with weight gain. Ovortrup argues that this is exacerbated for workers in low paid jobs who are more likely to consume fast food, thus contributing to higher levels of obesity. In Ovortrup’s view, it should not be surprising that the countries at the forefront of globalisation (especially labour market deregulation), are also the countries with the highest rates of obesity. This is mirrored in the statistics of less globalised economies, which report significantly lower levels of obesity. Ovortrup also observes that with more time spent in the workplace, there is less leisure time which may previously have been allocated to sport and socially directed recreational activities – factors that should be encouraged to avoid excessive weight gain.

Food marketing trends and demands are also part of globalisation. Mega–corporations are prepared to invest enormous sums of money to encourage consumption of their products. In one year alone, McDonalds spent in excess of one billion US–dollars on advertising targeting children (Brownell and Horgen 2003, p.60). Despite the profound effects of globalisation, not all countries have responded in the same way by bowing to market forces. For example, the Netherlands has chosen to restrict the exposure of ‘junk food’ advertising through public broadcasters during programmes aimed at children under twelve. Similar restrictions have been introduced in Sweden and Norway (Ovortrup 2008). Australia, however, has still refused to enter into negotiations with broadcasters and advertisers and maintains it is exclusively a parental issue. Obviously, Polynesians are not immune to the inundation of commercial food advertisements, and Zimmet (2005; 2000) refers to this process of relentless exposure and uptake of poor quality food and drinks as ‘coca–colonisation’. His concern is that the already compromised diet of Polynesian families, in terms of consumption of large quantities of poor quality foods, is made worse by the extremely high up–take of damaging snacks foods and drinks.

**Gastro–politics in the South Pacific: The tale of the mutton flaps**

Frederick Errington and Deborah Gewertz have traced the gastro–political landscape of Pacific Island countries since the 1980s, and drawn attention to their asymmetrical relationship with the larger powers of the region, Australia and New Zealand. In Errington and Gewertz (2008), they identify three intersecting components which are described as follows: gastro–geographies (who eats what and where), gastro–politics (who has access to which foods, where they come from, and what are the health implications), and gastro–identities (by eating a certain substance, how does this change one’s relationship to others). In the following section I will be concentrating of the first two
of these, while ‘gastro-identities’ will inform later discussions on food practices. Also examined here are the contradictions between recommendations to the governments of Australia and New Zealand regarding the health of Pacific Islanders, and the demands by those who benefit from exporting unhealthy foodstuffs to these countries.

A salient example of neo-colonial outsourcing of unwanted foodstuffs is the practice of marketing mutton flaps (sheep bellies) to cash-poor Pacific Islanders. The adverse health implications of the high consumption of mutton flaps in the Pacific are unambiguous because of their excessive fat content (see Swinburn 2004; Evans et al. 2003). This has led to them being banned in Fiji, attempts at regulation in Tonga, and a ‘sin tax’ has been imposed in Samoa and Niue. Still, Australia and New Zealand continue to export this product to these countries.

Flaps, or ‘sipi’ as they are commonly referred to by Pacific Islanders, are constituted from off-cuts of bone and fatty flesh from superior cuts of chops. Considered a by-product in developed countries, they have become a staple in the Pacific. Unlike pork bellies that can be turned into bacon, mutton flaps do not have an equivalent as they consist of over fifty percent fat. They have even been rejected by fast food producers as consumers do not like the fatty after taste. Consequently, flaps are cheap because they are so unappetising, and have been embraced as an inexpensive and plentiful meat source in Pacific. From an anthropological perspective, Gewertz and Errington (2007) have noted that the consumption of meat (even poor cuts) is regarded as being modern and having a ‘good’ life, exemplified by a plentiful supply of meat, compared with previous generations where meat was reserved for special occasions. In Tonga, where sixty percent of the population is already obese and almost a third of all deaths are due to cardiovascular disease, households now spend more on mutton flaps than any other food, ahead of chicken pieces, white bread and corned beef (Cumming 2010). For a population of just over 100,000 people, three million kilograms of flaps are exported to Tonga annually (Errington and Gewertz 2008).

Epidemiologist, Rod Jackson (in Cumming 2010) refers to this as ‘dietary genocide’. He and other medical researchers hold the exporters, Australia and New Zealand, responsible:

Australia and New Zealand have made a big song and dance over the years about French nuclear testing [but] mutton flaps have caused more deaths in the Pacific than 30 years of nuclear tests (Scragg in Cumming 2010).
The continued exportation of mutton flaps by Australia and New Zealand to their ‘protectorates’ (PNG, Fiji, Tonga, Samoa, Niue, Cook Islands) is revealing in terms of their geo–political and post–colonial relationship with the region. It reflects a major disconnection between the well–documented health concerns, and the economic preservation of trade profits, most especially, the political influence of the large meat exporters in these countries. Government commissioned reports, such as Clarke and McKenzie (2007) and Swinburn (2004) advocate a series of legislative interventions to prevent and decrease obesity in Pacific Island countries, nominating measures including the banning of flaps to these countries. On the other hand, vested interests in the meat industry and trade commissions continue to act to dissuade both the Australian and New Zealand governments from supporting bans on the export of flaps. This dynamic is summed up by public health advocate Wilson:

The people who carry political sway are the people who are getting economic benefit from selling mutton flaps, not the people that are having to pay for renal dialysis. I think they need to build some public health into their trade policies (Wilson in Cumming 2010).

Medical researchers and health workers are concerned that Pacific Islanders should not be left alone to address the demonstrated health consequences of such a damaging imported product, and that there should be leadership from the more powerful nations involved, even if this requires a ‘nanny state’ solution. There has been some support for this position with Samoa and Niue introducing a ‘sin tax’ on the purchase of flaps. However, this situation means the product is still available, and desired, but costs more.

From an anthropological viewpoint, Errington and Gewertz (2008) argue that the regional flow of lamb or mutton flaps encompasses the circuitous power dynamics of post–colonialism. Pacific peoples, desirous of becoming ‘modern’ and regarding themselves as part of the new globalised world, have embraced the consumption of flaps to the extent that they have now become part of the gift–exchange economy. These authors point out that the banning of flaps altogether may cause yet another disruption of reciprocal food sharing arrangements in these communities, as another affordable meat product of comparable social value would need to be found. The evidence is overwhelming though; flaps have a singular place in contributing to ill–health in the Pacific, and consequently, have come to have an exceptional role in the public health debate. Accordingly, flaps have different meanings:
Flaps are an export item from a country which produces them but will not consume them, [to] those who do consume them and what they mean, and [to] those who are refused access to them with the new banning of this food. Many health workers in the Pacific link the trade in flaps to the creation of an unhealthy Pacific body (Errington and Gewertz 2008, p.3).

In relation to Maori and Pacific Islander health, obesity remains the core issue. The obesity–related statistics are strong predictors of a growing health crisis amongst Polynesians whether in an urban or ‘traditional’ island setting. It is evident that the coalescence of post–colonial/neo–colonial marginalisation and current socio–economic issues described here, contribute to Polynesians being in the highest risk percentiles for obesity–related illness in the world.

Co–morbidity factors play a disproportionately large role in the statistics surrounding Maori and Pacific Islander’s overall health and mortality, and it is in the area of co–morbidity associated with obesity, that socio–economic disadvantage plays out: poor food choices, low health literacy, quality of treatment received, and rates of obesity that are, in fact, moving away from the recommended targets and are increasing. The prevailing Western notion of ‘blaming the victim’ for their obesity, operates by assuming that the individual ‘chooses’ to eat too much and declines adequate exercise. This has led to the development of public health messages, which on the face of it, appear reasonable: buy good–quality foods, consume them in reasonable quantities, calculate their caloric value, and exercise in proportion to energy consumed, but, this is essentially a middle class position. It does not take into account the socio–economic requirements of having to feed a large family cheaply, poor awareness of labelling ‘double speak’, nor does it address the cultural practices involved with the consumption and exchange of foods in Polynesian societies.

Perspectives on the self and the body

When considering the issue of obesity, Polynesian and Western views of what constitutes an obese (problematic) body, differ considerably in a range of ways. This discussion will also encompass how notions of selfhood are construed and interpreted in relation to the body. To examine one without the other has been deemed insufficient to understanding the complex interactions of mind, body and society (Charmaz and Paterniti 1999; Lupton 1996). Notions of the ‘self’, and accompanying perceptions of the body, are conceived within social and cultural paradigms that are in turn influenced by current societal values, historical experience, relationships of power and socio–economic positioning. For Polynesians, these social and cultural referents are contextualised to reflect a cultural, political and spiritual experience of ‘selfhood’ that is markedly different from
the Western model of the individual. In this section I will explore how Polynesian perceptions of ‘self’ and the body are divergent from prevailing Western notions of individuation.

How the individual body participates in social processes requires an interdisciplinary understanding. For example, anthropologists have been able to record and analyse social and cultural variations in the perception of bodies, and bodiliness, that are different to Western experiences. However, for the colonised and marginalised, the Indigenous people living in a Western society, their bodies are undergoing processes of enculturation, mediations and rapid transitions that require broader cross-cultural sociological understandings. Such understandings are central to this thesis. This section, therefore, will also examine the on-going impact of missionisation of Pacific Islanders and the resultant moral discourse surrounding the body. As required within the paradigm of Kaupapa Maori, this discussion encompasses issues of power (both post-colonial and neo-colonial) in relation to the social construction of the Polynesian body. This will focus on attitudes towards obesity in the extended Polynesian community that are considered problematic by Western health professionals. To accord appropriate awareness and respect to this central issue, I will explore understandings of how Polynesians regard the large and overweight body in cultural terms, in order to distinguish genuine health concerns from Western anxieties around the body generally, and the obese body in particular.

The relational or consocial self

According to Geertz (1984) the Western concept of each person being a single, encapsulated entity who marks and shapes their own destiny is not an understanding that is shared across all cultures. The idea that a ‘person’ is a: ‘…bounded, unique … integrated, motivational and cognitive universe … is a rather peculiar idea within the context of the world’s cultures’ (Geertz, 1984, p.126). Many Western theorists assume that the ‘self’ emerges from the act of locating, defining and differentiating oneself from others, as summarised by Charmaz and Paterniti (1999). However, as is well established, with Polynesians the opposite is true: Polynesians see the ‘self’ as where one intersects with others (Lock 2000; Strathern 1999; 1998; Lieber 1990). Lieber describes the Polynesian sense of self and identity as ‘consocial’, sharing a collective identity with others of the same kinship group. He succinctly explains the Polynesian constructs around identity and personhood: ‘The person is not an individual in the Western sense of the term … [they are] a locus of shared biographies: personal histories of people’s relationships with other people and with things’ (Lieber 1990, p.71).
Intrinsic to the way in which Polynesians socialities are maintained is that the family, clan, and tribe hold the identity, and the individual is located within this larger whole – a small part in a larger genealogical continuum (Lieber 1990; Pringle and Whitinui 2009). In other words, the individual is neither the centrepoint nor starting point of their own identity formation, but part of their family’s continuing story. This consocial identity and associated interpretations of ‘selfhood’ have been examined from a psychological perspective by Andrew Lock (2000). Lock maintains that cultural differences make it impossible to apply Western psychological ontologies to all people. Having a distinctive consocial identity sits outside of, and defies, Western interpretation. Lock argues, therefore, that we do not all share a common cross cultural psychological profile, as Maori and Pakeha have a fundamentally different perception of ‘self’:

Personhood’ in the two cultures cannot properly be equated. Superficially we might locate similarities, for example, in the conception of the mind–body relation, between the tinana and wairua. But these latter words are embedded in a complex web of cultural practices, and the direct translation of tinana as body, and wairua as mind, cannot be substantiated. The ‘map of the self’ is different in each culture, and each culture could be said to require its own separate ‘psychological science’ (Lock 2000, p.5).

Anne Becker (1995b) also makes a distinction between the dominant Anglo European models of selfhood, and the more mutable and relational concepts of Pacific peoples. She describes the Western concept of self as individuated, and abstracted from social relationships. This self is located within a paradigm of cultural valuation which prizes independence, autonomy, and differentiation. By contrast, her research has led her to conclude that for Pacific peoples, the body and the self are inherently relational: ‘ … [the body] is not a primary vehicle for expression of personal identity or excellence. Rather, it provides a means of integrating the self into the community’ (Becker 1995b, p.128).

Strathern’s works (1999; 1988) on concepts of personhood and self, spans both Melanesian and Polynesian cultures. Strathern maintains that in the Pacific context the body, and not just the self, is made up of composite reactions of past and present engagement with others, a ‘microcosm of relations’ (Strathern 1988, p.131). Strathern uses the term ‘dividuals’ to describe Pacific understandings of the person as faceted, multiple and not completely contained within the body: the ‘self’ evolves within the social and cultural construction and does not therefore adhere to a single, self–entity. This highly relational concept of the self is important throughout this thesis in understanding what constitutes well–being for Polynesians, as it embodies notions of being together, each holding a part of the collective identity, as a pre–requisite for happiness and
belonging. In turn, happiness and belonging, along with physical health, are essential elements for overall well-being.

The body as social agent

Anthropologists have spent many decades defending the position that the body itself is in constant interaction with the social, and the physical body comes to reflect the socialised practices enacted upon it. According to Mary Douglas (1970), it is the social processes experienced by the body, thereby creating the ‘social body’, which informs the way the physical body is perceived:

The physical experience of the body, always modified by the social categories through which it is known, sustains a particular view of society. There is a continual exchange of meanings between the two kinds of bodily experience so that each reinforces the categories of the other (Douglas 1970, p.93).

Critical examination of ‘the body’ as a site of broader social and cultural understandings has been one of the growth areas of cultural theory in the last twenty years. For anthropologist Terence Turner, the rise of the body to theoretical prominence has ‘filled the vacuum’ created by more generalised assumptions around social, cultural, and political theorising of the human condition. The cultural and social practices which constitute, re-constitute and maintain our bodies are no longer regarded as simple or ‘given’. Anthropologists use the term ‘bodiliness’, which as described by Turner, ‘…is rightly recognised as a fundamental unifying category of human existence in all its senses and levels: cultural, social, psychological, and biological’ (Turner 1995, p.145).

In other areas of the social sciences, there has also been a rise in interest in what constitutes and influences our bodies and the subjective lived experience of those bodies. For instance, Ann Game’s work (1991) aimed to deconstruct and redefine sociological theory and understandings of the body from a post-structural viewpoint. This was a radical attempt to broaden explorations of the body based on her conviction that the body is the ultimate source of knowledge and truth as it is the site of direct experience and subjective consciousness that is ‘pre-rational’: ‘… the body provides the basis for a different conception of knowledge: we know with our bodies’ (Game 1991, p.92). As social theorists debated the inadequacies of biological reductionism, the challenge according to Shilling (1993) was how to reconcile these perspectives in order to analyse the body as a ‘phenomenon that is simultaneously biological and social’ (Shilling 1993, p.100).
Despite criticism and rejection of reductionist paradigms, the social sciences have taken several decades to develop a spectrum of theoretical approaches to the body. However, Bryan Turner (2008; 1996) remains concerned that the sociology of the body has been ‘submerged’ in the sociological canon. He posits that this ‘submergence’ – as opposed to complete absence – is quite possibly an unintended consequence of sociology’s ‘hidden’ history and self-selected priorities. Turner describes the ‘macro–sociological tradition’ as examining the wider power systems of social structure and society, such as relationships between social classes and political parties, the state and economics, the family and the wider social order. By contrast, ‘micro–sociology’ convenes around notions of the ‘self’ as social actor, defined by actions and interactions:

…micro–sociology excludes the body because the self as social actor is socially constituted in action, macro–sociology excludes the body because its theoretical focus is on the ‘social system’ (Turner 2008, p.35).

For some authors, this interactive process has developed into the theory of the ‘posthuman’ body (Clayton 2002; Haraway 1991). Rather than being a singularly defined individual, this term refers to someone who can become, or embody, different identities and understand the world from multiple, heterogeneous perspectives. Clayton (2002) offers an explanation of how social experience is imbricated onto the physical body. For example, social disadvantage may translate onto a body which may then manifest physical, or physiological, responses. If one cannot afford dental care, this may have a deleterious affect on other aspects of health, or the body of a manual worker may exhibit greater ‘wear and tear’ than that of an office worker. Clayton refers to this process as ‘… the metamorphic display of cultural and social experience [which] is perhaps the most accurate narrative of the social reality’ (Clayton 2002, p.845).

The body as subjective entity in the social domain

It is through the delineations of the physical body as biologically and socially prescribed (man/woman, child/adult) that social roles are defined and experienced (Turner 2008; Clayton 2002; Connell 1987). In this body of literature it is proposed that the body is essentially a social space where the self and the world intersect. Social practices, therefore, not only have a profound influence on the human body, they also largely dictate the perceptions and language used to describe and relate to one’s own, and other people’s bodies. It is within this paradigm of the body’s external boundaries in relationship to others that not only symbolises personhood, but also defines
where the limits of personhood are drawn. It is the interaction of the physical body and its social understandings that foregrounds all other social and cultural experience.

Marcel Mauss (1979; 1973; 1935) originally employed the term *habitus* to describe the influence of culture on human physicalities. The body, Mauss suggested, was 'man's first and most natural instrument' (Mauss 1979, p.97). Mauss demonstrated that daily activities such as standing, sitting, walking and running are not so basic as to be universal. Rather, these are aspects of culture that are anchored in the body or daily practices of individuals, groups, societies, and nations. Physical expressions may be different because of culturally-specific behaviours, and/or gender. Bourdieu’s use of the term ‘socially informed body’ (1977) also reflects the idea that the body is used by a person in their interaction with the ‘outside world’: the natural or unadorned human body requires a transformation that enables the cultural actor to be shaped into an acceptable social being. The schemas and practices employed by the individual in this evolving and interactive process would appear to be influenced by various social, cultural, political and moral values pertaining to the body. Influenced by Mauss, Bourdieu (1984) uses the term *habitus* to describe the acquired perceptions, interpretations of taste, and physical mannerisms associated with the socio-cultural milieu in which an individual operates. He regarded the body as being trained to inhabit a *habitus*, learning the deportments which are prescribed by class and culture that become embodied, thus shaping the body. For Bourdieu, *habitus* represents the socialised thoughts, values and behaviours which are informed by both historical forces and current experiences that are familiar to us. This is a useful way to examine how Polynesian cultural practice differs so markedly from Western behaviours. Maori and Pacific Islanders live in a consocial *habitus* within an individualistic, capitalist world. How this post-colonial juxtaposition is negotiated is discussed extensively throughout this thesis.

**The body and relations of power: The ‘colonised body’**

The drafting of the colonised ‘Native’ body into an acceptable ‘subject’ was a process that preoccupied the early colonial authorities. Not only were women’s political rights reduced under the European order (see Mikaere 1994), their freedom to dress as they pleased, have multiple sexual partners, and the physical freedom to swim, run, dance and climb was severely and systematically curtailed in the process of colonisation and accompanying missionisation (Bolin 1997; Howard and Kirkpatrick 1989). However, to the imperial mindset it was the transformation of the Polynesian male from ‘warrior’, with its associations of being unpredictable and threatening to a vulnerable settler colony, into dependable citizens that was of the utmost importance. This required an
approach that would channel the physical energies of Maori men, first by doing heavy agricultural work, and second, through sport.

To the British colonisers sport was seen as the ideal platform for transmitting character traits and nationalistic values essential for service to the Crown (Hokowhitu 2004; MacLean 1999). Rugby, in particular, provided Britain with a view of the Maori as ‘the disciplined brute’, whose aggression and savagery was best displayed in the sporting arena.

In the nineteenth century Maori masculine physicality was, like the untamed countryside, something to be conquered and ‘civilized’ in the twentieth century it was something to be harnessed to provide manual labor for New Zealand’s developing colonial nation; in the twenty–first century it has become a spectacle played out by the overachievement of tane (Maori men) on the sports field (Hokowhitu 2004, p259).

Hokowhitu observes that a colonial education system severely restricted the life choices for Maori men and continues to have repurcussions on Maori masculinity today. In what Hokowhitu describes as the ‘neo–racist’ era, the almost exclusive representation of Maori as sportsmen and manual workers serves as ‘subconscious subjugation’, forcing each generation of young men to continue ‘…reinventing the power relationship between the intelligent/civilized colonizer and the inherently physical/savage colonized’ (Hokowhitu 2004, p.274). Hokowhitu further concludes that this dynamic serves the state in that highly feted Maori sportsmen act as a salve to social conscience and their success is used to demonstrate the egalitarian nature of New Zealand society:

The successful Maori sportsman, then, acts as an exemplar of a subject in an egalitarian state who has triumphed over adversity to succeed; combine this with the common notion that sport reflects society, and the essential suggestion is that Maori men are afforded equal opportunities in all walks of life (Hokowhitu 2004, p.271).

**Puritanism and discipline: A moral imperative**

For Pacific Islanders, it was the church that was the most penetrating instrument of state control in the remote islands. In the 2006 New Zealand census, ninety–eight percent of Pacific people described themselves as Christian, almost three times the rate of non–Polynesians and significantly higher than Maori (Statistics New Zealand 2006a). Adherence to church teachings and the religiosity of lifestyle in the Pacific Islands has therefore become an important component of what defines ‘Pacificness’. To better understand this blurring of ‘cultural’ and ‘religious’ mores, Wendt (1999) explains how the Christian church and traditional culture in Samoa have entered into an interdependent relationship and, thereby, have been integrated into people’s lives and identity:
Our people took another religion from outside and put it into their system. If you took away the Christian church today from Samoa, a lot of the fa’a Samoa [Samoan culture] would collapse (Wendt, 1999, p.97).

In other words, moral behaviours and practices imposed by early Christian missionaries, have come to be regarded as the ‘Island’ way. This observation provides some insight into the high commitment to church attendance and related activities exhibited by Pacific Islanders, as compared to Maori, or the mainstream Anglo–European population in New Zealand. The infamous ‘Blue Laws’ (see Kautai 1984), refer to a code of behaviours introduced to the Islands by the missionising agents of colonialism. These laws were introduced throughout Polynesia and, depending on the commitment of local administrators, banned or restricted dancing, drumming and tattooing. These laws allowed control of every aspect of the villagers’ lives such as when marriages could take place, who could leave their village for work, and how houses should be cleaned. Fines were issued for non–compliance. Although initially resented, and even ridiculed by Islanders, many aspects of social control such as monogamous marriage and the valuing of virginity, are now regarded as ‘traditional’ practices. Missionisation would appear complete when external surveillance and state control of people’s lives becomes internalised (Hau’ofa 1999). This transition reflects a poststructuralist understanding whereby a possibly modified and contingent self (or selves) forms the basis for subjective experience. This is described by Lupton (1996) in the following terms:

… the self, or more accurately, selves, are highly changeable and contextual, albeit within certain limits imposed by the culture in which an individual lives, including power relations, social institutions and hegemonic discourses (Lupton 1996, p.13).

The ‘civilised body’

In a modern Western sense, ‘disciplining the body’ has taken on different meanings. It no longer refers to corporal punishment, but rather ‘self’ discipline’. Shilling (2003; 1993) uses the term ‘civilised body’ to refer to the ways in which the body in Western societies is highly individualised and strongly demarcated from its social and natural environments. Implicit in notions of the ‘civilised body’, are the ways in which a person demonstrates their social responsibility and discipline by exercising strict control over their own body. The literature surrounding the ‘civilised body’, such as Elias (2000) and Lupton (1996), concentrate on the extent to which ‘body management’ has become the norm in industrialised societies. ‘Body management’ requires corporeal excesses to be curtailed, and the body disciplined by exercise and physical training as
evidence of an individual’s commitment to personal control, social inclusion and success. According to Lupton, the modern construct of the ‘civilised body’ is exemplified by ‘the body that is self-contained, that is highly socially managed and conforms to dominant norms of behaviour and appearance’ (Lupton 1996, p.19). In other words slim, fit and well-groomed.

Increasingly, in Western societies, the outward appearance of the body is deemed to demonstrate and reflect the intrinsic worthiness of the person. An individual’s physical body has come to be merged with how one regards oneself, and how others regard and relate to the individual. Lupton’s work on the ‘civilised body’ and the social construction of ‘power’, suggests that this extends into an area where the body is seen as a commodity which can (and should) be changed or modified to comply with socially pre-determined aims. This discourse promotes the idea that to ensure your social value, one must solicit a wide range of information and products to achieve and maintain your new ‘optimal’ body. In Western societies this has become synonymous with thinness: ‘A slender/attractive body is interpreted as a healthy, normal body, tangible evidence of rigid self-discipline. By contrast, an obese/ugly body is understood as unhealthy and deviant, out of control, a moral failure’ (Lupton 1996, p 137).

This association, referred to by Lupton as the food/health/beauty triplex, underlies the preoccupation with bodily presentation and management. Lupton’s view is that people are encouraged to see their bodies as amenable to change and ‘improvement’, for example, to lose weight. This is accompanied by a social imperative to do so in order to avoid being deemed lazy, unhealthy or un-beautiful. In popular magazines and media it is impossible to avoid warnings, advice and predictions of ill-health and fading beauty if this advice is ignored. These are warnings against behaviours which may result in an unseemly or ‘grotesque’ body shape. The obese or ‘grotesque’ body not only attracts the labels of ‘lazy’ and ‘unhealthy’, it implies the owner of the body is undisciplined, and therefore unpredictable and less employable (Carr and Freidman 2005; Rothblum 1992). This cultural assumption implicitly suggests the owner of the ‘civilised body’ is a better, more reliable member of society. Lupton and other authors are therefore concerned that the Western pre-occupation with bodily size, shape and presentation is at the expense of more well-rounded, holistic and diverse ideas of the healthy body.
Counter–positioning: The logic of ‘fat admiration’

The value system accompanying the discourse on the ‘civilised body’ rests on Western cultural assumptions that are not shared, in general terms, by most of the developing world. What constitutes an attractive, appealing, or useful body is related to other cultural mores and desired social outcomes related to the body. As Cassidy (1991) suggests, the body’s meanings remain primarily social and these are culturally mediated: ‘Although body shape and size have biological significance, for most people the important body meanings are social. The body is a social signaling device’ (Cassidy, 1991, p.186).

As a medical anthropologist, Cassidy’s global comparisons of social values around body size revealed ‘bigness’, particularly in men, is highly valued, and that ‘those who achieve the ideal are disproportionately among the society’s most socially powerful’ (Cassidy 1991, p.181). Cassidy’s study recognised that body size has two main components: height (a fixed point), and bulk that is constituted by bone structure, muscularity and fattiness. Given that bigness is population dependent, that is ‘big’ in one population may be ordinary in another, bulk is important because ‘heaviness’ and ‘weight’ are relationally calculated. Consequently, ‘obesity’ is a moveable measure when taken out of context of the Body Mass Index (BMI). A brief discussion of the BMI is necessary here, both because it is continually referred to in the literature about obesity, and also because it is the centre of some debate when applied to Polynesians. Using the metric system, the formula for a BMI is weight in kilograms divided by height in meters squared, with allowances for children and teens in relation to gender and growth. Criticism of the BMI index as Eurocentric, has been raised by international researchers and has led several scientific teams to argue that a different BMI index should be used for Polynesians (Gonda and Katayama 2006; Craig, et al. 2003). Gonda and Katayama’s analysis of the biometrics of Tongans concluded that the physical dimensions of Polynesian muscular and skeletal structures are indeed larger, overall, than that of Europeans. The focus on Polynesian obesity and resultant health issues, has essentially failed to recognise this propensity to overall largeness, or to take into account the cultural values attributed to being large.

Lupton (1996) has also questioned the rather narrow assumptions regarding the escalation of obesity in the developing world: ‘The link between body weight and the quantity and quality of food consumption is widely taken as a given, to the extent that any other explanation for heavy body weight is rarely countenanced’ (Lupton 1996, p16.) O’Dea is also equivocal when discussing the ‘obesity epidemic’ in Australian children. She observes the statistics regarding overweight and
obese children are inflated by low income Middle Eastern and Polynesian children, whose parents do not share the cultural ideal that a slender body is a universal goal:

There has been a suggestion that what we should do is weigh and measure every child and send a note home to parents. Well, I don’t think the parents will find that particularly helpful since bigness and fatness even, is often valued in some of these ethnic groups (O’Dea 2007, p.1).

In Polynesia, the large body remains an effective representation and medium of social value. In order to understand the Polynesian celebration of ‘bigness’, it is necessary to employ what Cassidy refers to as the ‘logic of fat admiration’, whereby the large body is regarded as the visual and literal fulfilment of plenty. In ancient Polynesia, males and females of high caste were secluded, overfed and prevented from exercise to maximise weight gain (Ford and Beach 1951). The connotations are that the really big person is wealthy, powerful, even blessed: ‘It illustrates abundance, implies fertility, and represents health, strength and beauty’ (Cassidy 1991, p.191).

In the historical (pre–colonial) Polynesian context, to be big was to be an asset to your tribe, regardless of gender. For women, there are still associations between a large, wide–hipped body and prolific child–bearing. This is regarded as having positive implications for the extended family, as the larger the whanau (family), tribe (iwi) and clan (hapu), the greater share of local power and political influence is available (Irwin 1984; Levy 1973). For males, bigness in itself implied physical power and was regarded as advantageous should there be a need to fight to protect the family and tribe. This cultural preference for a large body is clearly illustrated in a collation of early records of convicts and sailors who lived with Maori during the frontier period of New Zealand’s history (Bentley 1999). These men included a ‘native of Hindustan’ who was under the protection of a tribal chief. Described as a ‘pigmy among giants’, his diminutive physicality elicited a sympathetic response from Maori who perceived him as vulnerable because of his size. Another account by George Bruce, a runaway convict, concluded similarly that Maori were kind to him because of pity for his small stature (Bentley 1999, p.21). A residual appreciation of size retains value today. Such cultural explanations for the desirability of a large body are frequently at odds with the Western trend towards slimness, and are explored more fully in the data chapters of this thesis.

How the ‘self’ is perceived and described is dependent on the complex interrelationship of the body, mind, and cultural beliefs. Like many Indigenous peoples, Polynesians have a highly relational
concept of self. This is a view of a composite self with contributing elements that originate outside of the person as an individual. These multiple constituent parts to the Pacific sense of self are formed within the existing structure of family, village/tribal and clan identities. Such relational concepts of self also extend to notions of the body. How the Polynesian body is conceived in relation to social space is quite different from the Anglo–European perception of the body as that which houses the autonomous self. This reflects the dual nature of the physical body – on the one hand, living in a body is an intimate experience, and on the other hand, it is the body that circulates and interacts with ‘outside’ social domains. It is the body that is the tool to express social processes and be recognised by others. In other words, our habitus – a sub–set of habituated, socialised practices of the body – informs how bodies are regarded and used. This is part of a broad based theoretical discussion on the intrinsic social character of the human body encompassing biological, psychological, social and cultural dimensions.

Post–colonial transitions of the Polynesian body have also been influenced by historical forces. The relationships of power between the coloniser and colonised continue to be enacted in ways that impact on the Polynesian body. Valuing Polynesian physicality in the service of empire, over and above better education and broader employment opportunities, has inevitably contributed to post–colonial economic marginalisation. Low socio–economic positioning combined with cultural validation of a large body being preferable to a slim body, has placed Polynesians outside the hegemonic discourse of the ‘civilised body’. Obesity, within this discourse, leads to lower employability thus reinforcing the socio–economic cycle. Contained in the paradigm of the ‘civilised body’ is the idea that the individual is exclusively responsible for their own body shape, maintenance and health. As previously discussed, pre–colonial Polynesia did not have an obesity problem. The issue of modern Polynesian obesity, therefore, must explore many complex and interwoven aetiologies that have contributed to the current health statistics on obesity–related illness. These include issues of social justice, socio–economic positioning and perceptions of well–being that are discussed in this thesis.

**Reflections on the social meanings of food and eating for Polynesians**

Substances, techniques of preparation, habits, all become part of a system of differences in signification; and as soon as this happens, we have communication by way of food (Barthes 1975, p.51).
Anthropologists and sociologists share an interest in the symbolic nature of food and eating practices and how these perform in relation to culture. Discourses on food are articulated within various sites including public health, critical social theoretical perspectives on food, notions of embodiment, and cultural representation. This section examines social constructionist approaches to understanding the ways in which preferences for foods develop and are reproduced as socio-cultural phenomena. The discourse on food itself is a substantial part of the overall discussion of Polynesian health and well-being. It is, therefore, important to explore how food and eating have such a profound and complex role in regard to sustenance, pleasure, power and ceremony in Polynesian cultural practice.

In order to further understand how food–centred rituals function to maintain and preserve broader cultural practices, this discussion begins with an examination of the theoretical nature of food reciprocities in the Pacific context. This will explore more culturally specific notions of kai (food) that illustrate several key features relevant to this thesis. These include how foods are prepared and used in eating situations and the values on which such uses are based; specific food–associated events, such as feasting, and the social relationships in which food events are embedded. This section will also reflect on how foodscapes – the cultural spaces in which foods are derived and managed – serve to affirm cultural identity in migrant communities. This concept will then be used to discuss the geo–political transformations in the quality and availability of foods in areas of socio–economic disadvantage. Used in this way, the notion of foodscapes allows for the many and varied functions of food to be discussed:

The term ‘foodscapes’ provides a way to talk about the culinary culture(s) of a place as defined by the interactions of a variety of factors: geography, climate and environment; religion, language, and cultural practices; history; social organization, ethnicity, status and gender; science and technology. Foodscapes are dynamic, not static, continually undergoing change, diversification and homogenization (Campo and Campo 2006, p.2).

Perspectives on food, eating and the body

In the broadest sense, food is an edible substance that sustains life. As a biological process we eat, absorb food, and excrete waste. What is constituted as food, has many cultural referents attributing characteristics that may be appraised such as taste, texture, calories and nutritional content, as well as cultural associations, memories and meanings (Germov and Williams 2008). According to Lupton (1996; 1994) food is ultimately a liminal substance bridging the profound dualities of nature and culture, the outside and inside. Fischler describes this as ‘incorporation’: ‘…the action in which
we send a food across the frontier between the world and the self, between ‘outside’ and ‘inside’ our body’ (1988, p.279). The process of eating is accompanied by the senses of touch, smell, taste and sight. There is also an aural dimension, such as being called to dinner, the squeal of a pig being killed, or the sound of arrowroot being pounded. These sounds, smells and images underlie anticipation of the act of eating. Eating, therefore, is a highly complex physical and emotional phenomenon. Sensations of being hungry, sated, or anticipating certain foods or food rituals are all incorporated into body memories and associated with certain foods and people (Low 2006; Lupton 1994).

While many foods may be consumed in their natural state, there are diverse cultural practices enacted around the cooking of food, conceptualised by Levi–Strauss (1969b) as the ‘cultural transformation of the raw’. An important aspect of this work is how the transformation is accomplished in a way that exemplifies culture in every day life. In the case of Polynesians, the Maori hangi and the Island umu requires food to be cooked in the ground. Symbolically, Mother Earth, Papatuanuku, ‘cooks’ the food. This completes a cosmological cycle of the Sky Father, Ranginui, providing rain and Papatuanuku, representing fertility and abundance, producing the food. The alchemy of transforming the raw, and frequently less palatable, into the cooked and desirable, is a culmination of a detailed, and culturally informed series of actions. Consequently, food and food preparation, represent an externalisation of many things, not least of which is human labour and values (Mintz and DuBois 2002). In order to ‘put food on the table’, a series of activities needs to be enacted alone, or in combination, to ensure adequate food is secured. The food object may need to be cultivated via planting and harvesting, acquired through fishing or hunting, traded for other goods, or paid for by engagement in the wage system. Therefore, despite the illusion that we are all ‘free’ to eat what we like, the cultural, socio–economic and political factors that determine preferences and choices play a significant role in these decisions. Activities leading to the production, purchase and preparation of food reflect social dimensions and often gender roles.

For many people, the process of taking food into one’s body is not accompanied by much conscious thought (Overtup 2008). However, in Maussian terms (Mauss 1979; 1973) eating is a basic ‘technique of the body’; something we are taught to do in a particular way that is heavily mediated by culture. The act of eating is reflective of all the choices leading up to that moment. What is selected to grow, to buy, the care involved in food preparation, and the quantities chosen to consume, all attest to a social and individual commitment (or lack of it) to body maintenance and health, as well as to cultural/social position. Bourdieu (1984) suggests that food preferences and
practices are an example of the interaction of ‘free will’ and existing structures of power. Such interactions create *habitus*, or socialised ‘norms’, that often unconsciously, guide thinking and behaviour. Many of the elements of the Polynesian *habitus* are conceived and enacted in relation to food. In a modern context, these elements contain both residual traditional practices and economically driven consumption patterns emergent from socio-economic positioning.

There are a myriad of social practices informed by culture, ethnicity and class which circulate around food. A great many of these function to maintain a particular existing aspect of social order. For example, as posited by Lupton (1996), the sharing and eating of food in the company of others, implies the incorporation of the participant into the community, thereby simultaneously defining his/her particular ‘place’ within that community. Also, as Lupton suggests, food is the vehicle for other understandings of social positioning. For Polynesians, the act of eating is embedded within a broad range of cultural practices designed to reflect cultural values of giving, sharing and receiving (Alexeyeff 2004; Becker 1995a). These practices are central to maintaining, re-invigorating and extending social relations among and between Polynesians at home and in the broader diasporic communities.

**Eating and social order**

Since the rise of Structuralism in the 1960s, it has been popular with sociologists to examine the role of food as part of everyday life and social ritual. Around the same time, anthropologists such as Levi–Strauss (1969a; b) also suggested that food is ‘good to think with’. In other words, the preparation, presentation and consumption of food, and even its allegorical meanings, allow insight into broader cultural belief systems and significance of cultural practices. Mary Douglas (1970), who was influenced by both Levi–Strauss and Barthes, argued that food is symbolic of the social order. For instance, what foods are chosen, how they are prepared, by whom, and who is entitled to eat such foods in which order are governed by social and cultural determinants.

Regarding pre–industrialised societies, Falk (1994) describes these groups in a fundamental sense, as ‘eating–communities’. This may be of some help in explaining how food practices appear to support cooperative behaviour and affirm kinship structures in small groups. While Structuralist approaches may serve to describe static relationships between socio–economic groups and their food tastes and consumption patterns, they do not adequately address the rapid shifts in people’s relationship to food. Lupton (1996; 1994), whose work embraces aspects of sociology,
anthropology, history and cultural studies, enquires into the sociological issues of gender, power relations and economic privilege in creating and shaping the diet itself and the symbolic meanings associated with food. This has emerged as a post-structuralist position whereby the social construction of food practices and preferences, reflects historical and political realities wherein knowledge and meanings are produced and reproduced. For example, in many Western settings and contexts, the previously relaxed, pleasurable act of ‘eating’ or ‘dining’ is now described in the language of biomedical anxiety, such as ‘nutritional intake’ and ‘caloric load’. This suggests a monitored activity and gives new compositional meanings to the ingestion of food. Effectively this has made the family meal and the cultural bonding of joined festive eating a contested site. Premised on privileging moderation of food intake and its implications for beauty and health, this pattern is not shared by Polynesians, whose relationship to food remains centred on the concept of plenty, and the sharing of abundance. As Becker (1995a) illustrates, for Pacific peoples, it is looking after others – providing for others – that contains its own social reward. Not only does a plentiful array of food make people feel good, it simultaneously fulfils social obligations to others and ensures reciprocity in the future.

**Food (kai) as ritual and facilitator of social networking**

Despite high rates of out-migration reducing the number of able-bodied community members, the majority of people in the Pacific still rely on subsistence agriculture for their livelihood. The term ‘subsistence affluence’ has been employed by Yari (2003) and Bayliss-Smith and Feacham (1977) to describe these societies, in which the extended strength of family or community bonds, acts to alleviate extreme poverty. Food, in all states – fresh, raw, cooked, preserved – is shared and exchanged to ensure no one goes hungry, but also to evoke and reconstitute familial and social bonds. Via this cycle of giving, receiving and sharing food, families are supporting each other in practical ways and generating goodwill with other families that will be remembered and reciprocated in times of both economic hardship and/or celebration. In this way social relations circulate around the comparatively abundant commodity that is food, rather than money. In this way the Polynesian foodscape is foundational to all other social interactions.

The continual sharing and exchange of food products embeds the extended family in a plethora of social relations. For Mauss (1925) the Maori *hau* (gift exchange) risked creating a power imbalance in that the person receiving the gift was indebted to the donor and further, may not be able to enjoy the gift for fear of not being able to adequately reciprocate. This reading of cultural practice implies that the original ‘gift’ needs to be countered by one of an equal external value and that this
represents the potential for stress for those who are less well resourced than the original donor. However, as Henare (2007) clearly points out, this is not the case for Polynesians. He cites the adage in Maori: Ahakoa he iti kete, he iti na te aroha. This translates as: ‘Although the basket is small, it is given with affectionate regard’. It is the thought behind the gift, not its material value that counts. Also, as these exchanges are not commodified as such, they are often reciprocated ‘in kind’. As an example, a woman who receives support in the way of food from a distinguished tribal member, may offer the services of her sons to help set up a large event hosted by the donor in the future.

Exploring theories of ‘gift exchange’, Bourdieu (1977) suggested that it is the temporal space, the ‘interval’ between the gift and the counter–gift that establishes a pattern that is different from a present, a loan, or the activity of simply ‘swapping goods’. In the Polynesian context there are meanings associated with food exchange, other than simple reciprocity, and many of these require a passage of time as part of their construction. As an example, in Tongan communities, the tauhiva is the presentation of food goods to another group, and is identical in social purpose to the kura in Cook Island culture (Mahina 2004; Tongia 2003). It represents the exchange of kai (food) in anticipation of a social outcome: ‘The kura is a formal petition, request or message by one group, tribe or island to another’ (Tongia 2003, p.296). This is clearly a process of acquiring social capital described by Krishna and Shrader (1999), as the set of structural relationships that support networks, people’s membership of formal organisations, and the reciprocity that enables networks to function. The kura is undertaken in order to achieve a substantial outcome for the members of the relevant sub–groups.

As described by Tongia (2003), there are three parts to the kura. The first is the patia, derived from pati’anga meaning to ask, lobby or formally request permission. For example, this would be enacted in order to tour another village or island and/or participate in special activities. Both the second and third stages involve food. The second element is the kave, or taking of gifts to the host. The third and final stage is ‘aka’oki’, meaning to reciprocate by hosting your hosts, in other words, returning their hospitality. The kura takes place over years, each stage taking months. It can all only happen if the patia is accepted and in living memory it has always been.

Ritualised presentation and exchange of kai at such occasions, centres not only on the large amount of food (feasting), but the status of such foods. For Polynesians a feast is a highly anticipated social event. As the name suggests, vast quantities of food are supplied through established familial
channels. Commonly, family members closest to those hosting the event contribute a larger proportion of foodstuffs than those who are more peripherally involved. For Maori, this involves a large hangi whereby the meats and vegetables to be placed into the firepit are usually prepared and brought to the site of the hangi itself. The hangi will be followed by the consumption of plentiful desserts. An event considered worthy of a feast, such as the wedding or funeral of a high–ranking family or community member requires not only a large volume of food of all types, but a good representation of high status foods. Such foods are comprised of two types. For Islanders, the first are food products which could be described as ‘soul food’ and have a nostalgic association of simple, pre–colonial Island eating, such as fish and coconut dishes prepared in the underground fire pit. The second type of prestige foods are processed goods, in particular tinned corn beef, which has been allocated a socially recognised space as a symbol of Western affluence (Gewertz and Errington 2007).

The role of tinned beef in Pacific Island life cannot be overstated. Salted beef came with the first explorers, whalers and missionaries in the nineteenth century and became a high ranking food – one with ceremonial significance (Ta’irea 2003). In Island communities, feasts are where the family, church and community intersect, and tinned meats are essential. Povi/pulu masima (respectively the Tongan and Samoan terms for tinned corned beef) is now part of ‘traditional’ eating and food exchange (Hoetjes 2005). It is offered to fulfil family obligations and as a token of respect to senior village or community leaders. According to Hoetjes, the ‘traditionalising’ of tinned meat and its status as a prestige food item, is so complete that a forum of health workers and concerned community members, assembled in Auckland in 2004, found that no ‘healthy’ alternative would be an acceptable substitute: ‘Participants considered povi/pulu masima as a valued food item and an important part of traditional culture, holding connotations of the Islands and family’(Hoetjes 2005, p.2).

As Gewertz and Errington (2007) and Ta’irea (2003) point out, the exchange of these products has become symbolic of community solidarity and celebration, and strengthens the bonds of kinship. As Polynesian families are so large, often comprising many hundreds of people, these events and forms of food exchange serve to remind each generation of who they are related to, in what way, and from which common ancestor they descend. For older family and community members, these events are an opportunity to re–establish ties with other participants they may not see for long periods of time. Therefore, to ban or discourage the exchange and consumption of these products on health grounds, however well intentioned, may well have a destabilising effect on the entire community. This
presents a dilemma for health practitioners and community members who wish to find healthy alternatives to tinned, fatty meats without disturbing the social rituals enacted by their consumption and exchange:

The challenge that now faces us is to accept change selectively, adopting only that which is beneficial, and not losing sight of our culture, of the high quality traditional foods and means of preparing them, of the positive effects of distributing good widely to friends and relatives (Ta’irea 2003, p166).

**Contemporary Polynesian foodscapes: Gastro–identity in a globalised world**

The literature on foodscapes offers diverse ways to explore the social and health implications of food production, distribution and consumption. From a political–economy perspective it is possible to examine the political choices of what is grown and sold in each country and which foods are exclusively produced for export. For example, not only do Pacific Islanders earn much less for their bananas and other fruits sold to bigger countries under ‘free market’ globalisation, the local people are eating less of these foods themselves. Instead, despite earning less, these communities are spending more on imported foods (Evans et al. 2003). This approach also questions the economic power of processed or ‘pseudo–food’ manufacturers, in conjunction with the monopoly of supermarket chains, that restrict the ability of smaller fresh food outlets to trade. In the health sciences and urban geography, foodscapes help explain the distribution of poor health associated with living in certain geographically and socio–economically defined localities. For example, Cummins and Macintyre (2002) have employed the term ‘food deserts’ to describe working class areas of Glasgow and Leeds, where the health implications of an impoverished food landscape are considerable. Smoyer–Tomic, Spence and Amrhein (2006) also use the term ‘food deserts’ to describe the situation in the vast Prairies of Canada. This spatial domination of particular types of food outlets reinforces food ‘poverty’. These observations are resonant of many Australian working class suburbs and regional areas. Such districts tend to have an extremely poor range of options for good quality food and are usually populated with an array of fast–food outlets.

Panelli and Tipa (2009) acknowledge that the concept of ‘foodscapes’ is useful in describing the correlations between access to quality foods and the health impacts of being denied such access. However, these authors argue that the current body of literature frequently separates the issues of cultural, political, economic and geographic barriers to the consumption of affordable, healthy food into various disciplines and, therefore, decontextualises food from the broader relationships
between people, their environment and what they eat. This reflects another tenet of Kaupapa: Matauranga Maori – linguistic and cultural conceptualisations of the body and food. These authors suggest, in particular with regard to Indigenous cultures, that there needs to be further exploration of the ‘interconnection between foods and wider social, material and cultural contexts that affect the impact of these food terrains on groups and individual’s lives’ (Panelli and Tipa 2009, p.457). Working with the Maori concept of mahinga kai (the locating and gathering of traditional food sources), they demonstrate the multiple layers of interconnectedness enacted in traditional food provision and exchange. They also understand that many Maori now live in an urban setting and that such traditional knowledge varies between families and hapu (extended family/clan) in the extent to which they have, or do not have, access to this traditional knowledge, act on it and transmit it to their children. These authors highlight the futility of pursuing binary perspectives of ‘Western’ and ‘Indigenous’ worldviews and instead promote the examination of the intersection of these views. In this way, the cultural background and social reality of Maori and Pacific Islanders can be explored more effectively in a contemporary setting.

Errington and Gewertz (2008) have concluded that modern Polynesians are a ‘gastro–identified’ group. This definition includes the already discussed cultural preference for a large body exemplifying ‘plenty’, rather than a slim, ‘disciplined’ body in the Western sense. It also reflects how food reciprocities and other cultural practices around food, inform and affirm identity. This relationship to food and commitment to the sharing and exchange of food are significant both in the country of origin and also after migration. In regard to Pacific migration, Alexeyeff (2004) has described Polynesians living outside their countries of origin delighting in receiving packages of foodstuffs from home and conversely, those still at home enjoy food specialities from overseas. However, it is the food from ‘home’ which has the strongest connotations with identity and cultural continuity.

The complex emotional associations of food within migrant communities has been explored by Lassetter (2011) in relation to another Polynesian group (Native Hawaiians in the mainland USA). Lassetter found that ‘Hawaiian’ food provides the ‘social lubricant’ for bringing together disparate Hawaiians and promotes friendships in ways that are important to Hawaiian migrants’ well–being: ‘The role of Hawaiian food and restaurants may be even more important to well–being in Las Vegas than it is in Hawaii, where they are more likely to connect regularly with other Native Hawaiians’ (p.68). Using a colloquialism of the community, Lassetter describes a ‘Kanak attack’. This is the culturally sanctioned practice of over–eating and experiencing relief from homesickness, replacing
it with a sense of cultural connectedness while eating Hawaiian–style food. Similarly, within the framework of a South Pacific foodscape, Pollocks’ work (2009; 2008; 1989) examines ways in which these same food preferences and practices are enmeshed with identity for the diasporic population:

Food reinforces ties between Pacific peoples and their island homes, while linking them to a wider world. Food globalises while it localises, thereby crossing national boundaries. It links families through exchanges and shared ideologies and diversifies over time and space. Increased options of foods from the land or from the supermarket are part of that diversity (Pollock 2009, p.103)

Behaviours and choices around food act to preserve cultural identity in a diasporic population. In this way, food acts as an identity marker that functions to link families overseas to their ‘home’. However, as Polynesians strive to preserve a ‘gastro–identified’ culture in a rapidly globalised world, the quality (and quantity) of these food choices has implications for the long–term health of this population group. It is evident that Polynesians are now incorporating many more processed food products into their ideas of ‘traditional’ food, and their domestic food practices. However, Pollock’s idea that food ‘from the land or from the supermarket’ is simply an expression of choice or diversity, may be misleading. This position diminishes the strategic input of globalised agri–business, fast food corporations and government protectionism surrounding trade practices between wealthy countries and poorer ones. The global flow of food and the relationship between contemporary political economies is conducted in a climate of unequal power relationships. This not only has health implications as discussed throughout this thesis, but also represents a greater reliance on currency, as necessitated in the wage economy, to deliver goods that only a generation ago were free. As a consequence, more household income is directed to the purchase of poor quality, processed food goods in both the home islands and in the new host country.

**The socio–political context of economic marginalisation**

A large scale report commissioned by the Ministry of Health (1998) represented a compilation of the analysis and conclusions of many other reports in areas of specialised health interests. It became a watershed document for the New Zealand government in challenging its commitment to deliver better health outcomes for Maori people. The report highlighted the major social determinants of health disparities between Maori and non–Maori relating to income inequalities, employment, education and housing. Key ‘snapshot’ statistics from New Zealand around these issues, provide a baseline for this discussion. These are important as the primary motivation for Polynesian migration.
to Australia is the lack of economic opportunity in New Zealand. These figures also help explain the overall socio-economic positioning of Maori and Pacific Islanders in both countries.

In relation to the health of Maori and Pacific Islanders in Australia, there are also issues arising from their status as migrants. International research indicates that being a migrant, particularly an unskilled migrant, exacerbates existing risk factors associated with health and well-being. I will therefore explore the interaction of these elements – the post-colonial experience, low socio-economic status, and migration to another country – as social determinants relevant to the health and well-being of this population group.

**Employment and unemployment**

In the decade to 2008, the average unemployment rate for Maori in New Zealand appears to have been halved, from almost fifteen percent to approximately eight percent of the overall Maori population. When analysed by gender, the figures are more revealing. The number of unemployed Maori women decreased by almost a third, largely in response to government policies and sanctions on welfare payments (Department of Labour 2007). There is concern with these statistics that under-employment and part-time employment disguise the real figures of joblessness for both men and women. Also, welfare recipients who are denied payments through sanctions, come to rely even more heavily on family members, thereby contributing to household overcrowding that in itself has been identified as a marker of social disadvantage (Walter and Saggers 2007; Bailie 2007). Significantly, the National Equal Opportunities Network (NEON 2006) suggest that Maori unemployment will continue to be at least double the rate of the general population. As pointed out by Stevenson (2004) there has been an economic slowdown in construction, tourism and primary industries, with Maori being strongly represented in each of these sectors. As employment opportunity is cited as the most common reason for migration to Australia (Hamer 2007; 2008a; 2008b) such a high rate of unemployment in New Zealand will almost certainly translate into an accelerated movement of young Maori and Pacific Islanders across the Tasman.

In Australia, as a result of the national government’s 1997 directive that New Zealanders are not entitled to welfare benefits for up to two years after arrival, the number of ‘Kiwis on the dole’ has declined. Current Australian census data, while not disaggregated into Pakeha, Maori and Pacific Islander, reveals ‘New Zealander’ participation in the workforce to be high (Hamer 2008b; 2007). According to Hamer’s studies the biggest employers for Maori in Australia are the construction, entertainment, shearing, security and mining industries. As migrants, they are young, motivated and
willing to travel to explore well–paid work opportunities. The qualitative data also suggests Maori themselves see their chances of better paid and more diverse employment as far greater in Australia than New Zealand. Seventy–four percent reported employment had become ‘much better’ since being in Australia, and nearly thirteen percent said ‘a bit better’. Combined, almost eighty–seven percent of participants cited an overall improvement in their employment prospects (Hamer 2007, p.51). As Australian wages are significantly higher than those in New Zealand, it is clear Maori are considerably better off financially in both skilled and unskilled jobs in Australia. However, these gains in wages are frequently subsumed by the high cost of living, in particular housing, in Australia.

Educating Maori: Why education takes a back seat to sport

According to Hokowhitu (2004) and Barrington (1988), the concentration of Maori in unskilled and semi–skilled work derives from colonial policies and practices. The early colony of New Zealand needed a large manual workforce to build and feed the new nation. Administrators charged with the responsibility of state education decided that Maori boys should not be expected to accomplish complex or abstract thought, but be streamed into manual, technical and agriculture skills (Barrington 1988). As early as 1866, the Inspector of Native Schools, James Pope, was disconcerted by the successful academic results being achieved at the boarding school, Te Aute College: ‘Maori boys could be taught agriculture, market gardening, stock farming, poultry keeping and bacon curing; and yet all the resources of the estate were being diverted to literary work’ (in Barrington 1988, p.47).

Over generations, such policies have had a crippling impact on the educational expectations and accomplishment of Maori, confining the majority to manual labour and ‘blue collar’ industries. For these Maori, like many working class men, sport became the vehicle to express their prowess and ambition. Donaldson (1993) has analysed the variants of power relations in regard to working class men and the hegemonic discourse that is seen to define ‘masculinity’ for these men. There is a great deal of overlap in regard to accepted work practices, lifestyle and values as expressed by Anglo, ‘blue collar’ workers and Maori men. The role of sport for both groups is inordinately high, and valued at a premium above almost all other achievement.

In New Zealand, and now in Australia, the high–profile success of Maori and Pacific Islanders in sport is regarded as a counter–balance to underachievement in the education system (Hokowhitu 2004; George and Rodriguez 2009). The implication is that sporting success offsets the need for a
quality education leading to greater career options: ‘The mainstream discourse recognizes this phenomenon as an acceptable alternative to providing Polynesian boys with an education system that caters to their academic needs’ (Hokowhitu 2004, p. 273).

In New Zealand, while overall high school retention rates have increased to sixty three percent, only one in five Maori, and one in six Pacific Islanders, has a tertiary education and one third of Maori leave school with no form of qualification at all (New Zealand Qualifications Authority 2007). The lack of formal education inevitably translates into poorly paid work, with the median annual income of a Polynesian without qualifications is below $NZ20,000 (Ministry of Social Development 2006). The success story of education would appear to be the number of Maori women who completed tertiary qualifications, which grew 201%, from 3,999 to 12,049, over the last ten years. Allowing for this gender–specific advance, the figures would then indicate that Maori men are still struggling in the education system. The figures for Pacific Islanders follow a similar trajectory: about a third of Pacific Island women leave school with no qualifications, but the statistics for Pacific Island men are much worse. An Auckland study revealed less than fifteen percent of Pacific Island men had a post–school qualification of any sort (Paterson, Tukutonga, and Abbot 2004). When these figures are combined there is a clear picture of a cultural and socio–economic group performing poorly in education, with the boys being failed by the system entirely. Again, ‘hard’ figures are not available in Australia, however the small study undertaken by George and Rodriguez (2009) and anecdotal evidence suggests these patterns may be repeated here. As Durie (2007) points out, the poor educational delivery for Maori has on–going implications for health and well–being. When Pacific Islanders are included, overall education rates for Polynesians are significantly below the Anglo population. It is therefore likely that Polynesians will continue to experience poor health literacy, financial stress and a lack of leadership to address major health issues affecting their communities.

**Household population densities**

The consocial nature of the Polynesian family is well established. For Polynesians, the sharing of income and household resources with extended family members reflects a fundamentally different attitude to family responsibilities, and to money, than that of contemporary Anglo New Zealanders or Australians. Not only do the income providers support more people per household, as census statistics reveal, there is an expectation to support a much wider circle of extended family members than is common to non–Polynesian households (Wynhausen 2008; Rodriguez 2003). As a result, household overcrowding is common within Polynesian families whatever the income.
Polynesian protocol dictates that any relative is to be made welcome and be allowed to stay as long as they wish. New arrivals from New Zealand and the Islands, known colloquially as FOBs (Fresh Off the Boat) by other Islanders and Maori, are usually housed within the extended family group and expected to get work immediately. While many Maori arrive in Australia with some trade skills and a degree of work experience, for those Polynesians straight from the Islands, there has been very little opportunity to acquire such experience in their home country, and many of these migrants end up in unskilled jobs. However, although many Polynesians may earn a high wage (relative to New Zealand wages) in unskilled employment, as described above, the lack of formal education, skill qualification and inconsistency of employment often means that work choices are limited and income can be suddenly and drastically reduced because of redundancy or industrial injury (Hamer 2007; Hakaoro 2003). As a consequence of these factors, although Polynesian household incomes may be quite large when using the usual indicators of a high employment rate and good pay, that income is spread over a great many more people, and prone to unpredictable fluctuations, effectively keeping the family in a working class pay day–to–pay day paradigm.

The cultural expectation of providing a home for a large number of relations, as well as having a relatively young population, combines to make household itself a significant issue. This situation can only be exacerbated by the migrant experience, where the cost of housing in Sydney and other metropolitan centres has become critical for many families and a source of financial stress (Hamer 2007). Household overcrowding may also impact on the capacity for the next generation to achieve a higher level of education (Havea in Wynhausen 2008). In the socio–centric Polynesian home environment, there may simply be too many people in the house for children to be given the individual attention and support they need to compete in a Western education system. Also, many young Maori and Islander children do not experience a structured pre–school environment, as childcare is less formal and family–given. While childcare provided by older family members, in particular, may encourage traditional language retention and early transmission of cultural practices, it may also mean young children are not adequately prepared to enter an educational system that is culturally alien to them (Rodriguez 2007a; Thaman 2002).

Social class and mobility

Given the multi–layered connections between socio–economic status, class and health (Walter and Saggers 2007; Germov 2005), it is important to examine ‘class’ in relation to the Maori and Pacific Island migrant experience. In this section, I will discuss how socio–economic disadvantage, coupled with cultural commitments, converge to keep most Polynesians in a marginalised state, thus
reducing the opportunity for class mobility. As a measure of social positioning, the definition provided by Germov (2005, p.68) is straightforward, allowing a broad view of class: ‘…(a) position within a system of structured inequality based on the unequal distribution of power, wealth, income and status’. Both Poata–Smith (1996) and Rata (2000) argue that in New Zealand disparities in socio–economic status experienced by Maori result from issues of post–colonial exclusion and are also driven by issues of class. These authors point out that to ignore such structural inequality prohibits a fuller understanding of on–going disparities and apparent lack of class mobility within Maoridom. In the view of Poata–Smith this has been ‘an unmitigated disaster for the vast majority of working–class Maori’ (Poata–Smith 1996, p.110).

Hamer’s qualitative study (2007) indicates this is also a struggle in the diasporic population in Australia. Hamer has found that despite a high employment rate, and a moderate increase in labour skills compared with New Zealand, Maori are still firmly in a ‘blue collar’ reality. Eighty percent of Hamer’s participants agreed that their New Zealand qualifications were not being recognised in this country, and this represented a barrier to finding a higher skilled job. In summing up these responses, Hamer noted that many Maori migrants were willing to take on difficult working conditions for higher financial rewards than they would experience in New Zealand, but the lack of Australian qualifications frequently prevents them moving into well–paid and less physically demanding jobs:

Often, I was told the work Maori do – which is sometimes transient, remote, hot or dirty – is the kind that Australians simply choose not to do and leave for migrants. The key difference is that Maori can earn a lot more money at these jobs than in New Zealand. [However] upward occupational mobility remains out of reach unless they retrain (Hamer 2007, p.53).

In order to understand this contradiction between relatively high household incomes (see Table 1) and lack of social mobility, it is necessary to explore the relevant issues in the light of both class status and mitigating cultural factors. An important contribution to this discussion has been made by Walter and Saggers (2007) in the context of indigenous Australians. The authors express some reservation about conventional definitions of class, and the use occupational status models of class, to reflect an indigenous reality in Australia. They argue that for reasons of a complex interplay between class, social disadvantage and cultural practice, a purely income–driven assessment of class cannot adequately define the parameters and capacity for class mobility for Indigenous people. Using Aboriginal employment statistics from 2003, they cite that a quarter of employed Indigenous men and women are in professional, associated professional, or managerial jobs. This raises the
question of whether employment at this level means these Indigenous Australians are now middle class. The authors pose the theoretical perspective that Indigenous people may constitute their own class category. In exploring this notion, they argue that the accumulation and maintenance of wealth, the foundations of class mobility, are out of reach for most Indigenous people. In essence, the cultural expectation of providing for extended family members is paramount – the more a person earns, the more people they can (or should) support. In other words, family demands expand to engulf the new resources, thus preventing the accumulation of wealth. For the Polynesian migrant, it would also appear to take more than the good income of a family member/s to move class.

**Failure of the ‘Third Way’: New Zealand social policies and trans–Tasman lessons**

While New Zealand appears to be significantly advanced in the recognition of cultural factors, socio–economic deprivation, and post–colonial marginalisation as influential on Maori health and wellbeing, the practical steps and resources required to remedy on–going disparities in health have been grossly inadequate. Responding to the evidence and arguments that it was impossible to separate serious health issues from pre–existing socio–economic determinants, the New Zealand government launched a wide ranging initiative, ‘Closing the Gap’ in 2000\(^8\). This policy, or rather series of policies, aimed to reduce the disparities that divide Maori and non–Maori in relation to economic opportunity, education and health. I will discus how this approach has been widely criticised by Durie (2003) amongst others, primarily for being focussed on a ‘deficit discourse’, highlighting Maori deficiencies, and failing to address structural barriers to Maori class mobility and achievement.

Closing the Gap is closely associated with Third Way policies formulated in a climate of neo–liberalism in the 1990s. The Third Way sought to find alternatives to welfare dependence, and to reform centralised state delivered services (see Mudge 2008). As with many ‘first world’ nations, New Zealand embarked on a radical review of the way it regarded social disadvantage, its causes, and its potential elimination. New Zealand’s attempts to ‘level the playing field’ in relation to existing socio–economic disparities are significant in two ways: first, that Australia has also adopted similar (if not the same) language and ideology to address the health status of Aboriginal people, and second, New Zealand’s failure to successfully stem the tide of high unemployment has

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\(^8\) An overarching policy of the same name has been launched in Australia as an adjunct to the Northern Territory Intervention (see Awofeso, Brooklyn and Williams 2010).
arguably been the single largest prompt for Polynesian migration to Australia (Hamer 2007; Singh 2005).

National, state or regional economic policies all have the ability to impact on health in relation to social disadvantage. Correlations between high levels of unemployment and limited access to education, are reliable predictors that health status will be compromised (Dunbar and Scrimgeour 2007). This, in turn, becomes a double burden on the community, as the cost of health treatments escalates for the marginalised, while at the same time their ability to contribute to the overall economy deteriorates. Mason Durie sums up this conundrum: ‘Economic growth may be at the expense of social well–being while high levels of social adversity may reduce opportunities for economic gain’ (Durie 2003, p.157).

As the average age of Maori is now twenty–two, and Pacific Islanders twenty–one, it is the younger generation, who were born at the time of radical reduction of ‘blue collar’ jobs, and who have not been ‘picked up’ by the education system, who bear the brunt of these policy failures. Brendon Stevenson describes this as ‘Fordism’: mass production, mass employment, mass consumption – and now mass redundancies (Stevenson 2004).

Ignoring pressure from community workers, health workers, activists, and political critics, the New Zealand government continues to advocate Third Way policies. Supporters of the Third Way proposed an ideological shift away from notions of state responsibility for welfare provision in favour of promoting the benefits of capitalist self–sufficiency. In other words, access to the free market would counteract previous social disadvantage. This market–driven approach and lack of community consultation contravenes the Kaupapa Maori principle of ata – the active cultivation of respectful relationships between Maori and government agencies. Such ‘top–down’ policies seldom produce the desired results. As Poata–Smith (2007) points out, the ‘grab–bag’ approach of programmes administered in an ad hoc way by various government departments, has not achieved any measurable improvement in key social indicators. These policies have been in place for more than a decade, and have as yet, to deliver any significant progress towards their stated outcomes. The gap that these policies were designed to close may, in fact, be widening. In 2000, eighteen percent of New Zealand children were living below sixty percent of the median income poverty line. In 2008, the figure was twenty–six percent, mostly Polynesian children (Child Poverty Action Group 2009). Medical researchers (Blaiklock et al. 2002) express concern that despite the rhetoric of change, Maori health figures are still in decline:
Empirical evidence suggests that the health status of Polynesians is not significantly improving. Indeed, the policy measures implemented have not been enough to counter the escalating social disadvantage in these communities. Poor living standards, high unemployment and associated health risk indicators may indeed be rising, especially in relation to children (Blaiklock et al. 2002, p.5).

Under prevailing neo-liberal economic policies, the branding of social projects with titles such as ‘Pathways to Opportunity’ has done little to arrest the poor statistics on education, employment and health in Polynesian communities. Low socio-economic indicators have remained trenchant amidst the debate regarding the causes and possible remedial strategies needed to address inequality in broader terms. It is evident therefore, that the neo-liberal policies of the Third Way do not offer any solutions potent enough to counteract the damage of prior widescale marginalisation. Further, statistics for Polynesians in New Zealand and Australia reflect many of the patterns of household income and expenditure common to working class families. This continues to be the case regardless of increased household income.

Examination of comments by participants in Hamer’s (2007) study of Maori in Australia – allowing for the qualitative nature of this work (people’s perceptions versus hard data) – indicates an improvement on the New Zealand statistics in several areas, particularly employment rates. However, despite a higher rate of employment, indicators of residual, on-going social disadvantage are apparent. Hamer, along with other authors, in particular Poata-Smith (1996) and Walter and Sagers (2007), provide insight into why a lack of class mobility means Maori and Pacific Islanders are likely to experience a range of health problems and disabilities that are also associated with Indigenous and working class Australians. This is evidence of how the convergence of class and culture affects health understandings and outcomes in the Polynesian diasporic community in Australia.

**Neo-liberalism and public health policy in New Zealand and Australia**

To explore this topic I will provide an overview of the political dynamics concerning the relationship between socio-economic disadvantage, health and health service delivery for Polynesians. It is in New Zealand where the most detailed empirical and qualitative data has been collected regarding the correlations between social disadvantage and health of both Maori and Pacific Islanders. I will, however, concentrate on the Maori experience, although in some instances, I will also refer to relevant Pacific Island statistics. This is first because Maori, as the Indigenous
population, are part of a more extensively researched and developed discourse in New Zealand. Second, the Pacific Island communities in New Zealand that are also part of this study – Tongan, Samoan, Cook Island and Niuean – are being serviced by programmes derived from the Maori model, and share similar experiences around education, employment, housing and health.

In the context of the Polynesian migrant experience I will discuss how the pervasiveness of neo–liberalism in health policy is likely to impact this population group in Australia. According to the Australian Institute of Health and Welfare (AIHW 2006), ninety–five percent of the total current health care budget in Australia supports core biomedical activities and systems – diagnosis and treatment. It is evident, therefore, that a genuine commitment to preventative health will be difficult to achieve without an increase in funding. With the neo–liberal emphasis on ‘privatising’ health, a user–pays ethos and insistence that hospitals must somehow pay for themselves, it is the poor and the marginalised who are most likely to experience a deterioration in health care. This section will examine how health policies are determined and funded. It will also examine the role of Cultural Safety in being able to redress some of the structural elements that are at present perceived to act as disincentives to Polynesian access to mainstream health services. In this further exploration of the impact of neo–liberal ideology on government economic decisions in relation to health, there is a discussion of how these funding structures limit the capacity for Cultural Safety to be fully effective. This discussion will, therefore, include issues that are at the forefront of public health debate in Australia and offer insight into the pressures on allied health workers in this political atmosphere.

Cultural and structural barriers to optimum health delivery: An argument for Cultural Safety

In New Zealand, extensive analysis of hospital admission rates and comparative data on mortality rates for illnesses, reveal Maori and Pacific Islanders under–utilise health care services in the early stages of illness, and throughout the length of illness (Ellison–Loschmann and Pearce 2006). It has also been demonstrated that when treatable illnesses are neglected, they become more severe, and the effectiveness of medical intervention is greatly reduced (Scheper–Hughes 2006). In 1991, The World Health Organisation (WHO) acknowledged the desirability of cultural appropriateness of services in order to arrest this trend : ‘Health services need to embrace an expanded mandate which is sensitive to and respects cultural needs’ (WHO 1991). Nearly twenty years later, research compiled by Baxter (2002) and the Ministry for Maori Development (Te Puni Kokiri 2000) suggests the reasons behind this reluctance to engage with the health system appear to remain the same as
they did two decades ago. These include factors commensurate with social disadvantage, such as cost – general practitioner and specialist fees, dental services, pharmaceuticals, outpatient care and transport costs. Also cited are additional pressures such as possible job loss for absenteeism and reduced family income. However, Cultural Safety practitioners identify cultural factors as being as significant as social disadvantage as a determinant for this low uptake of engagement with the health services (Smye, Rameka and Willis 2006). For example, there may be a barrier in regard to a Polynesian man or woman being seen by a health worker of the opposite sex, or other cultural factors such as whakama (shyness), being misconstrued as politeness or stoicism.

In Australia, many health professionals and researchers are frustrated by what they consider a short-sighted approach by federal and state governments refusing to fund primary services for preventable illness (van Driel 2009; Doggett 2007). However, the lack of resources available to service those of non-Anglo ethnicity and with English as a second language is of particular concern. In Sundquist’s (1995) work, even voluntary migration to another country has an impact on health status. Sundquist concluded: ‘Being a migrant was a risk factor of equal importance to more traditional risk factors such as lifestyle factors’ (Sundquist 1995, p.128). Along with Sundquist, Robertson and colleagues (2003) also found that ethnic ‘visibility’ and poor language skills were predictors of both ill-health in terms of preventable disease and problematic use of health services. Concerned health providers and community advocates argue that there are systemic obstacles to offering improved health care to CALD groups.

As CALD groups are presenting in increasing numbers at Australian hospitals, this is becoming a more pressing issue. In Queensland, a quantitative study identifying Maori and Pacific Islanders as a CALD population (van Driel et al. 2009), and accompanying qualitative study (Bedford et al. 2009), suggest that Cultural Safety training for health professionals should be a matter of urgency and reinforce the need for more research in this area. However, persistent pressure on hospitals to cut costs, means the potential benefits of Cultural Safety practice for CALD patients are likely to be reduced due to inadequate resourcing and support. This has already happened in New Zealand under neoliberal cost-cutting measures. Dianne Wepa’s (2003) evaluation of Cultural Safety in practice in New Zealand identifies several key findings. Wepa maintains the effectiveness of Cultural Safety practice is undermined by inadequate financial resourcing for both training of staff, and funding to build an evidence-based body of research. She argues that without institutional support for an in-depth evaluation processes, Cultural Safety as both theory and practice will not be
acknowledged by prevailing medical hierarchies. Consequently, Cultural Safety educators run the risk of being increasingly in demand but not included as part of the dominant discourse.

Competition for the ‘health dollar’ is fierce, however, it is not always about the money as such, but also willingness to compile and share information. For example, researchers at a leading national centre for the study of diabetes, have produced a report critical of the lack of cohesion between associated services and institutions:

Currently in Australia there is no national body of information or formalized mechanism for sharing information regarding diabetes in culturally and linguistically diverse (CALD) groups...Therefore, information on the availability of diabetes education programs and resources developed specifically for CALD groups or health professionals working in the area of diabetes is difficult to ascertain (Australian Centre for Diabetes Strategies 2005, p.6).

With the growing numbers of Polynesians in Australia presenting with chronic illnesses such as obesity–related heart disease and type 2 diabetes, it is becoming more urgent for Australian health workers to be apprised of the structural and cultural barriers to accessing health services experienced by this community.

**Limitations of Cultural Safety in health practice**

In New Zealand, by the end of the 1990s, the structure of the health and disability sector had been condemned by the very department that was meant to implement these services. The Ministry of Health (1998) research review described the over–arching structures as state instruments which ‘…contribute to the alienation of Maori from participating in the design, development, implementation, management and control of the systems intended to meet their health needs’ (Ministry of Health 1998, p.33). It was partially in response to these criticisms, that the Cultural Safety model of health service delivery was promoted.

Cultural Safety advocate Diane Wepa (2003), reflects on some of the early attempts at a national level, to recognise the role of ‘culture’ as an influence on health. Wepa points out that initial proponents of the Cultural Safety model did not provide specific strategies on how to develop more pluralistic cultural knowledge and understandings, and nurse educators and other health professionals struggled without training in this area. In the early to mid 90s, there appeared to be a general perception that ‘culture’ meant ‘ethnicity’, and because Maori were the dominant ‘ethnic’
group, students were taught Maori words and songs and did not get to question their own cultural identity (Wepa 2003).

A study by Harris and colleagues (2006) analysed the effects of self–reported racial discrimination in regard to Maori health and reached similar conclusions: that health care providers needed to be taught to be more reflexive about their own cultural assumptions, as well as being sufficiently familiar with Maori and Pacific Island cultural values, beliefs and norms that impact on health. Without such reflexivity, cultural barriers continue to cause offence and discourage participation. Both these sources also agree that the Cultural Safety approach does not insist on total cultural immersion, nor to be exclusively ethno–specific, however it does recognise sites of power and marginalisation that need to be addressed by wider societal processes.

These contributions help explain why New Zealand, that has pioneered many radical innovations of Cultural Safety, still has disturbing statistics regarding Maori and Pacific Islander health and premature mortality that persist. The hurdle of language and understandings of health and disease in the Polynesian communities as discussed in this thesis are contributing factors, but there are also structural barriers to other aspects of Cultural Safety being addressed. Pressures on the ‘health dollar’ lead to policies that are rushed, ill–conceived and poorly funded – or ignored. This is particularly problematic in regard to entrenched patterns of chronic ill–health experienced by Indigenous, migrant and marginalised populations (Downing, Kowal and Paradies 2011; Saggers and Gray 2007). In what Sutton (2005) refers to as ‘the politicisation of disease and the disease of politicisation’, the policy ‘merry go round’ has failed to generate improvements in health disparities experienced in Aboriginal communities. This is a source of frustration both for those who support a stringent biomedical approach with little or no regard for ‘culture’ in the field of health, and also for those who are exponents of a culturally inclusive agenda for health and well–being. Fred Chaney (in Skelton 2008) argues that, in order for health statistics to improve for Indigenous Australians there needs to be a political commitment that transcends the three year parliamentary cycle. In other words, if any government is serious about reversing these trends, policy has to be implemented over the long term and should be intended to roll out to the next generation and beyond. However, Chaney doubts this commitment will be achieved: ‘…who is going to deliver on it, because it is a twenty year programme?’ (Skelton 2008, p.21).

Public health has become an expensive tax burden for both Australia and New Zealand and is a highly political issue. Under the auspices of the neo–liberal, ‘user pays’ ideology of the last twenty
years, the real cost of chronic illness that includes hospital admissions, expensive treatments, days lost from work and other factors, is pitted against the cost of reducing these figures. Sligo, Jameson and Comrie (1998) in their assessment of barriers to Pacific Islanders gaining access to health services and information in New Zealand noted that the health sector has undergone rapid changes and market–style reforms. As occurred under the Howard government in Australia, people were encouraged to join private health funds. These authors argue that privately–funded health schemes incur costs that are prohibitive to most constituents of their study – the working poor. They are also critical of the devolution of government responsibility for health to the individual.

Petersen and Lupton (1997, p.xii) refer to this as the ‘new public health’, whereby an individual is responsible for their own health, and that of their fellow citizens: ‘… the new public health is at its core a moral enterprise, in that it involves prescriptions about how we should live our lives individually and collectively’. By shifting responsibility for health to the patient, commonly referred to as ‘Individualist Health Promotion’ (IHP), people are encouraged to take responsibility for managing their lives and health in terms of prescriptive scientific and medical models (Richmond and Germov 2009). Crawford identified this model of ‘getting bodies under control’, as ‘healthism’ (Crawford 1980, p.365). Ideologically, IHP assumes shared knowledges and priorities. In reality, this translates into contradictory messages. On the one hand, people are asked to trust and have faith in medical and technological solutions, and on the other, to take responsibility for their own health status as an individual or community. Chang and Christakis (2000) suggest this creates: ‘…a general epidemiological tension between an individual level of focus on risk behaviours and a population level of focus that contextualises behaviours within a social and material framework’ (p.151).

This trend in health ideology and delivery has led some authors to further question whether this model of individual responsibility is applicable to the Polynesian sub–cultures of New Zealand that do not prioritise the individual. Sligo, Jameson and Comrie (1998) suggest that this model has implications for those with a ‘collectivist’ cultural orientation, in particular Pacific Islanders, in how they will respond to making provision not only for their own health, but also future retirement and social security arrangements. They predict that such additional financial stress and insecurity, in an already over–burdened community, will negatively impact on the potential improvements that may be achieved through the employment of Cultural Safety principles. This position is supported by the Ministry of Maori Development: ‘Big advances in health will probably not come from the health sector alone or from narrowly framed health policies. Policies relating to housing, justice, sport and
leisure, employment, and incomes will have a greater overall effect on health’ (Ministry of Maori Development 2000, p.45).

While ‘lip–service’ is paid to the alternative Structuralist–Collectivist Health Promotion model (SCHP) for communities, few resources are allocated to ensure its successful introduction, nor does it receive a great deal of support from biomedically trained health practitioners. Additionally, as Richmond and Germov (2009) point out, the Structuralist–Collectivist approach should be about community–based, targeted initiatives and structural change. Instead it is frequently simply a disguised attempt at health education. These authors argue that without significant structural changes, such as power sharing of professional health monopolies and broadening the base concepts of what constitutes good health, there will not be significant improvement in community health. This is compounded when looking at issues of health literacy, particularly in non–English language communities. In relation to Polynesian communities, Robson and Harris (2007), Durie (2003) and others, agree that without a commitment to social justice, cultural reinforcement via traditional language programs, and whanau based health and learning initiatives, these communities will continue to flounder. Therefore, unless there is a broader social realignment, there will not be real progress towards sustained improvement in Polynesian health statistics for preventable illness and psychological conditions.

**Socio–economic disadvantage and the Australian health system**

The upward trend of Maori and Pacific Island immigration, combined with a high birth rate and an increase in family reunions with older relations moving permanently to Australia, would indicate the health of this population group will become increasingly relevant to the Australian health system (Rodriguez 2007b). Not only will more people be accessing the available services, but also for reasons discussed in this thesis, this population group experiences very high incidences of long term, chronic conditions which are taxing on the health budget. The question then emerges of how Polynesian migrants will fit into a health system which is already over–stretched in relation to the cost of treating debilitating chronic illness.

In 2007, a team of medical providers and health economists produced a national health ‘atlas’ of Australia, the Page Report (Page et al. 2007). They found that the majority of *avoidable* hospital admissions, over half a million annually, were related to chronic diseases, and were clustered around obesity–related conditions such as diabetes, heart disease, circulatory and respiratory disorders – all conditions that are highly represented in populations of low socio–economic status,
including the Polynesian community. The authors were especially critical of the lack of access to primary health care via general practitioners, or well resourced community health centres, which could identify and monitor these conditions to ensure they do not become serious enough to require hospital admission. From an economic point of view, the authors argue the cost of hospital admission far outweighs the proportionate outlay for thorough early intervention (see also Doggett 2007). The Page Report confirmed disadvantaged areas were over-represented in this regard. They recorded sixty-one percent more avoidable hospitalisations from deprived areas than from more affluent districts. In keeping with Michael Marmot’s findings in the United Kingdom and Japan (1997; 1999; 2003; 2004), this is also a sliding scale: the greater the deprivation, the higher the incidence of long-term, chronic illness. This pattern was confirmed in the Australian context by the authors of the Page report: ‘The distinct, socio-economic gradient that is reflected in these figures, increases with each increase in disadvantage, as do the rates of hospital admissions for these conditions’ (Page et al. 2007, p.11).

Although the scale of the Page Report is impressive, these findings are not new. Health economist Paul Gross, commenting on the report reiterates: ‘We’ve known for years that two thirds of those admissions were due to six or seven chronic diseases’ (Gross in Pirani 2007, p.21). He explained that in other parts of the world, hospitalisation for these conditions would be regarded as a failure of treatment. This reflects the design of Australia’s health system that acts on acute episodes presenting for care and not around the management of chronic illness: ‘Every government report for the last six years has highlighted this problem. It’s part of the benign neglect that masquerades for health policy at the moment’ (Gross in Pirani 2007, p21).

As maintained in Marmot’s body of work on the social determinants of illness, and illustrated in the Page report, the message clearly is that reduction in the social gradient is essential for better and sustained health outcomes. Reducing such disparities has become a platform of the ‘social inclusion’ agenda of the Federal government. A commissioned report found that thirty-five percent of people with low incomes reported fair or poor health compared to only seven percent with high incomes (Faulkner 2010). This has led to a rhetorical move towards greater public health spending and an expansion of primary health care delivery. However, as pointed out by Gross above, the Australian government has been repeatedly advised that the correlations between socio-economic status and health are actually fundamental to the budget ‘blow outs’ experienced in the state hospital systems. Despite this, there appears to be resistance to shifting focus, and resources, towards prevention in real terms (Doggett 2007).
The move towards ‘healthism’, encouraged under neo–liberal governments in Australia and New Zealand, puts the onus on the individual to achieve and maintain good health. At the same time there is a thrust towards community empowerment and ownerships regarding health. This may be confusing for those with low health literacy. The design and applicability of such community–based health promotion strategies is questionable if insufficient community consultation takes place, funding is inadequate, and local health workers are not sufficiently trained.

In the Australian context, for identified barriers to be removed for this migrant population, or even significantly reduced, the government has a great deal of work to do to provide culturally effective services. In order for health providers to deliver culturally appropriate services that engage a marginalised population, it is necessary to build strategic alliances within and between sectors. This, in turn, requires professional collaboration and an unprecedented commitment towards public health being regarded as a social issue. The rhetoric surrounding ‘social inclusion’ presumably seeks to reduce disparities and hints at a social justice agenda. It is evident, however, that without far–reaching changes to tackle entrenched social inequities, the good health and well–being of the poor and marginalised will continue to be compromised. As is clear in the case of the Australian health service, especially in the climate of ‘economic crisis’, there is currently a lack of cohesion, appropriate mechanisms, and perhaps the will to facilitate cooperation in the interest of achieving the best possible outcomes for health consumers, and the allied workers who care for them.

**Identity, belonging and well–being**

Migration and globalisation have meant Polynesians are experiencing rapid transitions in identity. Concepts of identity are bound together with relational notions of belonging and as such, are capable of influencing health outcomes (Polaschek1998; Ramsden 2000; 1992). As these and other authors point out, well–being is contingent upon security of identity and a sense of belonging in relation to people and place. In order to understand these transitions, it is first necessary to briefly explore the history of identity formation in New Zealand and the Pacific. Despite the pressures to ‘nationalise’ Maori and Pacific Island identities in the Anglo–European sense of ‘belonging’ to the country of birth, Polynesian identities are infinitely more layered and complex. It will also explore the extent to which Polynesians are able to retain the consocial nature of ‘collective identity’ common to Polynesian family and social life, and examine how this is progressively under challenge from pressures to assume an attributed ‘national’ identity in a new country. As each generation becomes further removed in time and space from their country of ethnic origin, it is
inevitable that young Polynesians will begin to assert a variety of ways by which they define themselves. Issues of identity also encompass notions of how the migrant is perceived by the host country, particularly in relation to a ‘visible’ minority group. I will discuss how gender plays a significant role in how Maori and Pacific Islander men and women experience being in Australia.

The post–colonial experience: Ascribing a national identity

Durie (2003; 2001) has argued that post–colonial dispossession of land has resulted in a complex erosion of autonomy and identity, contributing to a decline in health and well–being generally. Dissolution of tribal lands and decimation of language deprive colonised people of ownership of the traditional markers of identity. Land dispossession also permanently disrupted food supplies that formed the basis of social relations both within the tribe, as well as in terms of trading with neighbouring tribes, effectively shattering the traditional economic base (Kunitz 1994). Essentially, the colonial process dismantled the ties between sovereignty and identity.

In the pre–colonial Maori world, each iwi (tribe) and hapu (extended clan group) regarded themselves as distinctive cultural entities. Tribal lands were constituted within recognised territorial boundaries, and marked out the contours of tribal identity. However, with the ‘internal colonisation’ process, Maori were rapidly outnumbered by Pakeha, and the colonial bureaucracy set out the new terms for a contrived national identity. In the aftermath of the Land Wars, the colonial government embarked on a nation–building exercise: Maori names for people and places were replaced with English ones, Maori language was banned in schools, and tribal lands seized and re–branded as belonging to the Crown (Smith 1999; Walker 1989). However, despite assimilationist policies aimed at breaking down the vestiges of distinctive Maori identity, New Zealand has remained a land of two peoples. Subsequent identity formation for both Pakeha and Maori has been entwined and, thus, highly relational:

The post–colonial discourse has compressed Maori and non Maori together as ‘New Zealanders’. The ‘us’ was moved from ‘us’ meaning one’s own tribe and ‘them’ as other tribes …The ‘us’ became a Maori collective identity and the ‘other’ Pakeha. At this point the cultural identities were defined by each group, but in relation to each other (Stuart 2003, pp48–49).
In this post–colonial period, a romantic European notion of the ‘noble savage’ was allowed to play out around Maori identity. Fearsome warriors were now good manual workers. Cultural practices were regarded as quaint, obsolete, and on the brink of extinction. The artist Charles Goldie (1870–1947) was commissioned to depict the ‘dying race of the Maori’. Goldie’s sombre, maudlin portraits of chiefly Maori were etched into the national psyche as they formed the backbone of what every New Zealand school child learnt was art (Rodriguez 2003). His paintings with titles such as ‘The Last Sleep’ and ‘The Last of the Cannibals’ were reprinted and sold in every conceivable form. What had not been accomplished by the British in the form of outright annihilation of Maori in war, was now accomplished by presiding over the death of a culture. The European expectation was clearly that the remnants of Maoridom would assimilate on the fringes of society and full–blood, ‘real Maori’, would die off (Belich 1996; Salmond 1991). However, this did not transpire, and instead, what it meant to be Maori came to be defined by a deficit discourse: to be Maori was to be poor, living in over–crowded conditions, with little chance of educational achievement. It was also at this point (1940s and 50s) that Maori language reached its nadir, with fluency confined to the elderly (Maori Language Commission 2010).

The emergence of widespread resistance to colonial practices, and calls for independence by many colonised peoples from the late 1950s, in turn underpinned the radicalisation of the 1960s, 70s and 80s. Maori began to question and challenge the assimilationist agenda and assumptions of cultural extinction. Public figures such as Dame Whina Cooper led a resurrection of pride in Maori identity. Not only were tribal identities once again pronounced, there was a broader identification with indigenous struggles throughout the world. Activists from this period used many media including writing, music and filmmaking to lead a resurgence in all things Maori (Stuart 2003; Awatere 1982). During these three decades, mainstream New Zealand media continued to work hard to promote the image of a united country. As a possible concession to the ‘resistance identities’ being acted out in protests across the country, media criticism of ‘radical’ Maori was now tempered with images of ‘acceptable’ Maori – hard working, jovial and talented in sport and music. However negative stereotypes of Maori remained prevalent in what Walker describes as ‘a periodic recitation of Maori failings’(1989, p.43).

In the last twenty years, Maoridom, collectively, has become more assertive, and acquired more Maori–run media outlets, enabling more positive, self–generated depictions of identity. There has also been a rise in the number of Maori academics, lawyers and policy–makers who have tackled the more intransigent issues of social justice for Maori. However, despite these significant
developments, and New Zealand’s insistence that it is pursuing a genuinely bicultural and socially inclusive agenda, negative representations of Maori are not uncommon. It is in the media spotlight (and subsequently in the public perception), where vestiges of stereotyping and arguably, racism, continue. A spectacular illustration of this was in 2006–07, when a leading New Zealand genetic epidemiologist, Dr Rod Lea, delivered a non–peer reviewed conference paper to the International Congress of Human Genetics, based on a sample of seventeen Maori men. The team led by Lea concluded that Maori carried the ‘Warrior’ or ‘Violence’ gene. In an address before his presentation, Lea stated: ‘Obviously, this means they are going to be more aggressive and violent and more likely to get involved in risk–taking behaviour like gambling …’ (Lea et.al. 2006). In another provocative announcement to media representatives, Lea commented: ‘It is controversial because it has implications suggesting links with criminality among Maori people’ (Lea 2007). This led to an international controversy amongst geneticists and health sociologists regarding Lea’s assumptions in the absence of any examination of social causalities of ‘criminal’ behaviour (see Rodriguez 2009). Lea, and his institution, were criticised for a lack of scientific, academic and ethical responsibility, however, to a large extent the damage had been done. Maori people had, in the public mind, been scientifically proven to be inherently aggressive, unpredictable and violent.

Pakeha New Zealand’s relationship to the Maori remains ambiguous (see Jackson and Hokowhitu 2002). The ‘Warrior’ identity associated with Maoridom has been symbolically and shamelessly used to shape New Zealand’s national identity, yet at the same time is used by Lea and others, to condemn Maori behaviour. Hokowhitu (2004) argues this preoccupation with Maori as Warrior, has meant that other pre–colonial traits of masculinity regarding kindness, compassion and negotiating prowess have been subordinated. Hokowhitu argues that the characteristics of Maori as Warrior has been brought together under the aegis of blue collar labour and sport to such an extent, it is virtually impossible for young Maori men to generate an alternative vision of masculinity identity.

Similarly, in the Islands, people have struggled to re–define discrete cultural identities in a fragmented post–colonial world. Having seen their cultures compromised, and targeted for assimilation, many young, educated Pacific Islanders in the 1970s and 80s, began to challenge this erosion of identity. Tongan writer Epeli Hau’ofa has played a significant role in the renaissance of pride in being Polynesian, and his work has influenced many Pacific scholars on this topic. As a teacher in Tonga, he questioned the colonial history he was required to impart to his students, and the associated diminution of localised identity and accomplishments. Hau’ofa criticised (neo)colonial education as being self–serving, and devoid of any accounts of the great Polynesian
feats of navigation, monumental battles, cleverly negotiated pacts with former enemies, or inspired oratory. The preoccupation with European ‘advancement’ and dominion reinforced the concept that Pacific Islanders were invisible, powerless and without value. In his later work, Hau’ofa warned: ‘Belittlement in whatever guise, if internalized for long and transmitted across generations, may lead to moral paralysis, to apathy and (a kind) of fatalism …’ (Hau’ofa 1999, p.30). Hau’ofa and many other Pacific writers and academics have continued to fight for recognition of Island languages, and the promotion of a Pacific literature and curriculum, arguing that this is essential if young Pacific Islanders are to be proud, confident and productive in a contemporary world.

Polynesian women and the Western gaze

To many Australians, the recognition of the Polynesian migrant is frequently confined to men – footballers, bouncers and manual workers – an association delineated in purely physical terms (George and Rodriguez 2009). Hokowhitu (2004) and Tengan (2002) amongst others, have convincingly argued that this portrayal creates an ‘asymmetrical identity’ which is damaging to more complex and nuanced identity formation for young Maori and Pacific Island men. However, there is very little critical literature on the Polynesian woman also being defined in exclusively physical terms, particularly the Pacific Island woman. The ubiquitous image of the bronzed Polynesian wahine, neither black nor white, exotic and beguiling, is pervasive. Depictions of the ‘inviting’ Polynesian woman have been exploited tirelessly in adventurers’ tales of the ‘South Seas’, Hollywood films and tourism campaigns. It has been informed by, and reflects, a racial and cultural hierarchy whereby Pacific Islanders have been defined from ‘without’, through the Western gaze.

In this discourse of ‘hyper–femininity’, Polynesian women are depicted as beautiful, carefree, and abandoned, in keeping with the Western vision of wahine as sexual plaything. This has meant the Polynesian woman (read young Polynesian woman) continues to be seen in the West, exclusively in terms of her body and its erotic appeal. Pacific academic, Teresia Teaiwa’s work (1999), suggests this stereotyping has had a deleterious effect on Polynesian women in particular, and Pacific peoples more generally. Her work illustrates how the Pacific is regarded by the West as a vast strategic military outpost and recreational haven. These imposed roles act together to force the local communities in these small island nations to become progressively reliant on the ‘recreational dollar’. The local people themselves are attributed an identity in which they are simply regarded as ‘players’. Their home becomes ‘…a strategic and commercial space where European, American, and Asian desires are played out’ (Teaiwa 1999, p. 251).This global fantasy – seeing Polynesia as the ultimate holiday destination, and Polynesians themselves as good natured guitar players and
erotic dancers, prevents serious issues such as poverty, cultural and linguistic decline, and environmental degradation from being addressed. Instead, the archetype of a dusky Island maiden on a tropical island has become synonymous with ‘paradise’. The reality is that many of these women are struggling to earn a living, supporting large families on sporadic remittances from relatives abroad, and are experiencing the health consequences of preventable illness and stress (Bedford et al. 2009; Rodriguez 2003).

The body of the Polynesian woman, therefore, is a source of interest, and even fascination, for the West only when she is young and sexually desirable. As an obese, older woman, her visibility declines. While Polynesian men may get ‘socially rewarded’ for their size, the overweight Polynesian woman does not. The empirical work of Rothblum (1992) would suggest this is indeed the case. To be seen as slim and beautiful, as opposed to fat and ugly, dramatically affects one’s chances at gainful employment, desirability in the marriage stakes, fertility prospects and even to be taken seriously as a social contributor. When combined with poor educational achievement, the opportunities for Polynesian women to access high status jobs where they may exercise some influence in a particular field, are slight.

**Navigating hybrid, bicultural and migrant identities**

Bhabha (1994) contends that a hybrid identity or subject-position is emergent from interwoven elements of the relationship between the coloniser and the colonised. He argues that it is a reaction to an essentialist imposed colonial identity that is replaced by one that is ‘mutual’ and ‘mutable’. Bhabha (1996), therefore, conceives hybridity as a liminal or in-between space, where the ‘cutting edge of translation and negotiation’ takes place, thus forming a *third space*. Contested notions of hybridity have been extensively discussed by Pacific academics in the last two decades (Mila-Schaaf and Robinson 2010; Thaman 2009; 2002; Baba et al. 2004; Hereniko and Wilson 1999). These works trace the significant numbers of Polynesians negotiating both their own collective post-colonial identity and new identity spaces formed in response to migration and, in the case of Polynesian youth, global youth culture (George and Rodriguez 2009; Zemke-White 2005).

For many Pacific Islanders, such negotiation is complicated by being twice removed from their country of ‘ethnic’ origin. For example, many Tongans, Samoans, Cook Islanders and
Niueans who migrate to New Zealand first need to bridge a cultural division for their children – being New Zealand–born Islanders (Macpherson 2001). As increasing numbers are now migrating to Australia, there is a growing contingent of Australian–born Islanders of New Zealand–born parents in search of identity. As well as the complexities of identity construction inherent in this double migration, increased Pacific mobility has prompted a rapid rise of ‘mixed’ families both in New Zealand and in Australia. The Maori and Islander family, quite rare a generation ago, is now common in New Zealand, with the children colloquially referred to as ‘Hula Hakas’ in reference to the two cultural forms. New Zealand census data also indicates the Pakeha/Polynesian family is much more common in the last decade. It is also inevitable, as more Polynesians migrate to Australia, that the number of Polynesians entering partnerships with people from a vast array of nationalities and ethnicities increases. In turn, the children of these unions will need to access an identity space that reflects their notions of belonging in Australia.

In Pacific language, literature and the visual arts, the metaphor of navigation is frequently used. It resonates with the idea of successful movement between places of importance in one’s life (Rodriguez 2003). For example, in 2000, an exhibition was held in New Zealand, called ‘Navigating Identities’; a title chosen to reflect the increasing numbers of people in New Zealand, the Islands and Australia who are attempting to bridge the worlds of two or more cultures. One participant of European and Polynesian descent revels in the latitude her ancestry and multiple cultural inputs have given her work as a visual artist: ‘It gives you lots of freedom…you have got the right to explore everything and take what you want. You can sort of accept and reject whatever you feel like …like pick and mix!’ (Hastings–McFall in Genoux, 2000). However, for many young Polynesians, the search for identity is not always as relaxed and celebratory as for Hastings–McFall.

Once outside the country of birth, or ancestry, individual and cultural identity become more complex and difficult to express. How one describes oneself may need to be adapted to the extent of knowledge of relevant geographical and ethnographic information available to the other person. For example, a Maori who might describe themselves simply as Ngati Porou (their tribal affiliation) in New Zealand, needs to modify this in Australia as an attempt to help the other person locate his/her history. Many young Polynesians, therefore, experience ‘coming of age’ in a vastly different cultural landscape from that of their parents and family prior to migration.

For first generation migrants, in particular, their sense of belonging remains tied to their country of origin (Hamer 2007; Sundquist 1995). Even for those who are happy with their decision to move countries, there is nostalgia for what they have left behind: relatives, food, collective singing; things
that are missed. Often it is the visual arts which capture and reflect this longing, and provide the ‘cultural security’ of familiar imagery. Stuart Hall’s work on cultural identity (1990) describes the migrant experience, and the attempts to preserve cultural practice, as being comprised of similarities and continuities alongside difference and rupture. In the case of second generation Polynesians, certain cultural practices have been retained and provide continuity, in particular ritualised activity around food, singing and traditional tattooing. On the other hand, language retention and familiarity with tribal protocols have arguably been in decline (George and Rodriguez 2009; Hamer 2007).

Trying to preserve cultural practices in a new country, while negotiating something as primary as ‘identity’, brings challenges for individuals, families and communities. These challenges are heightened in the case of young people bridging the values of their community of ethnic origin, and the expectations of the host country, ostensibly their new home.

How young Polynesians construe competing forces for their identities is not straightforward. For Australian–born Polynesians, identity is not a ‘given’, it is created, and continues to evolve. In Hamer’s work (2008b; 2007), a significant number of Australian–born Maori participants remain strongly linked to New Zealand in identity and outlook – ‘home’ is still New Zealand. Other young Maori and Pacific Islanders have elected to use a ‘hyphenated’ status, such as Tongan–Australian, while others may choose to stay with a single primary cultural identification, for example, Tongan. Vilsoni Hereniko, who has written extensively on reclamation of Pacific identity, articulates the dilemma experienced by many Pacific Islanders living between two worlds: Polynesian and Anglo–European: ‘They feel Pacific (for example, in their love of laughter and generosity of spirit and their emphasis on people rather than things) yet speak English, wear Western clothing, and pay rent or mortgages’ (Hereniko1999, p.150). He suggests that the key to reconciling this dichotomy, lies in embracing the notion of hybridity, having two or more identities that reflect a composite of cultural backgrounds. This position is supported by the work of Mila–Schaaf and Robinson (2010) who conducted a large qualitative study of Pacific Islander teenagers and young adults. The authors found that those who were the most successful in terms of educational and work achievements, attributed their accomplishments to having a secure Pacific Island identity, as well the ability to understand and engage with Pakeha and move between these worlds.

There has also been an increased usage and recognition of a ‘Pan Pacific’ identity (Hereniko and Wilson 1999). More young Pacific Islanders in New Zealand and now progressively in Australia are identifying as ‘Pacific’ in a more generalised sense. This is enhanced by a range of popular
musicians and visual artists, primarily from New Zealand who promote Pacific rhythms and imagery in their work and unite under a banner of Pasifika (Rodriguez 2003).

**Consocial identity, belonging and well–being**

Security of identity is integral to a sense of belonging. In turn, ‘belonging’ is essential for overall well–being (Heil 2009; Derne 2009). Polynesians, as a result of colonialism, have been externally labelled, first as ‘Other’ to the European, then attributed an identity as nationals of the dominant colonial power. Consequently, Polynesians are Americans in the case of American Samoa and Hawaii, French throughout French Polynesia, variously British and German for Western Samoa and Tonga, New Zealanders for Maori and migrant Pacific Islanders – and now ‘Australian’ is added to this litany. Despite this legacy, Polynesians have continued to demonstrate a strong cultural identity. The core of this cultural identity and the continuity it provides, lies in its socio–centric, or consocial, formation.

Schmidt (2003) is also aware of the ways in which the Pacific sense of self and composite identities are dissimilar from the Western notions of the ‘individualised self’ which have become normalised, and arguably, valorised, in the Western canon. In describing her insights into Samoan identities, Schmidt’s explanation has wider resonance throughout Polynesia: ‘Samoan identities are predominantly sociocentric and relational and occur as a series of contextual, situational and collectivist arrangements in contrast to the more internal, egocentric and individualistic self of the west’ (Schmidt 2003, p.418). The complex and resilient nature of consocial identity is largely unrecognised and poorly understood in Western countries committed to the rights and development of the individual. This contrast is marked from early childhood. In terms of well–being and belonging, the experience of school ought to provide a foundation of social inclusion. However, this is rarely the case for Indigenous or non–Anglo children in the Western school system (Ford 2009). When a child brought up exclusively in a socio–centric milieu presents at school, they are subject to a bewildering raft of expectations tailored to the ‘individual’ child. The UNESCO chair of education, Professor Thaman (2002) argues there ought to be recognition and regard for the collective experience and shared cultural identity instead of requiring students ‘… to hang their cultural identities at the school gates …’ (Thaman 2002, p.26).

Entering the school system can be traumatic for any child, however for Polynesian children the sense of ‘not belonging’ can be particularly difficult. As Thaman points out, it is often at school where the Polynesian child encounters Western ways of doing things for the first time. There is
frequently an assumption by teachers that children will know how to deal with their ‘own’ bag, or lunch box, or pencil case. Confusion and embarrassment at not knowing how to do things becomes a hallmark of these early experiences. The ingredients for ‘belonging’ – shared references, language, food, familiar faces, and a sense of knowing how things work – are all absent. This situation is compounded by the unfamiliar content of curriculum. It can therefore not be regarded as surprising, that Polynesian children lag behind Anglo children when assessed by conventional measures. Negative experiences and feelings of exclusion at school are not confined to very young children. New Zealand actor, Nancy Brunning, sums up a familiar disillusionment for older Maori and Pacific Islander students in a Western education system that in no way reflects their current or historical reality: ‘School’s the place where you’re supposed to learn your history, but I had to leave to find out what really happened’ (Brunning in Brown 1994, p.178).

As described in Mila–Schaaf and Robinson’s (2010) work on Polycultural capital, in order for this situation to be improved, young Polynesians need to be comfortable in both worlds: their consocial home and community life and their Westernised, more individualised school lives can be better integrated. Polycultural capital also incorporates other forms of social capital, that have been previously described by Baum (2007) as Bridging and Linking (see also Szreter and Woolcock 2004). This is when people are brought together via social networks, who may have radically different lifestyles, employment status, and value systems. These operate across differences of culture and ethnicity by allowing members of a ‘subset’ (such as a Polynesian sporting club or church group) to meet and interact with another comparable subset of a different nationality or ethnicity with whom they might otherwise not engage. In this way, the notion of ‘belonging’ both in a cultural and civic sense may be achieved.

**Living – and dying – away from home: Implications for well–being**

In general terms, life expectancy has been extended in the Indigenous communities of New Zealand, Australia, Canada, and the United States. However, analysis of mortality trends in New Zealand in the twenty years from 1980 to 2000 revealed the gap in life expectancy between Maori and non–Maori has increased among both men and women: 6.3 to 9.9 years and 7.8 to 9.8 years respectively (Ajwani et al. 2003). So although Maori may live longer than they did fifty years ago, so indeed do non–Maori, hence it is the remaining differential that is important. These figures are similar for Pacific Islanders.
Upon migration, the issue of mortality (premature or otherwise) is highlighted. The overall health status of immigrants is usually higher than the comparatively aged host population. This is both because most people choose to migrate at a time when they are in the early to mid–stages of their working lives, and because of rigorous health checks and age requirements of the immigration process. However, migrant health statistics frequently show a pattern of deterioration in relation to the length of stay in a new country, and a parallel evolution of preventable ‘lifestyle’ diseases (Sundquist 1995; Hudson–Rodd 1994). Sundquist (1995) details many of the complex ways in which migrant health is related to how migrants are treated in the host country, in particular with regard to visible minorities. This is borne out by Robertson and colleagues (2003) who argue that along with ‘visibility’, the political climate of the host country and its overall attitudes to migrants, impacts on the health status of immigrants and how services are experienced:

The pathways by which migration contributes to health outcomes are complex and involve many mechanisms that may be of a biological, social and cultural nature. Moreover, the complexity also includes the attitudes towards migrants and the reception of migrants (Robertson et al. 2003, p.103).

Along with the political and socio–economic issues detailed in this thesis, Polynesian migrant health is contingent upon an understanding of how this population identifies itself in relation to place, in this case Australia. Given the demonstrated role of ‘belonging’, in the literature surrounding perceptions of health and well–being, the previously colonised migrant is doubly disadvantaged. Having first lost traditional lands to colonisation, they are struggling to find a new place of belonging in another country. Hudson–Rodd (1994) prioritises this aspect of ‘belonging’ as instrumental to good health, and lack of ‘belonging’ as a major contributor to ill–health, even with voluntary migration: ‘The ill health of indigenous peoples is directly related to place or more correctly to dispossession from place’ (Hudson–Rodd 1994, p.122). Hudson–Rodd has drawn out this connection in relation to specific ‘cluster’ ailments; namely coronary heart disease, elevated body mass index (BMI), high blood pressure and depression, all of which are presenting in the Maori and Pacific Islander migrant community.

Of relevance here is the how the death of a loved one in a diasporic community, has arguably an even greater impact than the death of that person ‘at home’. In the migrant context, relatives of the deceased have to negotiate both the Pakeha, or Anglo, bureaucratic demands, and reconcile ‘traditional’ cultural practices, and if necessary adapt or forego these practices (Rodriguez 2003). In this process they are often dependent on broader community support by those who are not
necessarily blood relations. There is also the trajectory of inter–familial relational dynamics that are disrupted by death, particularly sudden, or early, death. As Heil (2003) describes with reference to an Australian Aboriginal community, the highly relational nature of consocial Indigenous societies means the death of a family or extended family member is experienced through a complex web of social and cultural behaviours. Similarly, in the Polynesian community, there is a matrix of social and cultural commitments and engagements that are enacted when a community member passes away (Hamer 2007). For example, the death of an eldest child means not only that the immediate sibling order is changed, but also the cultural responsibilities associated with that position have to be re–negotiated and if necessary, re–allocated. In the migrant context, the next oldest sibling may not be in the same country and, therefore, family positions have to be renegotiated both at ‘home’, and in the new host country. The issue of where to bury the migrant dead, is also a profound question for the Polynesian community in Australia. Until the late 1990s, the body was returned to New Zealand or the home islands. In more recent years, older Maori and Pacific Islanders are choosing to be buried in Australia to be near their mokopuna (grandchildren) here (Rodriguez 2009; 2003). This, in turn, is causing biographical disruption for family members in the home country who are also in mourning for their mother, grandmother, aunty who cannot be buried in accordance with traditional lore ‘at home’.

**Conclusion**

For Maori and Pacific Islanders, it is within the framework of relational, consocial identity that acceptance and belonging is found. There is the security of knowing you are part of a family, and a broader kinship network. Your place is determined in relation to other family or tribal members. However, in the modern world there are frequently strains on the previously unconditional nature of this belonging. ‘Belonging’ and associated ‘well–being’, to the Polynesian mindset, are also inclusive of belonging to (and being responsible) for land. As land tenure has been decimated, particularly in New Zealand, the sense of belonging, as cited in place, has been massively eroded.

Colonialism has severed the connection between sovereignty and identity replacing it with an externally attributed national identity. Since the 1990s, New Zealand has cultivated a significantly more reciprocal relationship to Maori identity in particular, and a broader Pan–Pacific identity more generally. Pakeha New Zealanders have been required to ‘lift their game’ in relation to cultural knowledge and protocols and this has been incorporated, to some degree, in health practice in an effort to understand and improve Maori and Pacific Island health. However, unless the
recommendations of *Kaupapa Maori* and Cultural Safety are observed in relation to identity and belonging, progress is likely to be limited.
Chapter Four

Methodology

Introduction

The aim of this thesis is to examine how cultural practice and socio-economic disadvantage interact to contribute to the extremely high rates of obesity in the Polynesian and Maori community and to understand how Polynesian food practices reflect and reiterate notions of the body, identity and health. This research is also concerned with how social disadvantage compounds the incidence and severity of obesity–related illness in this community. Qualitative research was therefore undertaken that allowed localised Polynesian perspectives to be highlighted. This required cultural beliefs, understandings and protocols to be taken into account from the beginning of the thesis process. It was fundamental to the success of this research that Polynesian ways of looking at the body, social practices around food reciprocities and attitudes towards health and well–being were considered and respected. These issues could, therefore, best be examined through the culturally specific lens of Kaupapa Maori.

This chapter outlines the rationale behind the selection of Kaupapa Maori rather than a more conventional Western methodological model. My Insider/Outsider status as an ‘adopted’ researcher is explained in the discussion of the role of the non–Indigenous researcher. The Methods section of this chapter details how the participants were recruited, interviews scheduled and data collected. This is followed by an explanation of the data analysis methods employed and reflections on methodological practice. The final sections of this chapter explain the limitations of this research and a description of strategies in regard to the dissemination of the findings after the completion of this thesis.

Research context: The influence of Western colonialist methodologies

To explore research questions into Polynesian eating practices and their implications, as well as socio–economic factors affecting overall Polynesian health, the research design needed to be flexible and relevant to the community. The context in which the research questions were conceived was in itself, a transdisciplinary and inter–cultural undertaking. In seeking the most appropriate research methodology, I explored a variety of approaches to health research in Indigenous communities (Denzin, Lincoln and Smith 2008; Ferreira and Lang 2006). These were then compared and localised with Kaupapa Maori understandings of ethical research practice.
New Zealand scholars including Cram (2001), Smith (2000; 1999) and Stokes (1992) amongst others, have criticised poorly conducted research on Indigenous groups that has left a legacy of deep distrust and suspicion in the Maori community. As these authors point out, the results of unsolicited research have been used to justify policies and decisions that have been imposed on Maori, often with detrimental results. Similarly, Samoan and Tongan researchers in particular have become more vocal in their criticism of Western research paradigms and, specifically, the procedures and requirements of university ethics committees (Baba et al. 2004; Hereniko and Wilson 1999). These researchers maintain that Western social research is value-bound and historically and spatially formed in ways that reiterate the underlying colonial dynamics. They argue that it is only when (Pacific) cultural protocols underlie the research process, that there can be a valid account of local cultural practices.

Other Indigenous Polynesian scholars, such as Bishop (2008), Thaman (2009; 2002) and Graham Smith (1990a), also regard standard Western methodological processes as an extension of broader post-colonial practices that are reinforced primarily through the education system. These authors maintain imposing Western standards, goals and practices of research, has had a negative impact on the acquisition and transmission of knowledge for Indigenous peoples. As the seminal work of Linda Smith points out: ‘research is an important part of the colonisation process because it is concerned with defining legitimate knowledge’ (Smith 1999, p.173). According to Green and Glasgow (2006) the reliance on interventions founded solely on Western scientific knowledge, particularly among the health sciences, do not generally demonstrate the external validity necessary to appeal to, or comprehend Indigenous knowledge systems (Kendall et al. 2008). In order for this to change, Indigenous knowledges and methods ‘describing knowledge, explaining and reporting it must be those that allow for diverse backgrounds, multiple realities, processes and contextual protocols to be captured’ (Sanga 2004, p.47).

**Kaupapa Maori methodology**

The nature of this thesis, which explores issues of social disadvantage, culture and ethnicity in relationship to the health of a non-Anglo community, demanded an interdisciplinary approach involving elements of health sociology, medical and applied anthropology, and cultural studies. In the Australian context, the challenges of conducting research with Indigenous populations has been addressed by the National Health and Medical Research Council (NHMRC 2003b) and guidelines have been updated by the New South Wales branch of the Aboriginal Health and Medical Research
Council (AHMRC 2009). While both of these provide advice, guidelines and issues for consideration in embarking on such research, *Kaupapa Maori* methodology offers a more culturally specific framework in relation to Polynesians.

In choosing the methodology I wanted to consider the realities, languages and knowledges of Pacific people – a ‘southern’ perspective (Connell 2007; Mahina 2004; Hereniko and Wilson 1999). I also wanted a theoretical and methodological model that allowed my long term association and embedded status with the Maori/Pacific Islander community to be acknowledged. *Kaupapa*, therefore, emerged as the logical and most appropriate model to pursue. With *Kaupapa Maori* research the impact of social disadvantage and understandings of the linguistic and conceptual associations relevant to Polynesians and their perceptions of health have been developed in tandem with Cultural Safety (Williams et al 2003; Cram 2001).

*Kaupapa Maori*, the Maori Way, and its Pacific equivalent, *Fa‘a Pasifica*, the Pacific Way, implies that those who are being researched are accorded understanding and respect in relation to how Polynesian people regard themselves, their families, their communities and their health. *Kaupapa*, with its resonance and application for other Polynesian populations, has several dimensions that are valuable for this thesis. These concern the way the research topic is conceived, how informants are recruited and how the interviews are conducted in keeping with Polynesian protocols. Both *Kaupapa* theorists and Cultural Safety practitioners argue that if Pacific voices are to be heard, and the issues of ‘inclusion’ and ‘exclusion’ are to be seriously addressed, it is necessary to have more flexible, interpretive frameworks for methodological practice (Denzin, Lincoln and Smith 2008; Nabobo–Baba 2004).

Essentially *Kaupapa* as methodology and as theory are inextricably linked. As a methodology, ‘how’ the research is done is as important as the theoretical ‘why’ it is to be undertaken. The issue or research topic needs to have relevance to the community and be of benefit to that community. In this way, *Kaupapa*, as a methodological approach, sets out to balance the needs and interests of the academic research with the needs and interests of the people who are being studied (Smith 1999). In other words, the research participants are encouraged to understand the focus of the research, why it is being undertaken, and to be able to contribute to the discussion in a way that is culturally familiar and appropriate. Reflexive practice, in terms of which questions should be asked and the ability to elicit divergent responses, is part of the challenge and ethos of qualitative research in general. As
required by *Kaupapa*, strategies employed by researcher should be culturally appropriate and take into account the relational aspects of the participants and the researcher.

*Kaupapa Maori* is not premised on hypothesis testing, but rather, theoretical concepts and ideas are allowed to emerge from the data and from the research process itself. It allows flexibility in the use of direct and indirect questions, semi–structured interviews, narrative and cultural context. In this primary sense, it is an effective strategy to explore issues such as health and well–being in this population group. As a result, this study is not about neutrality. It is about giving voice to a group that is in many ways marginalised and self–contained. At the same time, this localised methodology generates ‘validity’ by examining all the data and differing opinions and applying the rigour of professional practice. The relevance of this study is that it encompasses the real concerns of participants and contributes to much–needed ‘baseline’ data on this migrant group. It is, however, not only of academic interest, but is intended to have resonance and application to the wider Polynesian community. As explained by Edwards, McManus and McCreanor (2005, p.2), *Kaupapa* ‘goes further to provide possibilities for creativity and innovation within a framework that is responsive, reflective and accountable’.

**The non–Indigenous researcher**

In New Zealand where this debate is significantly more advanced in relation to research with Polynesian groups, guidelines have been established for non–Indigenous researchers like myself, to engage with this community and conduct research that is respectful and relevant to the host community. In 1991, Ngahuia Te Awekotuku in conjunction with the Manatu community, produced a paper on research ethics outlining expected observances by researchers into any area of Maoridom (Te Awekotuku 1991). This framework, designed to respect and protect the ‘rights, interests and sensitivities’ of those being studied, also forms the basis of a code of conduct for the New Zealand Association of Social Anthropologists. During the 1990s, despite this recommendation, outside of anthropology little changed in the way research was conducted. It was not until Linda Smith (1999) made a compelling argument that the role of non–Indigenous researchers must change if we are to be trusted with a place in the ‘post–colonial gathering of people–based knowledge’, that the issue was taken seriously. Her seminal work on ‘decolonising’ Western methodologies has become the foundation for international Indigenous scholarship in regard to this issue (Denzin, Lincoln and Smith 2008; Baba et al. 2004). It was also immediately derived from the New Zealand experience. The challenge of producing ethical, culturally appropriate cross–cultural research practices has since been expanded by Tolich (2001) and Spoonley (1999) amongst others.
As with any enquiry into Indigenous issues, this generates the question: can Westerners truly understand, appreciate and evaluate the experience of the Other? (Rodriguez 2003). Pacific researchers are divided on this issue, with some suggesting that non–Indigenous researchers should not engage in fields of Indigenous study (see Baba et al. 2004). However, given that Anglo researchers are in the field, an accommodation has been reached in regard to research of issues affecting Maori and Pacific Islanders (Smith 1999; Spoonley 1999; 1995). There are several models that apply to non–Polynesian researchers, such as the ‘mentor’ model, where the researcher who does not have a pre–existing relationship with potential participants is accompanied by a community member when engaging in field work. In relation to my own status, within modern Maori research practice, the term ‘Insider/Outsider’, or ‘Participant/Observer’ has been replaced by the notion of ‘whangai’ researcher – meaning ‘adopted’. The distinguishing feature of this model is that the interviewer is recognised within the Maori community and has ties to the community that extend beyond the project in question and will be sustained at the completion of the project at hand. In other words, to be eligible for the whangai model, the researcher must have roots in the community before, during, and importantly, after the conclusion of the project. This terminology reflects the on–going association of the researcher with the extended community above and beyond the traditional research parameters. The protocols within these communities demand a process of introduction of where the interviewer comes from and how they fit into the community. Identifying in this way is contrary to the usual conventions of ‘objectivity’ in Western research practice, however within the Kaupapa Maori paradigm it is regarded as essential. My extensive on–going involvement in the Sydney Maori and Pacific Islander community has given me invaluable insight and familiarity with the cultural and social practices of the community. This relationship was also instrumental in the access I had to potential participants.

Participants

The participants for this research are Maori and Pacific Islanders, over the age of eighteen, living in Sydney and Hunter region of New South Wales. Their backgrounds comprise those who migrated some decades ago, some recently and others who are born in Australia. The total number of interviewees was sixty–seven, comprised of forty family participants, fifteen focus group participants, nine individual participants and three key informants. A summary of participants’, migration histories, and income and education levels are available in Appendices A, B and C.
A combination of pre-existing associations and ‘snowballing’ was used. As is culturally appropriate, recruitment began with securing the key informants. The first, a male nurse of Niuean ethnicity, was a friend and colleague who agreed to participate. The other two Maori participants, a male and female, who are registered nurses working in Newcastle, were suggested via other contacts. All were born in New Zealand. The Nuiean male nurse trained in New Zealand and the Maori nurses in Australia. These three participants have all had a great deal of experience working in the Australian health system. These in–depth interviews took place over several sessions. This was deliberate as it provided an opportunity for them to reflect on the earlier discussions and think what they would like to include, change or expand on in subsequent sessions. For these health workers it was a welcome opportunity to express their concern at the escalating rate of obesity–related illness and mortality in their families and communities. Their observations and suggestions were extremely important for any long term recommendations that may be extrapolated from this thesis. They also played a role in further recruitment of participants by suggesting individuals and families who would be interested in participating and introducing me to these prospective informants. This was particularly useful in relation to obtaining interviews in the Hunter regional area. Participants were chosen to provide a diverse cross–section of Polynesian migrants in relation to age, marital status, parent status, those who were employed and unemployed, skilled and unskilled, with and without tertiary education, and primary carers for an aged or disabled family member.

**Method**

I spent a great deal of preparatory time with the key informants discussing the nature of the research being undertaken, explaining the process, talking through with them what they felt were relevant issues to be discussed and how to best approach the extended families. As advocated in the power–sharing model of qualitative research (Smith 1999; Patton 1990), they were also instrumental in the design and content of the Information Statement and Consent forms (see Appendix D). The tone and content of the Information Statement and Consent forms were straightforward and used language designed to result in genuinely ‘informed consent’. In the case of participants with whom there was not a pre–existing social or kinship relationship, I distributed the Information Statement several months ahead of a potential interviewing date, so that the decision to participate could be discussed among family members. As a result, participation rates were high and this allowed me access to a wide range of community members.
From the outset, my established role in the Sydney Maori/Pacific Island community and familiarity with Pacific protocols, enabled me to cultivate community participation within the guidelines of *Kaupapa*. For example, in general terms, it would be difficult and considered impolite to interview people on an individual basis in the family home and not speak to other family members. In order to speak to the family, it was necessary to speak first with the nominated head of the family and explain my relationship to the community and other participating families and individual participants. On most occasions I arranged to meet a family member ahead of the interview, to discuss how best to approach their family in regard to the issues being raised in this research and be alerted to any topic that might be offensive or upsetting to family members. As described above, they would then offer to introduce me to other families within the extended community. This works well in a Polynesian context. It is in keeping with the fundamental premise of *Kaupapa* methodology, which is to know and be known to your research subjects.

Each stage of this research project needed to be handled carefully and discussed with key informants and other community members with whom I had a pre–existing social relationship. As there are five discrete cultural groups represented in this thesis, it often required considerable periods of time to set up meetings with members of the various communities. It would then frequently be suggested I see another more senior community member and so on. I was fortunate to have considerable experience in this area, and the support of key informants to help me negotiate this process.

For this thesis, data was largely gathered via in–depth interviews informed by my long term participation in the community. In other words, ‘face to face’ – a prerequisite of the *Kaupapa Maori* paradigm. This provides a rich base in order to come to a more detailed understanding of how Polynesians construct their world based on their own accounts and observations from within a social collectivity. In my long involvement with the Maori and Pacific Island community it was clear to me that many Polynesians may be reluctant to speak to a Pakeha outside of their extended family group and may refuse to do so. This can be explained in terms of both intra and extra–cultural reasons. On occasion this may be for reasons of shyness (*whakamaa*). For others, it may be that within traditional cultural parameters there are protocols governing who can speak to whom, who can speak for others, and where the discussion may take place. In the case of younger people (under thirty), most would still seek permission from older family members or community elders before agreeing to speak to a researcher, particularly a Pakeha researcher. It was, therefore,
important to allow enough time, often several months between initial contact and agreement to interview to transpire.

The interviews were digitally recorded and complemented by note–taking immediately afterwards. These notes mainly comprised the ‘mapping’ of family relationships and biographical details to supplement information that was recorded. No more than one interview was held on any particular day. Even when people were to be interviewed in their own home, there were still delays for reasons such as waiting for the originally agreed participant/s to arrive home, or for other people in the extended family who wanted to be there, to arrive. In addition the interview structure needed to be flexible enough that people who were not originally set down for interview, could in fact participate if they were over eighteen, understood what their involvement entailed and agreed to the conditions required.

My involvement with the Polynesian community has provided a background of participation/observation on which I could draw throughout the process of data collection and, later, analysis. For example, during all interviews for this thesis, there was a great deal of eating. I took significant amounts of food to each interview and additional ‘food presents’ such as cans of corn beef. In the Polynesian schema, anything of importance must be done around food, and while sharing food. In all incidences, a vast array of foods were offered. This provided me with an opportunity to observe each person and family’s eating practices first hand as Participant/Observer. In terms of cultural practice, it is not considered polite to ask direct questions of this population group, hence the relaxed nature of sharing a meal, allowed a natural forum in which to discuss food.

**Family groups**

Semi–structured interviews were conducted with nine Polynesian families, a total of forty participants. These families were identified and approached as described above, and most were interviewed in their own homes. Conducting interviews with family groups, while time consuming, was extremely productive. It afforded greater insight into eating patterns across the generations and revealed more diverse examples of transitions in cultural eating practices. All interviews took several hours which allowed time to situate myself as a person in their home, effectively a guest. This also encouraged participants to relax, and express themselves in a leisurely manner, on their own terms.
Within a *Kaupapa Maori/Fa’a Pasifica* paradigm, traditional languages and cultural practices are incorporated into the research process. This allows for the extended family to be integrated into the research experience, and acts to harmonise different strands of research enquiry. The relationships within and between the researcher, participants and their families was thus enriched by having family members present who may, or may not themselves be officially recruited participants. In several cases, grandparents were ‘visiting’ from New Zealand or the Islands, and would not normally have participated in such a process. Of these, some chose to give consent and participate and others preferred not to do so. This was brokered by the senior family member involved, and not by myself as the researcher.

**Individual and focus group interviews**

Having conducted a ‘family interview’, it was then acceptable for me to follow up with questions to individuals from that family. In the case of other individual participants and the two focus groups, most participants were in the age group twenty to forty, and these interviews were more easily obtained and constructed. This cohort was also more forthcoming with answers to questions concerning the body, for example, that would be difficult with older family members present. They were also more willing to describe their relationships and economic status. The focus groups consisted of a variety of young people who were working, studying, unemployed or caring for family members. These discussions provided insight into the many forms of hybrid cultural practice being enacted in this migrant community and discussed throughout this thesis.

In the case of Pacific Islanders in particular, these are very conservative Christian communities that require sensitivity to explore questions related to the body, for example (see Tamoefolau 2004). Another issue is that, many older members of these communities have poor English language skills. If the family preferred, a younger family member acted as an interpreter. However, in the majority of cases, my familiarity with ‘Island English’, and appropriate forms of address, allowed me to ask questions in a way that was respectful and non-threatening and this helped secure the engagement of these older community members who might otherwise have not participated in this research. For

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9 The term ‘Island/s’ is used both as a noun and adjective. ‘Island’ has meanings that are descriptive, such as ‘Island time’, or doing things the ‘Island way’, or can have a more specific contextual inference, such as ‘talking Island’ means speaking Rarotongan if you are talking to Cook Islanders, or speaking Samoan if you are talking with Samoans.
example, when an elderly Tongan grandmother was present (unexpectedly) at a pre–arranged family interview, I adjusted my behaviour by sitting on the ground at her feet and not producing the digital recorder until an hour’s conversation had transpired. She later commented that I had very good manners for a white woman. Additionally, she actively recruited more members of her church group to participate in this study.

In producing interview transcripts, in some cases I have corrected gender pronouns as Pacific Islanders in particular, tend to inadvertently change these. For example, ‘My nephew, she’s been here for one year’. Familiarity with Island English, and the overall context of the discussion, means I was able to determine if the noun or pronoun was correct. I have included as much ‘authentic’ language and cultural expressions as possible into the extended quotes, with translations where necessary, in order to provide context and also allow local understandings of an issue to be highlighted.

In relation to the confidentiality of families, in the Appendices they are identified by self–defined ethnicity and residential region. Focus group and individual participants are described in terms of ethnicity, gender and age. In the results chapters, specific ethnicity, gender and age are used for all participants to enable the reader to ‘place’ the dialogue, for example, ‘Tongan male, 35’. On occasion, an informant might be described by another distinguishing feature, such as ‘Maori mother of seven’, or one participant aged eighty–five, who was referred to as ‘Tongan grandmother’ and her husband as ‘grandfather’ in deference to their age and family status.

The data for this thesis was based on observation and semi–structured interview responses. These mixed techniques allowed for stories to be told. This was valuable, not only for making the participants feel more comfortable, but also because the nature of stories provides context, nuance and complexity to understandings of this community in relation to the issues under discussion. As Eastmond (2007, p.261) suggests: ‘Such stories, properly situated, can rather bring out more clearly the ways in which experience and agency are socially and culturally mediated phenomena’.

Data Analysis

In regard to analysis of qualitative material, Kaupapa has similarities with Grounded Theory (see Glaser 1998; Glaser and Strauss 1967). It is essentially driven by those who are affected by the research and issues of importance are emergent from the qualitative data. As described by Thomas (2003) the fundamental purpose of such an inductive approach ‘is to allow research findings to
emerge from the frequent, dominant or significant themes inherent in raw data, without the restraints imposed by structured methodologies’ (Thomas 2003, p.2). This is in contrast to the logico–deductive nature of grand theories. Because of this, flexibility is needed by the researcher in terms of what is regarded as important, or central to the thesis. Research notes taken immediately after interviews were an important resource to clarify and prioritise participants’ responses. Detailed memos helped my understandings of how certain questions provoked different or more detailed responses and such observations were then incorporated into subsequent interviews (Bryman 2012).

Adherence to a culturally defined process, and familiarity with culturally distinct forms of expression required of a Participant/Observer has helped identify and define the aims of this thesis and refine the primary research questions. The focus, therefore, is on the narrative of participants using the epistemological approach of Kaupapa Maori. In this way interview content is examined through discourse analysis of family, as well as individual and focus group contributions, to elucidate participants’ discursive constructions of their bodies, health and wellness. I also draw upon the approach of van Dijk’s (2009, 1993, 1991) critical discourse analysis, which situates ‘texts’ within their socio–political context. Focus is given both by explicit expression as well as what is implicitly said. As van Dijk notes, the ‘analysis of the “unsaid” is sometimes more revealing than the study of what is actually expressed in the text’ (1991: 114).

Interview data were manually hand–coded thematically in two stages. The first was in regard to issues identified by community members such as their concerns surrounding high rates of diabetes and premature mortality and difficulties associated with maintaining cultural integrity in a migrant context. These were then integrated into the following broad themes that reflected the research aims and semi–structured interview schedule: perceptions of the body, health and well–being, identity (cultural and transpersonal), food practices and socio–economic positioning. In this way, analysis of interview content focussed on the following issues:

- Food consumption patterns within family, extended family and community
- Household income and distribution (including government benefits)
- Gender distribution of household and community tasks
- Household overcrowding
- What constitutes ‘wellness’ from the Polynesian perspective
- Points of access to health information and care
- Identifying bridging and linking opportunities for Polynesians in relation to existing services
I also looked at various ways of evaluating social capital, or the structural relationships that support networking within and between community members and other outside organisations. This was achieved by talking about the sporting, church-affiliated or other civic activities that involved the family or family members and encouraging participants to estimate how much time, energy and money were allocated to these. These responses were then discursively analysed into areas of relevance and commonalities shared between participants, and points of departure, or difference, noted.

In terms of the on-going impact of economic disadvantage, and potential social and cultural measures employed to offset this, open questions were asked, such as:

- What proportion of household income is spent on food
- Education levels and employment patterns
- Number of people (and ages) in a household
- Number of school age children and sharing of opinions as to how they are achieving at school
- The number of younger children receiving formal pre-school care
- Are there one or more private vehicles and/or access to public transport
- How many people (not living in the household) are being supported by this economic unit, eg. elderly relatives still living in the Island
- What proportion of household income is given as tithe to the church and remittances

In some cases, participants could be asked directly about their income. In other cases, I estimated from extended conversations, what the overall household income might be. For example: ‘My husband is on a disability pension, so my eldest daughter can’t work’. The implication is that the daughter is effectively the main carer for the father that could then be clarified by further questioning. Amounts beneficiaries received were calculated from generalised Centrelink tables.

Not all participants were directly asked their educational status, in order to avoid feelings of embarrassment or discomfort. However, this information often emerged through their personal narrative, particularly surrounding work prospects. This was then integrated into the participant’s profile. School achievement was discussed more openly in the focus groups and with the individual participants. Their insights into their own experience and that of other family members allowed patterns to be identified such as the lack of formal early childhood education across these communities.
Reflections on methodological practice

Participants were self-identified in terms of their own ethnic and cultural identities. There were further considerations, specific to these groups, that needed to be taken into account in achieving culturally acceptable research practice for this thesis. As with anybody being asked to divulge intimate details of their lives, Polynesian informants are likely to disclose information only when they feel trust has been established, and the context is appropriate. Trust is an integral component for research of this nature. Lincoln and Guba (1985) set out to establish ‘trustworthiness’ as an essential criteria for good qualitative research practice. This encapsulates the more conventional methodological concepts of validity, reliability and significance that are applied to quantitative work, and replicated in relation to qualitative studies. This notion of trustworthiness is relevant not only to the reliability of qualitative research results, it also has implications in regard to the researcher/participant relationship, processes of analysis and the management and dissemination of data.

Credibility and trustworthiness, in relation to this research project, was heavily dependent on my long term association with the extended Polynesian community and demonstration of family ties. This meant interviewees had faith in my commitment to a research process that reflected their real concerns, and trusted me to handle their stories with care and discretion. The application of Kaupapa Maori as methodology also addresses Lincoln and Guba’s (1985) notions of dependability, ensuring that the data collection, analysis and generation of theory are integrated. This is related to another aspect of Lincoln and Guba’s work, confirmability, or how well the findings are supported by the data. In this thesis, the process of data collection and analysis was dependent upon local understandings of the issues under discussion, and was designed to reflect Polynesian perspectives and solutions. In this way, the findings are directly generated from analytic outcomes of the data. Another important component of good qualitative research practice is the issue of transferability – whether this work can be applied in other related research endeavours. The uptake of Kaupapa Maori theoretical and methodological principles by an increasing number of researchers concerned with Indigenous health is indicative of its flexibility and applicability to other Indigenous and migrant population groups (Denzin, Lincoln and Smith 2008; Baba et al. 2004). In addition, health workers and researchers in New Zealand have for some time been employing these techniques as a form of ‘triangulation’ in relation to their own empirical research findings (Bramley et al. 2004; Cram 2001). More recently in Queensland, van Driel and co–researchers (2009) and Bedford and colleagues (2009) have been advocating for this method of triangulation of data on Polynesian health issues. In this thesis, I have used this method to verify my own findings by
comparing the corresponding empirical data and the work of other qualitative researchers in this field.

**Limitations of qualitative data**

The same methodological problems that have challenged researchers into issues affecting other Indigenous and migrant populations were experienced with this thesis. Government ‘paperwork’, such as ABS forms, do not allow for the reality of the extended family to be assessed or described. The mobility of extended members, the shifting definitions of roles within the family and a fundamentally different concept of what is a family, makes it virtually impossible to reduce these arrangements to a tick in a box (see Durie 2003).

Another limitation involves the nature of the topic itself – the health and well-being of a CALD (culturally and linguistically diverse) population. While this thesis is extensively informed by health sociology, it is not attempting to encompass a biomedical approach to the health status of participants. Those interviewed were not asked directly about their personal health status or that of their families. This information was often forthcoming, however, in the narrative flow of the interview. It may well be productive in future work to include specific questions on the incidence of known disease or ailments per household grouping.

At times I was conflicted between my role as a postgraduate student answerable to the Ethics Committee of an Australian university, and as a ‘whangai’ researcher in the subject community. For example, some people would volunteer to participate because I had been recommended as someone to ‘trust’ – regardless of the topic to be discussed. In other words, these people may be willing to engage in the process, but may not be aware, or have had time to digest, what might be involved. In these cases, I thanked them for their willingness, but declined to interview them. This meant that fewer participants were interviewed than may have occurred without such reservation. This returns to the questions of direction and ownership of the research. Within an exclusive *Kaupapa Maori* paradigm, community participants would have had a greater say in what research should be undertaken and how this should be done if not for the constraints of a doctoral thesis. Similarly, with the issue of confidentiality. If conducted outside these particular academic guidelines, *Kaupapa Maori* would allow participants to describe themselves more openly in relation to their family names, tribal identification, kinship descent and other features actively discouraged in the Western ‘ethics’ model.
Communication of results

The founding theorist for Kaupapa Maori, Graham Hingangaroa Smith, argues that this model encourages a more widespread ‘ownership’ of research than the traditional model of Western institutions (Smith1997; 1992). Kaupapa methodology lays the foundation for further participant negotiations within and between groups. This has particular relevance for the Key Participants and focus group participants who are currently studying at tertiary level and wish to work towards better health outcomes in their communities in the future. It employs techniques in common with the methodological practice of Transformative Research (Chiu 2003) and Smith (2000a; b), setting up a structured dialogue using a variety of methods to share knowledge and analysis to develop practical actions that may be observed and actioned.

In practical terms, participants as stakeholders fall into two main groups. For many, the sharing of information with myself is a ‘gift’ and there is a bond that the information will be handled in good faith. With this group, to ‘take back’ the results may be regarded as socially awkward or even insulting. For others, particularly those with an understanding of tertiary education and research goals, there is an expectation that the finished work, or at least a summary of findings, will be made available to them. This summary can then be used by them as a referenced text for their own studies or to lobby for future support from strategic organisations. In regard to my own involvement with the extended community, I intend to undertake future research on this topic in collaboration with Maori and Pacific Islanders in New Zealand and Australia who share these concerns.

Conclusion

The methodology of Kaupapa Maori has done a great deal to move towards a more inclusive approach in regard to the contribution of participants and to promote a synthesis of various disciplines in this research. A commitment to the relationship between the researcher and participants, as described in this chapter, has also influenced the selection of recruitment techniques and underlies the decision not to use a written response format such as questionnaires, but rather employ a semi–structured interview format that allows people to tell their own story in a way this is not hurried.

It is a requirement of Kaupapa Maori that non–Indigenous researchers should not only be aware of the basic customary protocols of a particular person, tribe or clan group being studied, but ensure that their project is wanted by that person or group. This does not necessarily mean the research
must be initiated from within the target group, but it is important that the aims and processes be explained in terms of local understandings. With Kaupapa Maori methodological practice there is a responsibility and expectation that the research process should aim towards making a positive difference to the community and those who have contributed. It further requires that the collection and analysis of data needs to be driven by an ‘Insider’ perspective, allowing for recognition of cultural practices, languages and ways of seeing the world. It is the understanding of the interrelationship between history, culture, language and lived experience that determines if the research truly reflects the voices of those being studied.
Chapter Five

Introducing the participants in their socio–economic and cultural context

Introduction

This chapter sets out to establish context for those interviewed regarding education, work, and sample household dynamics. These ‘snapshots’ of educational status, work skills and the socio–economic profile of Polynesians in this study are explored in conjunction with social and cultural modes of understanding. This is in keeping with one of the pillars of Kaupapa – Kia piki ake i nga naruraru o te kainga that reflects on causalities and experiences of socio-economic disadvantage. This addresses issues of socio–economic positioning and its mediation in relation to broader issues of social justice and marginalisation. Embedded are elements that cover individual and family income, over–crowding, informal adoption, and interrelatedness that form a nexus between cultural practice and associated notions of family, and class positioning. In this chapter I will set out to review how the socio–economic circumstances of the participants confer a particular social status that is associated with a range of lifestyle behaviours that arguably undermine good health. These same behaviours, regarded in Western terms as precursors to poor health, are also examined through the lens of Polynesian cultural practice. I will, therefore, examine how many of these practices are regarded differently in the context of Polynesian perceptions of health and well–being.

Education and employment: Realities, aspirations and limitations

Most interviewees who were themselves the ‘economic migrants’ – those who moved to Australia for work – admitted finishing school ‘early’, the equivalent of year 10 in Australia. The majority of participants remain unskilled with a small number engaged in semi–skilled work, such as book–keeping and allied trades to the building industry (see Table 1). In the family groups, there were no ‘professionals’ as such, but there is a growing expectation that the next generation will attain improved educational competency and have significantly greater opportunity for wider career choices. With the young people (aged 18–25) interviewed individually, or in a focus group, approximately one third were studying at tertiary level, or intending to study (see Appendix C). The majority of these participants planned to enter teaching, nursing or social work. For these younger participants, there were slightly more females than males entering tertiary education.

A marked difference between Maori and Pacific Islanders in this cohort was that more Maori had trade skills from New Zealand. Despite these trade ‘tickets’ not being recognised in Australia, most
participants appeared content to accept the higher wages in Australia and ‘prove themselves on the job’, rather than re-train. Nearly all adult women in this study worked outside the home (see Table 1), and predominantly in unskilled work. However, for Island women this was with greater reservation, and more likely to be part-time, than with Maori women who expected to work full-time and did not report any concerns regarding this.

As Hamer (2007) and other studies have pointed out, Maori and Pacific Islanders remain concentrated in blue collar work. This was also the case with this cohort. As one participant commented: ‘Everyone thinks we’re bouncers and shearers, and I think that’s a stereotype, but then, I don’t know any Maori accountants’ (Maori male, 24, musician). Many participants were aware of the drawbacks of depending on your body to sustain manual labour into middle age. Many also expressed concern regarding their vulnerability as unskilled workers in a volatile market place. These tended to be the main factors in wanting their children to have a better education and employment opportunities.

Not all participants were directly asked their educational status, in order to avoid feelings of embarrassment or discomfort. However, this information often emerged in the context of other dialogues surrounding work prospects:

Most of the Maori men in Australia are in blue collar jobs. That’s what happens when you leave school early. The problems come later when their backs are shot and they are still only in their forties and they want to work (Maori male, mid 40s, truck driver).

I didn’t get much education. It was more important for me to find work, so as soon as I left school I started working in the building industry. The problem is, without schooling you can’t progress. So far I’m alright, the money is good, but I also feel I’m getting too old to be doing what I’m doing (Samoan male, 48, construction worker).

Concern about the contraction of the building industry and other changes to the workplace are evident in the following comments:

All the Island men I know used to work in construction and security, and now that’s drying up. It’s starting to stress everybody out (Tongan male, 42).

I come from a shearing family – we all worked as kids, mum, dad, nanna, all of us, but that way of life is going now. I don’t want my kids to work that hard. In the cold, rain … I want them to have nice jobs (Maori female, mid 30s).
Expectations that their children will ‘do better’ by having greater educational opportunities is widespread. This is frequently associated with the idea that their children will then receive ‘respect’ that is not accorded to blue collar workers. The following exchange occurred within one Samoan family:

Wife: Two of our sons work, but I worry about them on the building site. What if something happened to them? One of the girls wants to be a teacher. They’ve seen me work – I work part time, helping children [teacher’s aid]. I hope she goes to university.

Husband: I would prefer my sons to go, but they don’t have the brains.

Interviewer: So you’d be happy for her to go on studying?

Wife: Yes, yes. It would be important to have a teacher in the family. So many of the Islander kids need help. If she goes to university the young ones will look up to her.

What the above statements illustrate is that parents harbour ambitions for their children beyond blue collar work, and that a child who achieves a middle class profession will bring prestige to the family. There is also an expectation that the community will benefit: the mother noting that the daughter, should she become a teacher, will be a role model for the extended community. However, these expectations can also be a source of stress for the student and these issues were discussed in the youth focus groups.

Participants were divided as to whether they regarded education as ‘better’ in New Zealand or Australia. Those who thought it was ‘better’ in New Zealand cited a more sympathetic cultural climate overall, reflecting greater visibility of Polynesians and a respect for Maori and Pacific Islander protocols. An example of this position is from a Maori mother of four children, two of whom were educated in New Zealand, and the younger two are in school here:

Over in NZ they are taught te reo [Maori language]. The families can go to the school. They have mentoring programs – it’s heaps better than when I was at school. My kids here don’t learn anything about their culture. I suppose that’s fair enough – they are not from here, but I don’t think they learn anything about Aboriginal people either (Maori female, late 40s).

However, other participants expressed the belief that their children were better off being educated in Australia. To paraphrase these responses, it appears they feel their children are not labeled as ‘dumb’ and ‘lazy’ and ‘hopeless’ as they were in the New Zealand system. Most parents appeared pleased that more of their children were staying on to Year 12 in the Australian system, however
this may be more to do with government policies that have been introduced in recent years, designed to increase school retention rates.

It’s better over here in Oz – our kids aren’t told they are lazy horis [perjorative term for Maori]. All the kids are treated the same (Maori mother of three, 35).

If you ask me, in New Zealand, Polynesians are still second class citizens [there]. Our kids just feel they are dumb. It’s not all of them, but most of them, hate school and come out feeling they’re not as clever as Pakeha [Anglo] kids’ (Cook Island female, late 40s).

My boys are going through to Year 12 here. If we’d stayed in New Zealand, they’d probably be in a gang by that age (Maori male, 40).

The young adults interviewed for this thesis offered a mixed response. Most felt Polynesian children were struggling in the Australian system, at all ages. This was mainly attributed to poor literacy levels and lacking confidence in their social skills in a predominantly Anglo environment. They also thought their parents wanted them to do well, but were unaware of the pressures their children were under in the Australian school system and at tertiary level, and did not know how to support them in their educational aspirations:

I know for Tongan kids at primary school – they just don’t know what’s going on. For the older ones it’s bad too, particularly for the boys. They fall behind, then they blame themselves; they just feel dumb (Tongan male, 23).

I know, it’s the same for the Maori boys. They are just doing time till they leave (Maori female, 20).

Most of our parents can’t read and write too well, so they have no idea what is going on at school. They don’t read any of the stuff that comes from the school, they just hit the kid if they don’t do well (Samoan male, 22).

Our parents want us to do well, but they don’t know how much pressure is on us at school. We get huge amounts of homework and then our parents just say: Get up and go to church. Go look after your sisters. Go get dinner. Go bath the babies – when are we going to do homework? (Samoan female, 22).

Concern about Polynesian teenagers (mainly, but not exclusively females) being expected to do the majority of the housework and childcare while studying was commonly expressed throughout the focus groups. It was often accompanied by an awareness that in Australia their peers from other ethnicities, most specifically Anglo, were not expected to carry such a large domestic workload.

One of the key informants for this thesis commented on the widespread practice of exclusively depending on family members for pre–school care, and is concerned about its implications, both for
the teenager who often has responsibility for a number of young children, and for the young Polynesian child entering the Australian school system. She identifies both economic and cultural obstacles in preventing a greater uptake of pre-school care for children of Maori and Pacific Island migrant families:

I think we expect too much of our teenagers – they are the unpaid babysitters. They have no choice. It’s hard for them to get any school work done. It’s a bit of a worry really. Our kids [Maori] are going to school and they’ve never picked up a pencil. They can peel potatoes and change nappies, but they can’t count to ten in English or Maori. I’m torn on this issue, because I want my own kids to spend time with their grandparents and learn te reo [Maori language], but if they don’t go to pre-school, how are they going to learn how Pakeha [Anglo Australians] think, and what’s expected of them in school? I think this is worse for Island kids too. Some of them have never seen a Pakeha except on TV…. And our kids are so shy – they are taught to never interrupt, never have an opinion … how are they going to engage? (Maori female key informant).

The same key informant also argues there is an economic disincentive in that the cost of childcare in Australia is prohibitive to Polynesian families who may have little interest or regard for the perceived values of structured care:

For most Polynesians, there is no way they would put their kids into childcare. They couldn’t afford it for a start, but they don’t want it. They don’t understand how important it is for the child’s development; they would just think you are mad – why would you pay someone else to look after your children – what’s wrong with you? Where’s your family? And to leave them with a Pakeha – what planet are you from? (Maori female key informant).

While many of the Maori participants could grasp the advantages to more formalised pre-school education, cost was still prohibitive:

That is the dilemma of being a mum and wanting to provide for my kids and give them stability and a roof over their heads. It is not that it is a drain, but it is probably my main focus at the moment, to earn money [to set up her own home]. I can’t afford childcare. That’s why I live with dad. He’s the babysitter, but really he’s just going to stop them killing each other (Maori single mother, mid 30s).

The implication of this last statement is that her father would make sure the children would be safe, but would not be equipped to offer them structured pre-school play. By contrast, for the majority of Islanders, the idea of childcare outside the family is bound up with cultural and Christian values which regard this as an inferior solution to keeping the children at home during their pre-school years. For an older Tongan woman, recently arrived from the Islands to look
after her own grandchildren, the concept of sending small children to childcare appears perplexing. Her suspicions are that parents just ‘didn’t care’, and that the children would not be taught basic practices to enculturate them into the Tongan way of life:

I think it’s not good in Australia. All the mums go to work. Who’s looking after their kids? Some have family but some just don’t care. Their kids will end up going bad. They won’t know their culture and they won’t know how to behave (Tongan grandmother).

The data illustrates the discrepancy between the elevated expectations of educational achievement by the migrant parents, and their ability to adequately support their children in this attainment. The Polynesian child who is expected to be domestically competent at an early age, is not necessarily being given the tools they need to feel comfortable and achieve within the new host environment of Australian public schools.

**Household over-crowding: Is it a problem?**

It is common to have considerably more people in a Polynesian household than in an Anglo–Australian household (Hamer 2007; Rodriguez 2003). The average household composition in this cohort was 9.5 persons. This is almost four times the number of people in Anglo–Australian households. According to Australian Bureau of Statistics (ABS 2010) projections to 2016, Anglo–Australian households currently have 2.2 occupants and this number is declining. There has also been a reduction in completed family size and increase in one/two person households. This is the converse of the Polynesian experience. Participants in this study have indicated that there is a steady stream of relatives arriving at their doors without the financial resources to house themselves in a new country. Within the framework of extended family reciprocal cultural practices, these new arrivals are usually integrated within the existing familial structure and expected to contribute in ‘cash or kind’. If they are working, their financial contribution will be decided for them, and usually distributed by the man or woman who may be considered ‘head’ of that particular household. If they are not working, they are expected to provide a service in lieu, for example, becoming the primary childminder or carer for a disabled or elderly relative.

In Polynesian families, there is a lot of movement of people within and between households. Increasingly often, a grandparent is brought over from New Zealand or the Islands to mind the children of a working couple. Also, the practice of informal adoption within families (whangai), is extremely common. This is usually where a child is ‘adopted’ by a blood relation. The practice of
was extensive in pre–colonial Polynesia and continues to be widespread today (Ritchie and Ritchie 1983). Levy’s ethnographic work (1973) concluded a quarter of Polynesian children were not raised with their biological parents, but by extended family members. There are many and various reasons for this. For example, should a teenage girl be considered too young to effectively parent a child, the baby may be ‘given’ back to the parents and will be raised as a younger sibling to the biological mother, or the baby may be given to another older sibling or cousin with an established family. Similarly, should someone in the extended family be unable to have children, they would typically be given children by their own siblings or cousins. Frequently, it can be to create gender balance in the household as illustrated in this response: ‘My sister had all boys so we sent our youngest girl to live with them’ (Maori woman, 35). Sometimes, it may also be in the interests of the child’s long term educational or sporting prospects as other relatives may live closer to a better school, or, indeed, a mixture of these reasons:

My biological mother was very young when she had me in New Zealand. She was only a teenager, and the family decided to give me to my mum and dad [whangai parents] in Sydney. They knew I’d get a better education over here’ (Maori male, 35, brought up by his aunt and uncle).

For an ‘outsider’ to understand the seemingly casual nature of this practice, and the special place of whangai babies and children, it is essential to appreciate that to the extended Polynesian family, all the children are our children in the first place – a departure from the Western nuclear family mindset. For the older family members making the decision about where a child shall live, this process reinforces deep cultural bonds between branches of the family. In the cohort for this thesis, the practice was widespread with most family households having whangai children adopted both in and out, and several focus group participants referring to the practice. However, now more people are living in different countries from each other, and marrying people of other cultures and ethnicities, this practice may be under challenge in the future.

Polynesian teenagers who are not working in New Zealand, or the Islands, are often moved to Australia to look for work, or care for relatives in another branch of the family. One Maori family described those currently living in the household, the informal adoption of a sister’s children, and the pending arrival of the teenage sons from the husband’s first marriage. Their comments also outline how the income derived from a number of sources is effectively pooled and allocated. With the exception of one family (Eastern Sydney 1), all other family households described a similar fluctuating dynamic:
Maori woman, late 40s (HS): Oh you know how it is … one of our daughters moved out, then moved back in – with her boyfriend and a baby. Then my sister threw a spanner in the works. She left to go back to New Zealand and her husband is working in the mines, so we [herself and another sister] took her kids.

Sister (PS): I took the girls and HS took the boys. I got three and she got two!

(Note: this sister also lives in the same house, so these nieces and nephews will also live there, but shift their primary affiliation to their new ‘mums’).

Interviewer: So how many people are living here now?

Husband of HS: I don’t know myself. We’ve had to get a floor plan out for sleeping! My two boys are coming over to live here soon [teenage boys from New Zealand]. I don’t know where they’re going to stay [laughing].

HS: They can go in the garage, we’ll put in bunks. I don’t want them tramping in and out all night.

Interviewer: How do the finances work out?

Husband of HS: All of them chip in except the baby!

HS: Yeah, most weeks they all give something. I try and grab the money before they go out. When the boys come over [referring to working teenage sons of husband] I’ll commandeering their bank accounts from the start.

HS: Let’s see – I earn $600 a week after tax, my sister earns more than me, she’s on about $700? [sister nods]. My daughter is on a single mum’s benefit [$350] until Xmas, then she has to get a job. The boyfriend isn’t working so that’s got to change … Our son earns $450 and gives us $200 – that’s full board and he’d eat that! My nieces – two of the three are working and they each chip in $100 a week until they earn more money. And him, his business [referring to husband’s trucking company], costs about $50,000 year to run without wages, and he gets about $50,000 back so that’s that. We get by and we’re managing to pay off this house.

As most participants were living in 3–4 bedroom houses, this would be considered a situation of household ‘overcrowding’ by Western standards. However, for the participants themselves this did not arise as a ‘problem’. As one university student commented: ‘I’m studying social work at uni, and they go on about ‘overcrowding’, but we don’t see it like that. There’s ten people in my house, that’s just how it is in Polynesian families’ (Tongan female, 22).

**Housing status, household income and distribution**

With the exception of three family households, all Sydney residents are renting. Many of those renting expressed feeling financially stressed and frustrated that they would be unlikely to ever afford to buy a home in Sydney. By contrast, most participants in the Hunter region were in the process of buying their own homes and one family had achieved this. Therefore, it would appear that the dream of home ownership is prompting ‘on–migration’ out of Sydney, especially to the
Hunter and south–east Queensland. For the first time, more Maori live in south–east Queensland than Sydney (Hamer 2007).

The average number of people per household in this study was 9.5 persons (6 adults and 3.5 children), Table 1 gives a detailed breakdown of income for family participants. The lowest family income (sole parent with dependent child) was $650 a week, and the highest (6 adults, 8 children) was $4,680 from waged work and two government benefits (aged and disability pensions). Most families had incomes of over $2,000 per week. The majority of income was spent on housing and food. As demonstrated in the diagram, a significant proportion of household income is laid out in relation to expenditure on food. The second biggest outlay was in terms of rent or mortgage payments. For a more detailed breakdown of household composition and income, see Appendix A and Table 1.

**Disposable income: Where does the money go?**

The majority of Polynesians who come to Australia are economic migrants who are driven by the availability of well paid work in this country and the overall employment rate is high (Hamer 2007; 2009b). Findings for this thesis reflect those of Hamer and the Australian Bureau of Statistics (2006) in that income is spread over a great many more people in a Polynesian household than an average Anglo–Australian household. Total income available to a family is usually distributed in a number of ways: immediate expenses concerning those resident in the household, supporting people in the extended family (*hapu*) in Australia, New Zealand or the home islands, and, particularly with Pacific Island families, ‘donations’ to the church. In other words, no matter how much income the family acquires, the financial expectations of family and community will absorb this, making accumulation of even modest wealth virtually impossible:

> Everyone in my extended family knows when I get paid. Sometimes it feels like every Samoan in Australia wants me to pay for something (Samoan male, 27).
>
> After the tsunami [in 2009], we all knew our family in the Islands would need more money. We already send about $200 a week – that’s between three of us. Now our parents have said we must send more. Sometimes I only get $20 for myself after working full time (Tongan male, 28, earning approximately $800 per week).
>
> All my wage goes to my family. There’s often nothing left. But my boss, he’s an Aussie, he’s really good and tries to slip me some of my wage in cash so I can go out (Samoan female, 20).

Overall, Maori families do not remit money regularly to relatives in New Zealand, but rather, give a lump sum for special occasions instead. Maori workers over the age of 18 and living at home, are
usually allowed to keep their wage, with an expectation that they contribute an arbitrary amount towards the household. With the Island families, as with the examples above, any worker or beneficiary is expected to give their entire income to the core family unit, and be given a very small amount of money for discretionary purposes. The rest of the pooled household monies are distributed according to priorities set by the ‘head/s’ of household, commonly a husband and wife team.

For Islanders, contributions to the church,\(^\text{10}\) and extended family members still living in the Islands, are accepted practices. However, these financial demands are beginning to cause tensions with the younger working adults who have been raised in Australia (see Wynhausen 2008). In this data, it was difficult to separate remittances (sending money ‘home’ to relatives) and tithe (payment to the church). Frequently, money given to relatives to help with an issue of health or housing, is then given to the recipients’ church. As the Niuean key informant commented: ‘Islanders would rather donate to a church and have everyone pray for them, than spend money on medicine that might improve their health’. Because this practice is so widespread, I have listed these amounts together. The average amount outlaid to the church and family members abroad was $166 per week. However, this amount does not include the misinale, an additional annual church contribution in Island communities. For Tongans, the misinale ‘requires’ a donation upwards of $10,000 per family. Also, for all Island communities, christenings and weddings incur an obligation to contribute large sums of money to the church. As this does not include other ‘emergency’ situations, such as flying in a seriously ill relative from the Islands for health treatment or an unexpected funeral, the outlays for Island families are considerable and, progressively, a source of financial stress.

Again, to an ‘outsider’, it may appear strange to pay significant amounts of money to the church and to family members you may never meet. Indeed, these practices are siphoning weekly household income that could, in other circumstances, help improve the lives of family members in Australia in many ways. However, there is a web of reciprocities represented by the misinale and remittances that inform the apparent dedication to the practice from first generation Island migrants. An hypothesis by Lee (2006), is that remittances give Islanders abroad a sense of ‘paying’ for the cultural integrity of those behind in the Islands. In other words, relatives still living in the Islands

\(^{10}\) This can mean there are contributions to be paid to the local church here in Australia, and the ‘mother’ church in the Islands. Sometimes spouses are of different denominations, and so this process is doubled.
are regarded as less Westernised – the custodians of traditional language and cultural practice. This sentiment was prevalent amongst the older Islander participants:

We have to send money home – they are the guardians of our culture. We owe it to those who can’t leave, to keep our culture alive for us – and the language (Samoan female, mid 40s).

In Australia it is easy [for them] to forget they are Islanders, their blood is Island blood. I tell my children and my grandchildren that – even if you were born here – never forget the ones back home. They can teach you your culture. That’s why we send money to our families back home (Cook Island grandmother, mid–50s).

Young adult Tongans interviewed in Wynhausen (2008) acknowledge that these economic practices can cause hardship and deprivation, and may well be challenged or discarded by the next generation. Most of the younger participants in this thesis exhibit some degree of resentment and/or ambivalence regarding the expectations of tithe and remittance:

When I was young, I used to watch my parents work really hard, factory work, struggling to feed eight kids. As I got older I used to resent it – they’d put in hundreds of dollars a week and we’d have to do without. I said to my dad ‘Why are you giving it all to the church? Dad, we are the poor!’ All I got for that was a hiding for being cheeky and disrespecting the church. Maybe it’s changing – I’d still say 90% of Islanders send money back home but now people are struggling to live in other countries, they really, really can’t afford it (Niuean key informant).

I’m hearing more of people here [in Australia] losing their homes over money for remittances and church donations. Some complain about this, but it is difficult to challenge – it is regarded as the ‘Island way’. I doubt the younger ones like myself will keep it up – I don’t know (Samoan female, 25).

We used to send back heaps, but once you’ve over here for years, you start to get slack. Well, not slack, we tend to still put money away for airfares and tangi (funerals) and stuff. But I know my kids won’t do it (Maori female, mid 40s).

Many Polynesian families are struggling with the economic constraints of looking after large families in marginalised, working class communities. However, in the case of Pacific Island households, there is the additional strain of meeting community and religious ‘obligations’ that are arguably exploitative. As a Tongan participant explained, it is not difficult for a self–appointed ‘reverend’ to demand payments from poorly educated church members, under a guise of cultural reciprocities:

In our church no one goes to theological college or anything. It wasn’t until I started going to university I realised things were actually going very wrong in our community and in our church. It’s like a cargo cult – is that the right word? Anyone can be a minister. He just sets up
a new church. His relations follow him to make up the numbers. Then everyone starts paying him. Next thing, he’s in a four–wheel drive, kids at a good school – but what about the others? [church members]. They tell us it’s the Island way, but in the old days, you would just take flowers and food – that was the Island way. I don’t trust these guys any more. They have affairs, they have children out of wedlock … all they have to do is make a payment themselves to the church and all is forgiven. I know young Islanders are getting really sick of it, but they don’t know how to change it (Tongan female, 46)

Given that most Polynesian households have several adult and young adult incomes coming in, individual Pacific churches have done well from this practice.

Conclusion

The data reveals the practical correlations between low income status and poor health may be exacerbated by high rates of work in dangerous industries (such as security work, mining, and construction), and poor educational achievement. Although younger participants are staying at school longer and are entering tertiary education in greater numbers, their parents (the economic migrants), and grandparents, are arriving in Australia with low educational achievement which frequently translates into low health literacy in the overall community.

It is evident, that although many households have a reasonably high combined income, this is utilised in ways that reproduce patterns observed in New Zealand and the home islands. Firstly, many more people are supported by the income earners in a Polynesian home, compared to an Anglo–Australian household. Additionally family demands in the form of remittances for relatives overseas, and contributions to churches both in Australia and abroad, are impacting on the amount of disposable income available to family members. These factors arguably restrict the ability of Maori and Islanders in Australia to engage in upward ‘class mobility’. However, there are many positive outcomes for Polynesians who pursue this collective family–oriented lifestyle and sharing of assets that offset the financial limitations illustrated here.
Chapter Six

Food and lifestyle: The *habitus* of Polynesian migrant households

Introduction

Food has an ostentatious place in the Polynesian social order. This chapter will examine cultural practices around food, and eating, in order to understand the intrinsic and complex way food operates in Polynesian families and communities to sustain social relationships and shape identity. Food has also become a repository of health concerns and post–colonial anxieties, in particular via the current rates of obesity–related illness facing this extended community. This chapter contains a discussion on traditional food practices and how these have been retained, or modified in the Australian context. It also examines perceptions of participants about why they choose to consume the foods they do, how and where this occurs, and the cultural associations it may have for them.

From a Polynesian perspective, the offering of food to another person or group is regarded as a friendly act, just as the acceptance of that food is an indicator of willingness to partake in this relationship, forging new affiliations, or strengthening existing bonds. While most cultures have a strong food tradition and pride themselves on generosity and hospitality, the sheer scale of the food exchanged and consumed by Polynesians is what is at issue here. The quantities of food that are consumed as part of the Polynesian lifestyle are prodigious, and arguably excessive, especially to the Western gaze that privileges moderation in food consumption as integral to social acceptability, beauty (attractiveness) and health. The lifestyle issues of smoking and exercise are also discussed in this chapter. This chapter explores what was described by Bourdieu (1984) as *habitus* (in this case the normalised values, tastes and behaviours of a working class community), interacting with cultural practice in ways that reduce the likelihood of full engagement with public health messages aimed at reducing the incidence of obesity–related disease through increased exercise.

Eating as a legitimate pleasure

To a Maori, food is where it’s at. Food is better than sex. There’s nothing beats sitting down with your *whanau* [family] and having a gigantic feed –then you have a nap (Maori male, mid 40s).
Tongans are big eaters and that’s the truth. An ordinary meal, compared to an Australian meal is so much. With Tongans we have a tendency to eat as much as you can – its pleasure…. even in the olden days …(Tongan female, 46).

Eating large amounts of food, over and above what is required for sustenance, is a practice that has roots in pre–colonial Polynesia and continues to have a resonance around notions of ‘pleasure’ and happiness. For Maori, all the broader Polynesian associations with eating large amounts of food in a collective context are active: food is still the centerpiece of large social gatherings and the sharing of food is part of the daily lives of most families. Food is freely given and exchanged and remains a site of deep pleasure, both as a physical sensation and an expression of positive familial and communal bonding.

These associations are also active for Pacific Islanders. However, in addition, for the majority of Pacific Islanders the rhythms of church life are integral to their overall lifestyle. Family domestic and social engagements are much more closely aligned with restrictive nineteenth century church practices than is typical for New Zealand Maori. Within this framework, food – eating – becomes the only ‘legitimate’ pleasure allowed within an overall context of self-control and social vigilance. This is particularly true of Mormons, Seventh Day Adventists and Presbyterians who do not drink alcohol or smoke cigarettes. As one focus group participant explained: ‘If you’re brought up SDA [Seventh Day Adventist], food is everything. You can’t drink or smoke – and you can’t have sex until you’re married’ (Samoan female, 22). As most members of these denominations also do not drink tea or coffee, they are colloquially referred to as ‘Milos’ by other Polynesians, in reference to their drink of choice, even on special occasions: ‘My cousins are all Milos. I feel sorry for them, ‘cos they can’t come out and go to a nightclub with us’(Tongan female, 24).

The Islander participants in focus groups also pointed out that in their communities, food and the pleasure of eating, was regarded as an earthly pleasure sanctioned by God: ‘It’s like in our church – we aren’t allowed to do anything else … our family does not approve of alcohol, we can’t go out … so we just eat. Everyone sees it as our reward from God. Food makes our people happy’ (Samoan female, 18). Depending on family circumstances, in this schema God may be attributed as providing food for a family in which there is no wage earner, despite the food being provided by relatives or bought with government benefits. In another example, God is regarded as having brought home the workers safely from a dangerous workplace, an event worthy of feasting:
God has been good to us. We always have food, even when we first came over [to Australia].\textsuperscript{11} My parents planted out a vegie garden. Now I have two boys working in the mines in Western Australia and I am worried, but I know God will look after them. They work hard there. We’re having a feast for them – they are coming home for Christmas (Tongan female, mid 40s).

As community members would have prayed for their safety in a dangerous work environment, the planned feast acts both to celebrate the boys’ return home and is a social reward for others in the community who will get to enjoy an Island feast.

The data for this thesis reinforces the findings of Higginbotham and colleagues (2010) and Pont’s (1997) studies of working class coal mining communities; that to eat large amounts of food, in an accustomed way, reinforces family bonds and is a reward for hard work. To take away the pleasure of eating certain foods and replacing it with fear and anxiety about the type of food, analysing its content, and restricting the amounts eaten, means a break with tradition: ‘If feelings about food were to change from being a source of easily accessible comfort to only a further source of restraint, the whole relationship between hard work and the system of morally appropriate rewards would be upset’ (Pont 1997, p.241). In this way, ‘traditions’ of class combine with cultural traditions to establish certain eating patterns that may, when observed as part of the middle class discourse around good health, appear to be detrimental, but persist because of emotional and cultural gratifications these afford. In New Zealand, Evans and colleagues (2003) examined the reasons behind the persistence of Pacific Island eating habits in defiance of the ‘health message’ regarding over–eating and the onset of type 2 diabetes. The authors determined there were a myriad of cultural associations with an array of food types and eating situations, and that it would be extremely difficult to modify this behaviour.

**Traditional food, its processes and practices**

There are many differences between Pacific Island food preferences and those of Maori. These have emerged both through availability of certain foods due to the radically different climates of tropical Polynesia and New Zealand, and also the period of exposure to Western foods. I will first explore Pacific Island foods and food practices and then discuss why ‘traditional’ foods are very different for Maori.

A study of the Cook Island diet in the late 1940s by Faine and Hercus (1951), describes a community in transition from subsistence agriculture to a waged–based economy. Staple foods such

\textsuperscript{11} The implication here is that this was before family members attained work.
as *kumara* (sweet potato), *taro*, and its leaves (*rukau* greens), breadfruit, arrowroot and green bananas were common foodstuffs that formed the basis of the daily diet. Coconuts were also consumed daily and in many forms. The watery contents were given to babies as a supplement to breast milk and the flesh used in many dishes. Dairy products were extremely rare and limited to a few days a month after a refrigerated boat had arrived. Protein was principally provided via fish and other seafood. Fresh meat was a luxury item, mainly pork or chicken, and was reserved for special occasions such as a ritual feast. At the time of their study, breakfast was bread without butter and tea without milk, or no breakfast. The main meal was lunch, with an evening meal similar to breakfast. Although imported tinned meat, flour and sugar were becoming more readily available and sought after, they were expensive by local standards, which inhibited the take-up of these products by most families. By the 1980s, as remittances arrived from relatives abroad, imported food was being more readily consumed, particularly tinned meats, sugar and margarine, and vegetable oil replaced cooking with coconut oil or water. This pattern of advancing consumption of processed foodstuffs was similar throughout the home islands of all participants.

An older couple now in their eighties, grandparents in one of the family groups, share their memories of food growing up in Tonga in the late 1940s:

Grandmother: Well now it’s all from the shop isn’t it? We ate everything fresh. We grew everything.

Grandfather: Yeah, you didn’t just sit around, walking to the fridge and back.

Grandmother: The food in my country now is very bad. When I was little the people never got sick. We never saw a fridge. We had a good life in my country because we ate the leaves, mainly *taro*, and the ripe banana we cook it with water, not oil, we eat that everyday. I like pawpaw. Everything was fresh – no food left for the next day, unless they are cooking the *umu* [underground fire pit], then they knew it would last to tomorrow, that’s all. They never ate any processed food, never. The people in my country never got sick because they never ate food from somewhere else, only local.

Grandfather: The people take sick now because the food is from overseas. Food in a freezer and then they bring it to Tonga! Tongan people eat fish and sometimes we kill the pig because we feed the pigs and chickens. But you know, mainly it was the coconuts – you could show off to the girls how you climb a tree and bring her coconuts.

In the Islands, it is the ubiquitous coconut that forms the basis for many traditional dishes, both sweet and savoury. For example, *mitiore*, which is grated coconut fermented with onion and seafood is extremely popular throughout the islands, particularly for the elderly, and until about twenty years ago was eaten daily. Nowadays, it is prepared for big family meals at the weekend and for feasts. The following description of the preparation of *mitiore* by a Cook Island participant is
significant for several reasons. First, it is illustrative of the crossover between ‘traditional’ and ‘Christian’ value systems and practices in the Islands, as the overall structure of domestic labour is centred around a Christian framework. Second, the gendered division of labour is both traditionally based and yet modified through a Christian lens. In pre–colonial Polynesia, men fished, prepared the fire pits and grated the coconut. Women would collect seafood from the shallow lagoons and weave the coconut and banana leaves into baskets and platters for the food to be prepared and served. While this still occurs, since the missionisation of the Islands, the women’s work has become more oriented towards ‘cleaning the house’ (Tengan 2002; Bolin 2004).

I’ll tell you how it was for me growing up in the Cook Islands. The food for Sunday is usually prepared the day before. Men and women have different jobs. The men and boys go and get the crabs and things. It’s their job to peel the taro and the other vegetables. They have to make sure there’s enough firewood for the oven [underground fire pit]. The girls, they have to do all the housework – everything spick and span, do the washing … Sometimes my mother would take me or one of my sisters and get the rori pua (sea cucumber). Then we’d come back and clean them. The mitiore takes a day and a half to make because it has to marinate…. So after the dawn service [on Sunday], you have to work on it and add the coconut. Then we go back to church. After the second service, around lunch time we would eat (Cook Island female, early 70s).

Similarly, a Tongan participant shared her experience:

Saturday is a big work day [domestic chores and food preparation] and Sunday we do no work. The feast on Sunday is when you are getting together, all the family. In Tonga everybody’s house is open to each other. It’s the Tongan lifestyle, their houses are open. If you’re hungry you just stop by any house and if people were eating …but Sunday is family day. Saturday people like to do their washing, get everything done. Saturday is a big thing for them. That’s the day they prepare for Sunday, which is a sacred and special day. On Sunday there is no work, you’re not even allowed to go without a shirt. The children don’t play. There is so much restriction in regards to the people, how they dress for church and even if you stay home. In the old days, all the food was fresh and prepared at home (Tongan female, late 40s).

As described by these participants, the relationship of church, social and family life is firmly entwined. The prohibition of work on the Sabbath is strictly adhered to and the focus is on accomplishing all extraneous domestic tasks in order to devote the entire of Sunday to worship and eating.

While the term ‘feast’ is still used in relation to the Sunday meal, this is more usually a very generous smorgasbord of foodstuffs, rather than the large scale ‘feasts’ reserved for signature community and family events. Interestingly, the enforced nature of the Sabbath, and its reward of
eating a substantial Island meal, has arguably led to the retention of certain traditional food practices that may otherwise have been discarded as being too labour intensive and time consuming for a busy working family. The following statement displays a range of sentiments concerning the preservation of such traditional food practices, perceived health benefits of traditional foods and the social role they play:

We now have the challenge to keep our culture strong – to teach the young ones about traditional foods and their health benefits. Many of these foods are really excellent. We have to be careful with all these Palangi [Anglo] foods – not just about getting sick – but our culture revolves around how these foods are prepared. We share so nobody does without (Samoan female, 38).

It is considered important that the children of each new generation learn the skills of how to select, pick and handle all types of traditional foods, including vegetable, fish and meat sources. This is important for health reasons so people do not get food poisoning, but it is also an opportunity for the old people to pass on the traditional associations of particular foods, such as taro being associated with physical strength. Along with the gathering of ingredients come the stories from pre–colonial times of the gods and goddesses, such as Talanoa, god of the sea, common to all Polynesians with slight variations in spelling. Stories of Talanoa contain elements of marine knowledge that are essential for a sea–based island culture. The repetition of ancient techniques employed in the gathering and handling of foods affirm continuity of tradition, while the cooperation necessary for everyone from oldest to youngest to contribute to the meal that will be eaten, reiterates intergenerational role positions. In addition, the nature and quantity of these foods permits generosity and communal sharing.

For Maori, there have arguably been two significant departures from food preferences and practices of other Polynesian populations. New Zealand with its comparatively harsh, cold climate meant early New Zealand Maori were forced to adapt to a different diet on arrival. The plentiful fruits of tropical Polynesia were no longer available, and food needed to be cured and preserved to provide nourishment during the difficult winter months (Bentley 2007; Bellwood 1987). These early Maori adapted extremely well, as evidenced by their fine stature and relative freedom from illness. As previously discussed, imposed colonial occupation meant access to traditional lands and hence the capacity to grow their own food was greatly diminished. Combined with the colonial co–option of Maori into waged labour, these factors have translated into a more Westernised diet for Maori over a longer period. As a direct consequence of the
colonial process, the Maori diet deteriorated markedly in the first decades of occupation as more families came to rely on inferior quality purchased goods that had survived long sea voyages, and were introduced to nineteenth century cooking techniques of the urban European poor.

When Maori talk about ‘Maori food’, what they really mean is meals such as ‘boil ups’ which we got from the Scottish settlers. It became about feeding a big family cheaply. It’s food from the Depression years – a big pot of stew boiled for hours … bread, potatoes, and dumplings which are really just flour and water. You didn’t want the kids to go to bed hungry. We stick some puha [watercress] in, but the rest is not really traditional (Maori female, 66).

Despite these pressures, many Maori still maintain certain practices such as netting eels, fishing, diving for paua (abalone), and collecting puha (watercress). Many older Maori continue to produce working gardens with fruits and vegetables. Durie (2003) and other commentators point out that these are a healthy source of both fresh food, and also well-being, as the cooperation and physical effort needed to acquire these foodstuffs are beneficial in their own right. However, it is the hangi (meat, vegetables and sometimes seafood cooked in the ground) that remains the highlight of Maori social gatherings. Taking many hours like the Island umu, the ‘pulling up’ of the hangi still has the power to resonate with expectation: ‘When the men pull the hangi up, there’s always that slight worry – is it cooked? Did the fire go out? I still find it exciting and my kids want to learn, so that makes me proud’ (Maori female, 42). Not only is there the excitement of seeing a great many relatives for the event being celebrated, there are the anxious moments when the pit is opened, and if the fire has not been set properly, it may have gone out meaning the food will be inedible. The quality of the cooking is a source of pride and family prestige. A raw, or partially cooked hangi is a massive disappointment and reflects poorly on the family hosting the event, hence the participant’s children expressing the desire to learn how to do it properly.

While efforts are underway in New Zealand to reclaim the use of more seafood options, vegetables and herbs that were commonly used in pre–colonial, and early colonial times, the exposure of Maori to European foods has occurred over a sufficient length of time, that arguably, the modern Maori taste for such ‘Indigenous’ foods has diminished (Randell 2010). Combined with the globalisation of commercially produced food, the modern Maori diet is comprised largely of foods that are not conducive to good health such fatty foods, white bread, sugary cereals, and cheap cuts of meat:

Our people love food but they don’t really understand how their diet is bad for them. Islanders eat more fruit, for example, because they are used to fruit. Most Maori don’t eat much fruit or
salad – we like our stodge. We eat lots of meat, but in the old days [pre-colonial times] meat was only for special occasions and you had to go out and get it – like catch mutton birds. Now they just eat for the sake of it (Maori female key informant).

Changes and distortions in cultural practice: The impact of modernisation and globalisation on Polynesian alimentary trends and behaviours

Fats and sugar … have modified in some ways our human relationship to nature, while playing a special role in the remaking of the food habits of the entire world (Mintz 1992, p.18).

The Western diet in the last thirty years has increased its use of chemical additives, animal fats, transfats, sugar and salt to levels known to be damaging to health and instrumental in the rise of chronic obesity related disease (Cordain et al. 2005). As Jenkins (in Lupton 1996, p.86) argues in a critique of food trends in developed countries, the preference for highly processed foods with dubious nutritional value underlies the escalating rates of chronic ill-health, or so-called ‘lifestyle’ illness: ‘It seems that the more industrialised our society, the more unbalanced is our diet and the more susceptible we are to the diseases of civilisation’. While educated middle class consumers are more likely to avoid these foods or use them only moderately, it is the working class, the marginalised and the poor who consume these products in significant quantities (Page et al. 2007).

Until approximately twenty years ago, the cost of highly processed goods meant they were out of reach for large Polynesian families (Evans et al. 2003). Now, as globalisation has contributed to the lowering of prices of certain foodgoods, and exposure to television has arguably generated an appetite for ‘modern’ foodstuffs, the demand for such products has increased dramatically (Yari 2003). This observation is borne out by the Niuean key informant:

It is different today. Twenty years ago, even though there was food in the shops, no one could afford it. Now our people get lots of food from the shop – our meats, tinned corned beef, even the fish is in tins. You see a fisherman sell his fresh fish and buy a tin! Bread, margarine, noodles – full of MSG…. rubbish food. And don’t start me on Kentucky Fried Chicken ….I call it the fatty trinity – KFC, tinned corn beef and mutton flaps.

International food corporations have invested vast sums of money cultivating a taste for these foods. Inevitably, there have been shifts in the ‘global palette’ that are reflected in changes to the foods that are available, and/or desirable. Aggressive marketing in developing countries, not just Polynesia, has meant certain processed foods are highly prized, especially corn beef. In Polynesian cultural practice, most people bring food to social events and also expect to take food home. Large
cans of the salty, fatty meat are distributed to guests at social gatherings in New Zealand and the Islands, and the practice has continued on migration to Australia:

You can’t go to an event in the Pacific Island community without tinned corn beef. I’ve even heard that in Samoa, people have been fined by the courts in cans of corn beef! Seems like it’s become currency at home, but it’s the same here. People feel cheated if they go to a social event and there aren’t tins of corn beef to take home (Samoan male, 26).

I was surprised when I first came to Australia. I was worried I wouldn’t be able to get the corn beef for special occasions, but it is very popular over here. There are shops in Sydney and now in Newcastle that stock it specially for us (Tongan female, 48).

I buy things at the supermarket, and my husband goes fishing sometimes, but it’s his job to buy the corn beef for the church. They are so heavy. Our kids don’t get a lot of lollies, but we do stock up when we are going home [to Tonga] (Tongan female, mid 50s).

The statements by this last participant refer to two common practices. In most Island families, large tins of corn beef are bought wholesale and stored. They are then taken as ‘gifts’\(^{12}\) to the church, or contributed to large social events. The second, in reference to lollies, is that Tongans returning to the home islands, rarely make and wear the traditional lei (neck garlands) of flowers, but instead make multi-string lei of chocolates and lollies that are then worn on the plane and distributed to children on arrival.

In Polynesian families togetherness is experienced around food and demonstrations of cultural practices are thereby maintained, however, as Evans et al. (2003) and other authors suggest, the ‘traditional’ is under attack from the ‘global’. Although many Polynesian food practices are being retained, they also have to compete with the introduction and widescale promotion of fast food:

When you come to Australia from the Islands the ones at home think you’re going to eat a lot of meat, especially chicken. That’s classic. They [other Islanders] think of Australia and it’s like – all that ice cream, all that food … A lot of Islanders just pig out when they come here because the food is cheap: ‘All you can eat’. I think Islanders have sent these places broke – Sizzlers and that’ (Samoan male, 25).

The scale of eating being encouraged by such advertising is of concern especially because for Polynesians meals consumed in a chain outlet such as Sizzlers, or other ‘takeaways’ often are not considered meals in themselves. This was explained by the Maori female key informant: ‘If you buy a Maori a bucket of KFC – great – he’ll eat it and then go home for dinner’. In this way, processed junk foods, while popular with Polynesians, are accepted as a stop gap measure, a fill–in until the ‘real meal’ takes place. It is the real meal – eaten with family – that retains connotations of importance and legitimacy.

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\(^{12}\) This refers to the practice of giving offerings in cash and goods to the pastor, who may or may not distribute them amongst members of the congregation. It can also refer to ‘High church’ days where a special ecumenical service is followed by a large meal.
How cultural associations and practices around food are retained in the migrant context

This topic is central to the research aims of this thesis. The pre-eminence of food in the social order for Polynesians, and the exaltation in food generally, has become a cornerstone of the diasporic migrant identity. For younger, second generation Maori and Pacific Islanders, it is often around food practices that their culture is played out. Participants for this thesis under twenty-five, considered food and traditional food practices as a central tenet of their cultural identity: ‘It’s hammered into us at an early age, our culture is a food culture. We eat and share food – that’s the Maori way’ (Maori female, 22).

As Bourdieu’s insights into the modality of ‘gift exchange’ (1977) indicate, how people offer and receive ‘gifts’ and the nature of expected reciprocity, underpins other cultural relationships and practices. Sharing of food also reflects social bonds with family and guests. It is often a time of intense communications and is an opportunity to reinforce the inter-relationships of all participants. For Polynesians, food exchange follows a series of tacit protocols based on existing courtesies and acknowledgement of need. For large Maori and Islander events, often called ‘socials’, people contribute what food and often money (koha) they can afford to help offset the expense of feeding so many people. As mentioned above, people then expect to take food home. How such food packages are allocated is itself an exercise in community negotiation. For example, dignitaries and other high status guests usually receive generous amounts of good quality foodstuffs that they may then choose to sub-divide and share, but also someone who has suffered a recent bereavement or economic hardship will frequently be given significant quantities of food to help in their day to day lives. In this way cultural practices build social and cultural capital (Wichman 2003).

Food gifts after a social event are often referred to as ‘food parcels’. The use of the word ‘parcel’, while commonly used, may be misleading as these offerings often comprise sacks of potatoes, pumpkins, squash, kumara, watermelon and fruits, as well as cooked dishes.

We always try and make sure everyone has something to take home with them. It’s important to us. People have come a long way and they don’t want to have to go home and cook tomorrow (Maori female, mid 40s).

For Polynesians, it is not uncommon to have several hundred people attend a christening, wedding or 21st birthday, and for many hundreds of people to attend a funeral or other rite of passage, such as a haircutting ceremony held by a large, well-respected family. For these more substantial signature events, relations travel from overseas, and monies are gathered before, during and after the event. It
is acknowledged there will be large numbers of people to billet, transport and most importantly feed, for the one to two weeks it takes to perform these rituals satisfactorily.

In the case of Islanders, particularly Cook Islanders and Niueans, haircutting ceremonies are extremely large cultural events involving a gathering of relatives and feasting to celebrate a young boy ‘coming of age’. Traditionally performed at puberty, the ceremony was designed to act as an initiation ritual. This was traditionally a circulatory practice in which each relative would cut a lock of the boy’s hair, and in return offer him gifts such as woven mats, pigs, food and land, to set him up as a marriageable young man. In terms of Bourdieu’s (1977) understandings of the processes of gift exchange, it also served to reinforce relationships between communities. In the modern world this has changed over the last few decades. In New Zealand in the 60s through to the 80s it was common for boys to have the ceremony before entering high school. Now in Australia and New Zealand it usually occurs much younger, during the primary school years. It is evident, therefore, that a ‘haircutting’ no longer represents the onset of manhood, but rather is a residual cultural practice asserting specific cultural identity. Gifts continue to be exchanged and perform similar functions to those described above. These are now are largely comprised of tivaevae\textsuperscript{13} and cash.

One of my key informants, the son of Niuean migrant parents to New Zealand in the 1960s, was one of the transitional generation:

I had a haircutting ceremony, which is a sort of rite of passage for a young Niuean boy. I was about eleven back then. I was about to go into intermediate school. It was sort of frowned upon in New Zealand in those days for a male child like myself going into the next level of education with long hair. Nowadays they do it [the haircutting ceremony] much younger, like my nephews are still at primary school. But boy, do they make some money! It’s still like in the old days – a huge feast and all the relatives are given food – but at the last one I went to, they raised over $80,000! (Niuean key informant).

My son had a haircutting ceremony here in Sydney. He didn’t want to have it, but he knew he had no choice. My husband and I are active in the church and our son was the first to have a haircutting here, so it was a big event. Relatives came from New Zealand and the Islands. A lot of work – all the cooking and you have to provide food, not just for the feast, but you have to feed everybody for the week they are over here [in Australia]. It was really beautiful. He was given fourteen tivaevae! He also got quite a lot of money so now he’s not complaining. Now the other boys want theirs. Everyone’s waiting for the next feast, that’s what it’s really about (Cook Island mother of seven).

The rituals around haircutting are an example of how cultural practices are played out, in relation to the individual, family and community. I have drawn on these examples to illustrate that such practices not only persist in the post–industrial world, they appear to have survived migration to Australia and the fragmentation of the Polynesian communities as people move to different states.

\textsuperscript{13} Tivaevae are elaborate hand made embroidered bedspreads made by women’s sewing groups. They are popularly used in gift exchange amongst Tahitians, Cook Islanders and Niueans.
They act to bring together the more disparate elements of these communities, with the centerpiece remaining the ritualised feasting.

It’s all about the food. It doesn’t matter if you’re talking about Maori people or Islanders … first and foremost, our world revolves around food. That’s what we do, that’s who we are (Samoan female, mid 30s).

Ikeda and colleagues (2002) point out that recent immigrants faced with new and unfamiliar foods and food practices often become protective of traditional ‘foodsca pes’. These authors suggest the challenge is to be inclusive of Western food habits without sacrificing foods and eating practices that are regarded as integral to cultural identity. Some older participants for this thesis (aged over forty) exhibited this reservation about their children’s traditional tastes being subsumed by the attractiveness of ‘fast food’:

For Islanders it is not just about the food; it’s not just about filling you up; it’s about how it is prepared … it’s about keeping our traditions. If we don’t teach our kids, they won’t know their culture, and how to eat the real Island way, how to fish … They’ll be off to MacDonalds and then they will have brown skin, but they won’t really be Islanders (Cook Island female, mid 40s).

A significant number of participants claimed that, despite embracing processed foods, they were still confident they could retain traditional food practices. As one participant commented: ‘We are bicultural – we love food of both cultures [both ‘traditional’ and Western ‘commercial foods’]’ (Maori female, 24). When participants were asked how often they would prepare Maori or Island meals, there was a varied response. Most admitted to trying to prepare traditional dishes at least once or twice a week, usually on weekends. A Maori mother of five gave a response that was typical:

I cook Maori food about two or three times a week, usually on weekends but often on Thursday ‘cos that’s when my husband and the boys get paid and after work and they like a boil up and fish heads and all that. My sister cooks rewana [Maori bread, usually served with butter and jam] on the weekends and that’s always a winner (Maori female, mid 40s).

My family will always cook traditionally – at least on the weekends – and it takes the whole weekend. They [other Samoans] regard ‘traditional’ food as good for you, so turning your back on traditional food is seen as turning your back on your culture (Samoan female, 21).

This last comment reflects two commonly held views. First, that traditional Island food has health benefits that are direct, for example pawpaw is associated with better digestion, and second, that the preparation and consumption of traditional food is synonymous with Polynesian culture. It is the collective process of preparing the food, and eating as an extended family that is valued, hence the avoidance of traditional foods is regarded as ‘turning your back on your culture’; indeed if you do not eat traditionally, you will be an Islander in superficial appearance only.
Impact of socio–economic disadvantage on food choices

This section explores the extent to which social disadvantage compounds the likelihood of obesity–related disease in this community. This raises issues around the availability and choice of foods by examining the selection, quality and amount of foods consumed by Polynesian families. The National Health and Research Council has produced dietary guidelines for Australian adults in the interests of improving national health outcomes (NHMRC 2003a, p.1). These advise eating ‘lean meat, fish, poultry and/or alternatives’, to be consumed in moderate ‘serves’, and to eat ‘plenty of vegetables, legumes, and fruits’. This model promotes amounts and types of foods that have little resonance with working class and/or Polynesian dietary patterns. According to Baghurst (2003), the understanding, motivation and literacy required to interpret these instructions, as well as the cost of eating these foods, is prohibitive to many less educated and poorly paid population groups. Baghurst maintains that studies in Britain and Australia have indicated that unless there is an accompanying fundamental shift in pre–existing dietary patterns, being able to follow these guidelines would be beyond the capacity of the most seriously disadvantaged. This position is supported by Duff (2004, p.151): ‘Policies that emphasise individual choices but ignore the social circumstances that present different groups with different choices must, in the final analysis, be regarded as flawed’. For Duff, if these public health dietary goals are to be effective, it is necessary to acknowledge the cultural and economic influences that are exerted on socio–economically disadvantaged and ethnically diverse groups. These include cultural preferences for foods in different social groups, differences in knowledge about food and diet, varying ability to pay for food, significance of food in the lives of people and the ‘convenience’ factor.

In a globalised market economy, it may be difficult for people with lower health literacy to interpret which foods may or may not be good for them. For example, highly processed foods such as confectionary, bottled sauces and canned foods that have little or no food value, rely heavily on their appearance, especially their bright–coloured contents and packaging, to give them meaning (Lupton 1996; 1994). There is also the maze of labeling to navigate in regard to what constitutes ‘healthy’ food products. Marketing associations with health, affluence and leisure are employed via the naming and presentation of goods such as ‘low fat’ products, ‘high performance’ breakfast cereals, ‘energy’ drinks and ‘healthy choice’ takeaways. Whether Polynesians are swayed by such advertising is moot. Cultural preferences and socio–economic realities are more common determinants of what to buy. The need to feed large numbers of people affordably results in a great deal of bulk buying of ‘no name’ products, many of which are of poor quality. As the Maori female
key informant put it: ‘Our people buy crap food and eat vast amounts of crap food. There’s no way round it’. There were many examples of the socio-economic rationale applied to food purchases amongst participants:

Most Polynesians know someone with a Campbell’s [grocery warehouse] card. Ten families will use the card. I don’t like the groceries there – but when you’ve got fifteen people to feed, you don’t have a lot of choice’ (Maori female, 38).

It’s a shame really. Maori and Islanders are the very ones who should be looking after their health, but you can’t pay $5 for a box of ‘good’ cereal that’s going to last one breakfast, if that. Most times we would go through two boxes a day, so we buy the cheapest (Cook Island female, mid 50s).

… Like with eggs. I’d like to buy free range, but we go through ten dozen eggs a week. In the Islands, all the kids had fruit, it was falling off the trees. Here I can’t afford to buy them fruit, only sometimes. We water down the milk for breakfast (Tongan grandmother, mid 80s).

Most of our money goes on meat. We buy some canned foods, like spaghetti and that, and mostly we buy the vegies from the market. You know with Islanders, it’s a sack of potatoes, a sack of onions … the kids would like us to buy Palangi [Anglo] food but there’s no way we could afford that (Samoan female, mid–40s).

Many Polynesian households have a dedicated space for the warehousing of food, often in the Australian context, the garage:

I try and keep the garage full. There’s always a 21st [birthday], a wedding or something coming up. We’ve got two freezers in there. We can’t afford to buy everything all at once. When there’s a sale on I try to take advantage of that – even soft drinks – it’s cheaper to buy them by the case (Maori female, 42).

As discussed, the expectation that people will peruse labels in supermarkets and pay more for a better quality product, is unlikely in terms of feeding such large numbers of people affordably. Possibly because people cannot afford the foodstuffs, many Polynesians now purchase great quantities of cheap ‘fizzy’ drinks such as Fanta. Those participants over thirty, spoke of the change in household drinks. Some regarded the purchase of commercial soft drinks as ‘luxury’ items: ‘When we were growing up, we just drank water or cordial on special occasions. My kids all drink Coke and Fanta. They’re spoilt (Maori male, mid 40s). Others, most particularly Islanders, offered a nostalgic view of life before these drinks:

Back in the Islands we only drank water or niu [milk from a young coconut]. I miss it so much. You can buy coconuts here but they’re old. We used to love it – watching the boys climb the trees and teasing them. It tasted beautiful. Now all they want is that Fanta rubbish (Cook Island female, mid 50s).
For younger participants, the composition of these drinks, high in chemical volumisers, colourings and sugar substitutes, is largely unquestioned. As these drinks have become cheaper, both through mass marketing and bulk purchasing, more Polynesian families are incorporating crates of these drinks into the weekly shopping as a ‘treat’ for the children.

‘Just eat less’ advice is ineffective for Polynesians

Attempts by the Australian government to counteract the ‘obesity epidemic’ such as the Healthy and Active Australia initiative (Department of Health and Ageing 2010) continue to rely heavily on the nutritional science perspective. This regards the socio–cultural factors around food as relevant only in how they operate as a barrier or enhancement to people achieving the ‘correct’ diet. Programmes and campaigns designed to address the issue of obesity via restraint, hold no resonance with Maori and Pacific Islanders. As one participant commented: ‘Maori don’t have snacks – we EAT’ (Maori male, early 40s).

With cultural associations of being generous with food, and a perception of obesity as normal, even desirable, Polynesians are unlikely respond to health directives that simply say ‘eat less’ (O’Dea 2007, p.1). In the Polynesian context, authors such as Hoetjes (2005) argue there is a need for culturally appropriate nutrition programmes that consider how advice on food choices and preparation is going to impact on someone’s ability to maintain social relationships and cultural identity. For example, the omission of certain foods also involves the sacrifice of social benefits that these foods, and their exchange, hold. These authors suggest that better targeted, responsive programmes should encourage dietary change while retaining the socio–cultural function of traditional food habits (or pathways), when economically viable. Key participants for this thesis agree:

You’re not going to get Polynesians to stop eating huge amounts of food by giving them a pamphlet at the doctor’s. You have to sit down with them and talk and explain how they can eat better. There’s got to be ways to keep many of the traditional elements of how Maori and Islanders eat – but we need to make them understand that it’s alright to have a feast for a special occasion, lovely, but you can’t eat like that every day (Maori female key informant).

Our people [Polynesians] have to understand that if you eat two buckets of Kentucky Fried Chicken, it’s not an entrée! Seriously, I think the answer lies in doing it in stages. First try and eliminate the fizzy drinks, then everyone having a loaf of white bread with every meal – that would be start (Niuean key informant).
This comment emphasises the Polynesian mindset described above that regards a fast food meal, regardless of the size, to not be a ‘real meal’. The consumption of poor quality bread with meals is also an issue, again due to the quantities involved. This pattern of eating has serious health implications for Polynesians. Medical researchers working specifically with this cultural group agree that the vast amounts of processed food being consumed by Polynesians, in conjunction with what is eaten at home, is contributing to an unprecedented acceleration of obesity rates (Evans et al. 2003; Zimmet 2000).

**Trifecta of risk: Eating, smoking and a sedentary lifestyle**

The statistics surrounding obesity-related illness for Polynesian are already high and climbing. The key informants for this thesis, all nurses, maintain that there would not be a Polynesian family that is unaffected by disability and premature mortality from such preventable conditions. This was summed up by the Maori female key informant who said simply: ‘Obesity is killing our people’. Participants who were better educated and had higher health literacy are also aware of this:

> Mum’s mum, my grandmother, just died from diabetes. She lost a leg a few years back. It’s the same with Maori. They just eat themselves to death. It’s a cultural crisis. I try and tell my son ‘Eat for life, don’t eat yourself to death’ (Samoan female, 32).

This observation acknowledges the connection between dietary choices and associated obesity-related illness and premature mortality. Her description of over-eating as a ‘cultural crisis’ reflects both how widespread the phenomenon of obesity-related illness is within the broader Polynesian community, and also that there is an urgency to address this in culturally relevant terms.

‘Lifestyle’ is where social disadvantage and cultural practice converge. The ‘healthy lifestyle’ message circulates around three common areas of risk: obesity related to a high fat/low fibre diet, smoking, and a lack of exercise. Polynesians are in the highest percentiles of these risk areas, globally. As one Cook Islander (male, 60) observed: ‘Well at last Cook Islanders have made the world rankings – third fattest people in the world’\(^\text{14}\). In this section I will concentrate on attitudes to food in relation to health, patterns of smoking, and Polynesians’ apparent indifference to exercise. I will then further examine concepts and techniques suggested by interviewees, that may be effective in inspiring Maori and Pacific Islanders to adopt healthier lifestyle practices.

\(^{14}\text{This was after Samoans and Tongans.}\)
The correlations between lifestyle and health have been extensively documented and promoted in the public domain. Consequently, the rising obesity levels and general ill–health experienced by working class Australians in general, and Polynesians in particular, have perplexed health professionals. Polynesians manifest a number of working class ‘traits’ and behaviours, that are then reinforced by cultural practices, that arguably undermine the overall health of the population (McCarty and Zimmet 2001; O’Dea 2007). O’Dea (2007) argues that it is necessary to acknowledge both socio–economic position and cultural paradigms in order to address these issues:

I think it’s glaringly obvious that you have … your low–income Polynesian, Pacific Islander children, who are actually obese … and those communities need something, some special program for their children, since bigness and fatness even, is often valued in some of these ethnic groups. So, I think that the whole approach needs to be more thought through and sensible and less knee–jerk and less emotional and in consultation with those communities.

The trend towards fatter children and bigger babies is concerning, as there are known associations between childhood and adult obesity (Paterson, Tukutonga and Abbott 2004). As well as the physical complications of ill–health for children who are overweight, there is also a high likelihood of lifelong complications such as respiratory ailments, heart disease and type 2 diabetes. As noted by these researchers, there has been a marked drop in the number of Polynesian mothers who breastfeed their babies. Until approximately a decade ago, babies were breast fed until approximately ten months to one year, and wet nursing by family members was common. In the last ten years that has changed:

The young ones just want to go out and party, so they put baby on the bottle so they can drink. In my day you left the baby with a sister who wasn’t drinking and she’d feed your baby (Maori female, 55).

Oh you know, Polynesians love their white goods. Now everyone’s got a blender so they just put the roast dinner in the blender and give it to the baby. I’ve seen relations give little babies six Weetbix. They’ve just got no idea (Samoan female, 40).

Despite the advice of health professionals to encourage women to breastfeed for longer, this aspect of the public health agenda is not getting through to this community:

It’s a real worry. People stuff their kids – you know, they think fat babies are cute … but they don’t realise the implications for Sudden Infant Death [syndrome], asthma, juvenile diabetes….They stop breastfeeding much earlier now. It’s so sad, we’re killing our kids with too much of the wrong foods. And today, the kids don’t walk anywhere, they just blob, and
you see them at eight or ten and they are huge! It’s not good but I don’t really know how to tackle it … (Maori female key informant).

More broadly, the traditional ‘top down’ delivery of health service providers that distances the intended community beneficiaries from decision-making, and discourages them from participating fully, can create resentment. Higginbotham and colleagues (2010) and Duff (2004) attribute the reluctance of working class communities to comply with public health warnings and suggested lifestyle adaptations, as being due to the bureaucratic and pedagogical approach taken by ‘nutritional experts’. This would suggest a resistance to the mechanisms and approach rather than the ideas. Middle class health values and goals are unlikely to make an impact in a community that perceives itself as ‘outside the mainstream’ in the first place. For example, how people rank their health issues may not be a priority in marginalised communities: a Maori or Pacific Island parent might be more worried about their children going to jail, than having a diabetes test. As an example, one of the older participants outlined her immediate concerns:

They tell us to watch what we eat, but I’m stressed enough as it is. My sister is dying of lung cancer, my husband passed away last year with heart problems and my daughter has lost her job. Now my youngest boy is playing up and I have to go to court on Monday (Tongan mother of five adult children).

This brief story affirms Heil’s findings (2009; 2006) in regard to Aboriginal health and well–being. Heil’s work demonstrates that for socio–centric communities the perception of health and well–being are relational: the wellness and security of those comprising the social group holds greater significance than the biomedical health status of the individual. By contrast, the middle class/Anglo thrust of health promotion campaigns is directed exclusively at the individual. By implication, the responsibility of the individual is to be tested for potential ailments and modify their lifestyle accordingly. This includes moderate food intake, as well as abstaining from certain ‘bad’ foods altogether. This restraint is then ostensibly rewarded by good health. This message falls on deaf ears as Polynesians socialise together around food; the cultural correlation being the greater the amount of food, the greater the well–being of all participants. Further, many interviewees shared the view that they feared becoming sick if they did not eat the way they always have. This association between eating ‘Polynesian style’ and perceived ‘health’ is a difficult nexus to challenge: ‘Islanders find it hard to change their diet – if we change our diet we become more unhealthy …’ (Samoan female, mid 50s).
Key informants who understand the correlation between diet and health, and general participants alike, dismissed the present public health recommendations as being irrelevant to this community:

You can tell Polynesians about the ‘tick’ for a healthy heart and bring out the tape measures and try to scare them, but it won’t go in. Two serves of fruit and five vegies isn’t going to cut it – they don’t see that as related to their health. They feel happy if they’re eating and that is almost more valuable than being ‘healthy’ to a Western person (Niuean key informant).

New Zealand is twenty years ahead of us. They work with families in health – huge strides. The staff here [in Australia] were lovely, but I guess they just don’t know how to get through to Polynesians. I mean, I took my mum to the hospital … what’s with the food pyramid? That is not going to go down in a Maori house I can tell you. Two serves of this and that … our lot have a loaf of bread with every meal, and that’s per person! (Maori female, 35).

For those who are primary carers in their families, it is often around the subject of food, that the two worlds collide. Often, but not always, the carer is the most informed family member regarding the person’s medical condition and expectations of treatment. Consequently, they are frequently regarded as the unpopular ‘gate–keeper’ by other family or community members. For example, a Samoan man was upset that his daughter, under instructions from the hospital, was restricting his wife’s food intake: ‘How’s my wife going to recover if she can’t eat Island food? Where’s she going to get her strength from? I get angry with my daughter – doesn’t she want her mother to get well?’ (Samoan male, 44).

The use of ‘Island food’ in this context may be misleading. While it does refer to certain traditional dishes that may be quite healthy such as fresh fish and fruit, what the father actually means is eating ‘like an Islander’ – eating large amounts of any food, either traditionally prepared or Western, processed food. Notions of well–being are entwined with the process of eating, to the extent that deprivation of food is commonly regarded as antithetical to well–being. Similar stories emerged throughout the interview process. For example, in one Maori family, the siblings who were not carers were critical of the carer’s attempts to vet the food given to the diabetic mother:

Mum’s supposed to be on this really strict diet. She just wanted some chippies [french fries] and my brother accused me of being mean not letting her eat what she wants, but I’m the one that has to front up to the doctor. Mum loves everything in batter, especially homemade Maori bread which is really just saturated fat. I can’t get my brothers and sisters to monitor her eating when I’m not there (Maori male, 45).
Similarly, the risks associated with smoking and associated campaigns to curb tobacco consumption, have led to a significant reduction in the number of smokers in the middle class/Anglo populations of Australia and New Zealand. However, in New Zealand, smoking rates remain highest amongst the working class poor, with considerable ethnic differences between Polynesians and non–Polynesians: almost forty percent of Maori men and fifty percent of women smoke, nearly double the non–Polynesian rate (Wellington School of Medical and Health Sciences 2006). While the Maori have smoked heavily for decades, what is of increasing concern is that Pacific Islander smoking rates have risen sharply in the last decade and continue to rise commensurate with the length of time in New Zealand. As at 2006, thirty–two percent of Pacific Island men and twenty–four percent of Pacific Island women reported being smokers: ‘It’s really sad. Twenty years ago, hardly any PIs [Pacific Islanders] smoked. Maybe a few men at work. Now our women are smoking too and the numbers are high. The young people are picking it up’ (Niuean key informant).

Further evidence by Cram (2002) and Laugesen and Swinburn (2000) suggests that smoking contributes to thirty percent of all Maori deaths. According to these authors, this does not necessarily mean that the single factor of smoking leads to these deaths, although lung cancer rates are high, but rather that smoking compounds all other existing health problems. In relation to this thesis, the risk these figures represent is a high co–morbidity rate for obesity–related illness. Still, overall, most participants for this thesis seemed aware of the health risks of smoking and the majority were non–smokers, or ‘occasional’ smokers. Smoking was more common in the Maori household groups, and participants smoked throughout the interview process, whereas for Pacific Islanders, this did not occur. From my ‘insider’ experience in this community, this may largely be due to the somewhat illicit nature of smoking in Pacific Island families where it is common, even for adults, to hide their smoking habits. In the focus groups, some younger Pacific Islanders admitted smoking, but suggested the price of cigarettes was prohibitive. Given that most Pacific Islander teenagers and young adults have virtually no discretionary income, this could explain the disparity with Maori groups. Overall, the proportion of smokers in this study was lower than the New Zealand figures suggest, which may be attributable to the more pervasive health warnings issued in Australia, and/or be related to the cost of cigarettes in this country.

Part of accumulated health literacy is understanding the correlation between ‘lifestyle’ factors, such as those described above, and the likelihood of acquiring an illness that may otherwise be preventable. Crucial to this association is the role of exercise in off–setting the health disadvantages
of the modern ‘sedan and screen’ lifestyle. However, as Pont (1997) illustrates, the concept of ‘exercise’—how it is perceived and discussed—has different meanings for working class communities. Questions such as ‘How likely is it that you will be able to do exercise?’ or ‘How often do you tell yourself that you should have adequate exercise?’ are problematic for two reasons. First, the compound construction of such questions render the intent of the question unclear. Second, the use of ‘exercise’ in this context can be misleading in that it implies these are activities separate from everyday life. This was also the case in this cohort. For example, most participants did not consider sport, or physical work, to be exercise. Nor did they consider culture group practice, where community members learn physically demanding choreographed dance routines, to be exercise. ‘Exercise’ and its implications of formulated exertion, remains an abstract middle class construction:

Don’t talk to Maori about exercise – they wont know what you’re talking about. Some are very fit because of the work they do, like brick laying or something – they don’t consider that exercise. The lazy ones that don’t get off the couch, well, I don’t know how you’re going to convince them …(Maori female informant).

I said to my mum she should come to culture group and do some dancing – it would be good exercise. She agreed to come dance, but said she wouldn’t exercise. This is what Islanders are like (Samoan female, 22).

In terms of how the participants regarded exercise, there were basically two groups. Less than half of interviewees (approximately thirty participants) were conscious of the benefits of exercise and were engaged in a number of physical pursuits. The majority of these were young adults and teenagers who exercised and this tapered off between the late twenties and early thirties:

We take the kids to football three times a week. I know we should be doing more ourselves [adults], but at least they are healthy’ (Samoan female, 35).

I used to play a lot of netball, and still try to get out and coach the younger ones. I think it’s important if you want to stay healthy and look good. I don’t want to look like the cuzzies [cousins] in New Zealand (Cook Island/Maori female, 28).

The remaining participants who admitted they did not exercise, expressed some degree of awareness that they should exercise more. The following exchange between sisters was typical, in that it suggested the younger members of the household did some exercise, but progressively spend more time in passive leisure activities. Also, despite the jocular nature of the exchange, the sisters acknowledge the importance of exercise in relation to overall health, and that this was not being met in their household:
Interviewer: What about exercise?

Sister 1: What about it? [laughs]. No one in this family exercises, that’s for sure.

Interviewer: Any family members do anything physical – sport, dancing?

Sister 1: Oh, the boys [son, boyfriend of daughter and cousins], go run around and play touch footy. The rest of the time they’re playing pool in the games room, or are clocked onto the game machines. My daughter swims occasionally – well I don’t know if she gets wet – her Pakeha mates take her to the beach. She buys a swimsuit every year.

Sister 2: Remember you bought a membership to the gym?

Sister 1: Yeah that was a waste of money! [both laugh].

Sister 2: Well sis, we’ve tormented our uncles and aunts all these years for parking on the couch and getting fat, and now look at us! Diabetes, heart [disease] – all staring us in the face.

Sister 1: I’m not fat – I’m luscious!

Sister 2: Yeah, well ‘luscious’ is going to kill your ass.

Conclusion

Polynesians, like many other colonised people, appear trapped in a food cycle that is demonstrably bad for their health and bears little or no resemblance to their pre–contact diet and lifestyle. There has been a rapid decline in the physical effort expended in the form of gardening, hunting and fishing and a corresponding uptake of processed foods both in New Zealand and the Islands. Until comparatively recently, every family produced its own food, which also provided enough exercise to keep up fitness levels. The more sedentary lifestyle associated with ‘modernisation’ translates into Maori and Pacific Islanders doing less physical activity to generate food production. Additionally, as most Polynesians are now living in Western societies and are wage dependent, this influences food and lifestyle choices.

The capacity of individuals and their families to adopt ‘lifestyle’ changes that may be beneficial to specific health conditions and their outcomes is compromised by both socio–economic circumstances and cultural behaviours. People do not eat what is recommended but, rather, what is available to them in terms of household economics, and what is desirable in terms of both ‘traditional’ and commercially produced food. The patterns around food and dietary behaviour are deeply embedded in cultural practices of social exchange, obligation and dependence that inform household, family and community life. Food brings the family together. It is regarded both as a reward for hard work and a source of comfort and pleasure. In the migrant context, food rituals have largely been preserved as a form of social solidarity and act to strengthen the bonds of kinship in the wider Polynesian community. Food and food practices, therefore, represent togetherness, tradition and identity. For younger, second generation Maori and Pacific Islanders, while they nominate food
as a primary identity marker, it is yet to be seen whether they will pursue the more time consuming labour-intensive traditional food practices as they move into their adult lives.

In regard to the health of this population there remain serious concerns in relation to obesity–related illness, in particular heart disease and type 2 diabetes (Sundborn et al. 2007). Despite all the evidence in Western terms for the consequences of eating a vast amount of high fat/low fibre foods, together with white bread and fizzy drinks, many Polynesians continue to associate volume and ‘tastiness’ of food with good health. The fondness for fatty foods, the sheer volume of food consumed, and lack of physical activity combine to heighten the health risks associated with obesity. As argued, class positioning contributes to these behaviours. Further, the dominant health philosophies of biomedicine permeate health care provision and circulate around the individual’s responsibility for their own health. Such models have little resonance with Polynesians in cultural terms, nor do they service working class constructions of health and wellness displayed by this community. Therefore, for significant improvements in the rates of preventable illness in the extended Polynesian community, widespread change is required not just to how health is conceived and healthcare delivered, but for issues of social inequality and education to be addressed.
Chapter Seven

Polynesian embodied experience

Introduction

In Western countries, while there are broadly accepted social ‘norms’ surrounding the body and bodily deportments, such as wearing clothes in public, there remain many cultural preferences and determinants that are made in relation to an individual’s subjective notions of their own body. These notions may also change considerably when influenced by external factors such as migration to a country with different values associated with the body, a rise in educational status, or life transitions. In this chapter I describe the insights of participants in regard to cultural practices around the body, and also explore how traditional cultural concepts of the body have been challenged by the migrant experience. For Pacific Island migrants in particular, it is not until they live in Australia that they are exposed, in a sustained way, to exclusively Western imagery, media and values. This chapter also examines the idea of embodiment resultant from socially acquired practices, including deportments reflecting social class, whereby the physicality of Polynesians acts to reinforce social positioning of this population group.

In keeping with the spirit and directives of Kaupapa Maori and Cultural Safety, it is necessary to gain an understanding of how Polynesians ‘see’ their own bodies, interpret information about the body, and to examine how practices involving the body are described and enacted. I have included comments on domestic and group activities as this helps understand the collective nature of the Polynesian social practices surrounding the body and the Polynesian way of life.

‘Traditional’ view of the Polynesian body: Body as sacred continuum

For Polynesians, localised conceptions of the body contain social, cultural and spiritual resonance not only with each other, but frequently, with the ancestors – ‘those who have gone before’. One’s predecessors are regarded as present, and active, in the Polynesian perception:

For Polynesians, no one ever dies, they simply pass into another spiritual dimension. They are here with us, watching, helping – making everything alright. My talent as a carver comes from my great grandfather; I know he’s with me when I work. Our ancestors help us heal when we’re sick (Maori male, 55).
When we get tattooed, we do it for the ancestors and they are there for us (Samoan male, 28).

I am a jeweller and when I work, I feel my tipuna [ancestors] are working through me. I don’t have any issues with that (Cook Island/Maori female, 36).

In the Western tradition, there is also some support for the concept that temporal understandings may be acting on the body. Barbara Clayton’s work, for example, looks at the body ‘as the site of a dialogic interpretation of the past and future simultaneously’ (Clayton 2002, p.845). In the Polynesian worldview, the body at ‘present’ is constituted from past and future inputs, life experiences and cosmological factors. There are many examples of this, particularly around pregnancy and childbirth. For example, the Maori word for uterus is whare tangata (house of human kind). It is regarded positively as a happy, comfortable environment in which to grow until meeting the rest of your family. The placenta and umbilical cord (pito) of Polynesian children are often kept and buried at a place of spiritual significance to the family. This provides children with an assured continuity of place, their turanga wai wai – the place where they stand. The cord itself is tangible evidence of their connectedness with those who have gone before, beginning with their mother. In the case of my own daughter, born in Australia, I was expected to return the umbilical cord by mail to New Zealand to her grandparents, who would then preserve it and take it to the Cook Islands for burial. This would still appear to be common practice as most participants did acknowledge they have done this after the birth of their own children:

I have taken back the cords of all my kids. It’s just the old way. It connects them with ‘home’, it’s their part of New Zealand. It connects them to their tipuna (ancestors). I think most Polynesians do this if they can (Maori female, 35).

The sensual body: Post–colonial policing of the ‘Native’ body

Many early historical and missionary accounts of ancient Polynesia centre around the ‘libidinous nature’ of the natives: relative nakedness, erotic dancing and what appeared to be unfettered sexual activity. To the colonisers of the Victorian era, this was deeply shocking and regarded as justification for a range of repressive actions (Bolin 1997; Tangapatoto 1984). Apart from the puritan, religious drive of early missionaries, Stoller (1997) is critical of what he describes as Eurocentric and phallocentric assumptions about the body that largely exclude the sensual. Stoller argues Western perception tends to privilege the visual (aesthetic) appreciation of the body, and neglects the other senses of smell, touch, taste and hearing. In Polynesia, ‘beauty oils’ and herbal lotions were applied to the skin of babies and the practice was maintained, with variations, for all
ages. Fragrant oils were associated with cleanliness and personal hygiene, but also tied to a wider Polynesian valuing of beauty and the body within the pre–contact culture. In the Islands, with missionisation, oiling of the body and cultural adornment were discouraged and semi–nakedness replaced with the standard calf–length ‘mission frock’ or ‘mama dresses’ (Schmidt 2003).

Stoller (1997) also maintains that the ‘closing off’ of the body to sensual experience inevitably reconfigures the social construction of the body. For many Pacific Islanders in particular, there is a dichotomy between their ‘church’ selves, requiring bodily deportments that are relatively deprived of sensory input, and their ‘Island’ selves who engage in cultural ‘performance’ that re–enacts the pre–colonial celebration of the body. This is particularly well illustrated in watching the preparation and transition of Polynesian cultural entertainers. The drummers and dancers who comprise these performance troupes are usually active Christians, whose day–to–day dress is prescribed by nineteenth century church restrictions – women to wear their hair tied back, modest calf length dresses (no trousers allowed), and for men shirts and ties. Elaborate headdresses, shell necklaces, and ‘grass skirts’\(^\text{15}\), that were actively discouraged by church authorities, now reappear in the guise of ‘cultural performance’, as does the use of coconut oil to enhance skin shine for performance.

This contradiction of post–colonial realities – on the one hand being ‘exotic’, on the other, being good Christians – is played out by individual families, and even amongst members of the same family. It is not uncommon for family members to attend different churches with divergent ideas on the issue of cultural performance. Some denominations succeeded in the outright banning of traditional dances and drumming, while others remained more tolerant. As a consequence, some families embrace the bi–cultural elements of church and cultural practice, while others will not allow their congregation and/or family members to drum or dance.

Our church doesn’t allow dancing. We’re SDAs [Seventh Day Adventists]. Even disco dancing is out – they are really strict (Tongan female, 21).

We were taught to hula from when we were little. They say if you don’t learn by the time you’re seven, you’ll never really be a good hula dancer. The older women teach us and they are amazing! Even the really old ladies, the church mamas: get them in the mood and they’ll show you how to dance! We run around in our costumes, then – it’s back to church and long dresses (Cook Island female, 22).

\(^{15}\) Today these are made from plastic.
Perhaps the most exceptional embodiment of this transition from conservative Christian to sensual ‘native’ occurs in relation to the erotic physicality of the dancers. At issue is not only the relative nakedness of the bodies, but the blatantly sexual nature of Polynesian drums and dance. Given the sexual naivety, surveillance and restriction governing Pacific Island youth, it is in the arena of cultural performance, that missionisation is temporarily stayed, and the ‘old ways’ reconvened. Male drummers, bare-chested, play the intense rhythms, while the dancers, both male and female, execute the athletic and unequivocally erotic hula movements. It is therefore not surprising that the provocative nature of Island dancing remains the subject of much discussion within communities:

It’s just SO sexy. I took my Australian husband to the Islands and he couldn’t believe it. I thought his eyes would pop out of his head. These beautiful girls he’d only seen traipsing around in ‘mama’ dresses – and here they were – dancing, just stunning! (Cook Island female mid 50s).

Growing up, mum and dad didn’t dance and we weren’t taught. Their religion would not allow it. I just didn’t think about it. Then, when my daughter was christened, it was a big deal. I’m the first born, and she’s my first born, so it was a big gathering, with relations flying in from the Islands, from Europe. I’ve lived in Australia, away from the family for so many years, I really didn’t anticipate the scale of the event back in New Zealand. It went for three days and three nights. The most exciting thing for me was my dad doing traditional Cook Island dancing. I’d never seen that growing up. The aunties and everyone couldn’t believe it either. They hadn’t seen him dance ‘traditional way’ for over forty years (Cook Island male, 60).

Samoans dance sitting down! We do a lot of those ‘hand dances’ but our men still do amazing dancing, particularly the fire dance and the spear work. But our women’s dance is not the same – maybe it was the missionaries … we’re not as sexy as the Tahitians and Cook Islanders, or the Hawaiians – man those missionaries have a lot to answer for… we’re good drummers though (Samoan male 35).

When I dance, I just channel the ancestors – they knew how to party! (Cook Island male performer 28).

**The somatically felt body**

The shared, collective physical experience is acknowledged in Anthropology, although seldom in other disciplines, as it tends to be regarded as related to primitivism. It is also difficult to define. Blackman (2008) suggests there is an often neglected dimension to be explored in relation to the corporeal experience. For Blackman, these are ‘somatally felt’ responses – embodied reactions to collective, harmonic activities that transcend purely physiological processes – that are not easily articulated. For Polynesians, many aspects of personal and cultural life involve participation in the collective via group singing, dancing, rowing, martial arts, as well as other aspects of daily life.

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16 Reference to group singing conducted sitting cross legged, with the head and hands ‘translating’ the dance.
Perhaps the best known of these activities is the Maori haka. All the Island cultures represented in this thesis, perform their own variations of the haka – a choreographed martial challenge. Hakas are performed when an outsider approaches tribal land, to prepare men for battle, or to celebrate a significant event. However, it is Ka Mate, a haka performed by the New Zealand All Blacks Rugby Union team for nearly a century, that is best known and has been described as one of the greatest sights in international sport. There are, in fact, many hundreds of hakas, both ancestral and modern, that play a role in the deep cultural identity of Maori. Below is a description of one participant’s experience of haka training practice in preparation for a performance at Bondi Pavilion in 2000. His deep emotional response gives some insight into what is involved to make a large group act ‘as one’:

Everyone says Bondi Maori are ‘plastic Maori’ – you know, not real Maori. They all said we would never get a haka group together, but we did. We trained for months and learnt four hakas. Some of them were really long, complicated. Our tutor was really good, he encouraged us all the time. One day, we had a long practice and we were all tired, our legs were sore and we just started to lose it a bit. Some of the young fellas got the giggles or something … our tutor was really hoha [cranky]. We’d never seen him angry before – I mean really wild. He stopped us, and lined us up, and said that this haka we were doing was done by the Maori battalion in Italy in World War II, just before they went into battle. Almost half of them died that day and this was our tribute to them. He said we had to go outside and think about things, and come back and do this haka like it was the last haka that was EVER going to be performed on this earth. Man, we were all upset, shamed. We went away up the beach and had a long korero [talk]. Some of the little boys were crying. Our wives and girlfriends all heard about it and came down. Anyway when we came back in, we started chanting together from way up the beach, when we came back everyone said we sounded like a thousand men. I’ve never had an experience like that – it was awesome. People still talk about it! I’m really proud to have been part of that (Maori male, 42).

Another example is singing in large groups. While there is an element of religiosity to collective singing throughout Polynesia, the enthusiasm with which Polynesians sing together extends beyond this. It is a profound shared embodiment of identity:

Whenever we sing as a family, I feel united with the ancestors, you know. My grandmother knows some of the old [traditional] songs, we still sing those, but it doesn’t matter if it’s Bing Crosby or Michael Jackson … singing together, brings us together (Maori female, mid 40s).

Csordas (1993) describes this interactive process as ‘somatic modes of attention’, a concept whereby the body experiences a particular cultural practice as part of an inter–subjective milieu. There is an added dimension to what might otherwise be described as a ‘performance high’:
We’re good singers, but it’s more than that. When you perform, you are bringing the ancestors through, you are making the whole *iwi* [tribe] strong again (Maori male, 35).

When we do culture practice, we learn the dances, the songs. I just love it. We’re all on a high for days after a good performance. It’s something we share. I learnt the drumming rhythms from my uncles. I know I can go anywhere in the world and meet other Samoans and we can share that (Samoan male, 26).

As discussed, many aspects of Polynesian cultural life centre around the ‘somatically felt’ experience, shared activities. There are also learned, culturally distinct behaviours that are transmitted to children to govern other physical activities. Central to the study of the body is the contribution of Marcel Mauss (1979; 1973; 1935). His work focusses on the ways we learn to use our bodies as members of society. The cultural differences to be found in techniques of walking, sleeping, standing, sitting and eating, as well as other basic biological functions, capture the way in which we are formed by these learned techniques of being and doing. Polynesian children are taught to sit for extended periods of time as part of a range of physical and social skills. They are also taught to sleep. In Polynesian societies, sleeping is socially constructed in many more complex forms than simply a biological response to feeling tired. For example, to go to sleep after a meal is regarded as good manners. Sleep is also a common reaction to stress:

I remember when we drove down from Alice Springs to Sydney. Four brothers. We hadn’t been together for ages, all working in different places, so we decided to do this long drive together – a sort of a ‘getting to know your bro’ trip. The car broke down in the middle of nowhere. No other cars for miles…. So the first thing we did – we are not mechanical in our family – the first thing we did, was pull out the guitar and had a sing. Then we all had a big sleep. That was it, we just slept and eventually the next day a car stopped to help us. Typical Polynesians – when something happens – you just sleep (Maori male, 44).

A similar function of sleep is described by another participant:

My nephew had to go to court. Fortunately he was released, but it was very stressful. Everyone came back to my place and slept, then they all went home (Cook Island male, 60).

Another example of the social construction of sleep for Polynesians is described in the context of a large culture group ‘preparing’ to go on stage:

A few years ago, I was in charge of a big multicultural concert in Sydney and it was my job to look after the Tongan culture group. There were about thirty or forty members of this choir and I had to make sure they were looked after until they performed. When it was time to go on, I couldn’t find them. I panicked, because as a Tongan myself, I wanted it all to go smoothly. I asked my mum in the audience, had she seen them. She said, go and look upstairs in the
rehearsal room. I went upstairs and there they all were – sound asleep. Looked like forty beached whales had washed up. Big brown bodies everywhere (Tongan woman, 50).

Another point of cultural difference is the relative disregard for the paraphernalia that accompanies babies and toddlers in Western societies. Polynesian babies are expected (and do) sleep regardless of the noise that surrounds them. Most usually they sleep with other people who may or may not be their biological parents. Although many Maori families may buy a pram, it is still rare to see high chairs, play pens, and even cots in most Pacific Island homes. As people migrate and ‘Westernise’ this can be a challenge for new parents:

We are Samoan, but my husband and I are now very Western. We’ve both got good jobs and we have a house full of nice furniture. But every year we always go the big Samoan Christmas social in western Sydney. It’s amazing to me now watching how they handle the babies. There are no prams or anything. They thought I was weird when I got a pram for my children. In the Islands, the babies get carried – there are always arms to carry the babies. My mum always said that if a baby gets cranky, you put them down the front with the drummers (Samoan woman, 45).

**Disciplining the body and the justification of corporal punishment**

Within the paradigm of *Kaupapa Maori*, the confluence of European ideas propagated by church and state by the early colonisers has resulted in a discourse around children that is antithetical to their well-being (Smith 1997). Early European missionising notions of self-discipline (self-denial) and corporal punishment, particularly of children, were regarded as moral imperatives. This was not the way Polynesian children were treated in pre-colonial times (Turia 2007; Salmond 1997). These authors and others have documented early colonial accounts of Polynesian children being ‘indulged’ and not physically punished. Further, they were included in all aspects of family and tribal life. Some participants were aware of this history and were critical of the idea that hitting children being should be regarded as ‘cultural practice’. One participant offers his explanation:

Like Maori, Island children were treated as adults. They had a role to play in the society they lived in. I don’t remember any of the old stories, even legends, where the children were treated harshly. The missionaries showed up, and they were often taken aback with how the children were attending meetings on the marae. They were shocked how children were included in everything. It was only when they went to European schools, it all changed. Before [the missionaries], children were never physically punished. Then, later, someone was caned, or hit

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17 Traditional tribal meeting place
with a ruler or strap. It’s the church influence. Islanders are really biblical (Niuean key informant).

The frequency with which the topic of corporal punishment was raised in interviews demonstrates the importance of this issue in the community. It was often given as the reason Polynesian children are so ‘well–behaved’. For example, the majority of Polynesian children ‘do as they are told’, do not answer back to adults, contribute to household tasks, do not exercise ‘pester power’ as a way of acquiring what they want, and share what they are given. The discussion around how this behaviour is achieved was spirited. Participants were divided between the ‘old school’ who think it is a parental responsibility to strictly discipline children, others who regard corporal punishment as ‘old fashioned, but deserved’, and the ‘new school’ who are not comfortable with the idea of corporal punishment for minor transgressions. The term ‘hidings’ is frequently used to describe corporal punishment involving more than one hit, which is more usually referred to as a ‘smack’. 

I think others would agree with me – the hidings you got … sometimes you deserved it and the message you got was – ‘these are the rules’. The hidings I used to get would be called vicious or brutal today, but I think back and, well, I’m not surprised at some of the hidings I got from Dad (Samoan male, 27).

We got hidings. That’s how they discipline kids, they give hidings. Although there should be a minimum, sometimes it’s a bit more than that. I deserved some hidings (Maori woman, 38).

These two responses reflect the idea that ‘hidings’ are old–fashioned, but at the same time there is the notion that they were in some way ‘deserved’ and therefore justifiable.

In the Islands, you got punished. If you didn’t do your homework, first you got a smack, then put in the sun working hard, then the belt. For my mother it is a very important thing to be good at school. For her, it’s like prayer, then education – that is like the first and second thing. So the lesson was: do my homework or a big smacking (Tongan woman, 21).

This response also indicates the degree of acceptance with which most Polynesians regard the physical punishment of children. It also confirms the position that hidings result from infringement of the ‘rules’, meaning the social expectations of conformity for Polynesian children in relation to the carrying out of domestic tasks and educational expectations.

While most Maori families also expect their kids to be quiet when adults are speaking, and to sit still from an early age while cultural events unfold, there is a tendency to be more tolerant of a
child’s attention span. For many Islanders, complete stillness is required of children from a very young age, especially in the context of church:

I married a Samoan and I had no idea about the church thing. I mean, us Maori go to church, but only like special occasions. Her family go three times a week! It’s hard on the kids ‘cos they want to play and hang out with their friends but they have to go to church on Sundays. We don’t make them go the rest of the time but they can’t get out of Sunday – and it’s like five hours. I feel sorry for them’ (Maori male, 44).

For other participants, such as the Samoan woman below, there is a re-thinking of this model of parenting and they are concerned about the impact such unquestioning obedience may be having on their children:

I don’t hit my kids like I was hit. I don’t think it’s right. You have to talk to them. Particularly here in Australia – you can’t just deal to them all the time. They need to learn to express themselves (Samoan woman, 32).

The following exchange from a group discussion with young Polynesians offers an insight into why they think their community views corporal punishment of children in this way:

Our kids have to learn to sit, sit and not wriggle and run around. Mind you everyone’s so full of food, most can’t move much anyway. You have to be able to sit through long oratories, long sermons. You learn very young (Samoan male, 22).

If your child plays up it reflects on the family. It’s shame on the parents. That becomes so conditioned … there’s layers of guilt stuff in it (Tongan female, 25).

Is it anger or embarrassment? They’re not angry with the child, they’re embarrassed. They don’t want the elders criticising their parenting skills (Tongan female, 18)

Many of the younger participants (under 35), including those with young children, are beginning to question the role of corporal punishment. This may be due to the criminal sanctions in Australia for hitting children, and therefore, may be indicative of a second generation marker of being part of another culture that does not share these views:

I think most Maori and Islanders are beginning to get the fact you can’t beat your children like the old days. I spend a lot of time with Polynesian youth and they are really starting to resent it. I work with their parents and some of the younger parents are trying to communicate with their kids differently. Others, well you know … that’s how they were brought up and that’s that (Samoan male youth worker, 32).
As indicated by the Niuean key informant, Pacific Islanders tend to have a more literal relationship to the Bible and associated moral restrictions than do Maori. The following examples are illustrative of the restrictions applied to young Pacific Island women within this moral discourse:

They brought us up to be very conservative. We weren’t able to go to friend’s places. Chaperoned everywhere. I wasn’t allowed to go out alone on a date, I had to have my brother with us sitting in the middle (Tongan female, 25).

They [parents] won’t allow me to have a boyfriend at high school or even university, until I finish my education. With my parents, it’s education first, get a career and boyfriend last. You don’t have sex until you’re married. We didn’t actually talk about it (Samoan female, 22).

For Maori, where the churches play a less prescriptive role in people’s lives, attitudes to sex are markedly different. There are no significant social sanctions for loss of virginity, premarital sex and illegitimate births. As the Maori female key informant explained:

Us Maori, we love sex [laughs]. It’s no big deal to have a baby young, or if you are unmarried. If you get hapu [pregnant], the whanau [family] is happy. It’s another baby for the family.

This position appears more in keeping with the pre–Christian Polynesian view and the attitude that babies are not the sole property of their biological parents, but rather a gift for the entire extended hapu or clan. This more relaxed attitude to sex, sexuality and illegitimacy is reflected in rates of Maori children raised by de facto couples and Pacific Island children. Thirty percent of Maori children in two–parent families were in de facto couple families in 2006. By comparison, only thirteen percent of Pacific Island children lived in de facto families (Statistics New Zealand 2006b).

**Big bodies: The cultural validation of a ‘large’ body**

In pre–colonial times, the cultural preoccupation with food and subsequent ‘bigness’ in Polynesians was kept in check with the nature of physical work in order to maintain a high quality subsistence lifestyle. In the modern world, the social and cultural paradigms that inform the Polynesian preference for a large body have interacted with ready availability of processed foods, along with the advent of widespread takeaway options, and sedentary lifestyles, to produce a high level of unhealthy weight gain. In order to examine the complex issues regarding Polynesian obesity, it is important to understand how Polynesians themselves regard and value their own body size.
A body that may appear ‘gross’ to the Western gaze, has other implications and associations for Maori and Pacific Islanders. A young Tongan woman who was thin as a child, describes her memories of childhood rejection:

Tongans consider being chubby is good for traditional performing. You need to be chubby to show off in traditional dance. When I was young I was more skinny. I took it as a reason they didn’t take me to cultural events. One day they put my sister to dance before me because she was fatter than me. Both my sisters could dance on special occasions, and my brother. Only myself could not. I thought I was ugly. I remember talking to my grandma ‘How do you do this dance?’ Grandma what’s wrong with my hands? Something’s wrong’. My younger sister could roll the hands– whenever she’d speak with her hands it was perfect. Grandma would say it’s because I was too skinny. My sister would say ‘Eat up if you want to dance’ (Tongan female, 21).

Thomas and Ahmed (2004) refer to the ‘cultural body’ as a combination of ethnic or racial characteristics such as skin colour, texture, hairlessness and body shape, with ideas of attractiveness and desirability. It is these deep processes of enculturation that define each society by its own members and, with varying degrees of accuracy, by outsiders. For example Polynesians do not see themselves as ‘fat’, but rather see the Western body as ‘skinny’ and undesirable:

Who wants to be a weakling? Maori – we think big. If you have a big body, you have mana [power/prestige] (Maori male, 50).

I lost a lot of weight living in Australia and went back to New Zealand. They [the relatives] all said I was skinny and puny looking. Was I sick? Was I on heroin? I couldn’t get a date in New Zealand. I was like Cinderella (Maori woman, 24).

For a Tongan woman in her eighties, there is a deep cultural reverence in relation to size with ‘big’ being preferred over a slighter build:

Before to now there is a big difference. My daddy was a big man. Some still have the strong traditional belief that being a beautiful Tongan is your physique. It is normal to be big… But now with so many palangi [Western] influences …Tongans now have exercise programmes to help the people [lose weight], but some people don’t believe in that – they still want to be big (Tongan woman, 85).

The pressures of being exposed to a contradictory Western message of thinness as desirable has not eliminated the cultural preference for a larger body shape that is still strong in these communities.
Negative associations with thinness

Within the discourse of the ‘civilised body’, relentless media images of impossibly thin women, and ‘buff’ male bodies, cultivate the idea that sexual attractiveness can only be achieved via a slim body. A slim body, and perceived associated good health, are regarded as moral accomplishments, representing the commendable values of control, self-denial and restraint (Lupton 1996). In contrast, the following comments provide an insight into a range of positive associations for Polynesians in relation to larger body size, including mana, with connotations of personal power, influence and generosity, as well as physical prowess and attractiveness:

I think for most Maori and Islanders, they are proud of their size. It gives them mana. They don’t admire being skinny – what do they call it, metrosexual? [laughs] No, most of us are big boys (Maori male, 55).

We just eat too much, simple as that. Polynesians love their kai [food] and everyone’s big – we think if you’re skinny, there’s something wrong with you! (Samoan male, 28).

In Tonga, big is sexy. If you’re skinny they won’t look at you. But if you are big – big legs, big everything – they look at you ‘Oh man’. But if you’re skinny they say things like ‘Go overseas you don’t belong in Tonga’, ‘Go to New Zealand they prefer skinny people’. If it’s a palangi like they won’t comment, but if you’re a Tongan, they will comment (Tongan female, 21).

My cousin is big and she can box and she says ‘I’m stronger than you’ and if you are too skinny you hear things like: ‘I could snap your bones’. You get scared, and think I should get big so I won’t get picked on. That’s the opposite of the Western thing. For us, fat’s the norm (Maori/Samoan male, 18).

You see young Cook Islanders or other Islanders, and they are beautiful. Then they get married. And four or five kids later, they are in Mother Hubbard dresses, they’ve put on six stone and you think ‘Oh my God’, but they feel sorry for me ‘cos I’m skinny (Cook Island female 22).

Physical habitus: The embodiment of class and culture in work and sport

Bourdieu (1984) regards the body as being the site where social milieu, culture and class are enacted. Polynesians are predominantly working class. In relation to this group, therefore, cultural habitus intersects with working class habitus. Hokowhitu (2004) reflects the Foucauldian discourse, when he describes the ‘genealogical construction’ of Maori as inherently and exclusively physical. In the Western societal framework, large Polynesian bodies are frequently drafted into the service of physically demanding work and sports. Maori and Pacific Island men are clustered into ‘blue collar’ industries, in particular the construction industry, security, shearing and mining. This may be attributed to a lack of class mobility, however, there may be other explanations. Higginbotham and colleagues’ study of coal mining communities of New South Wales (2010) and Pont (1997) noted
that ‘conventional’ analyses of working class behaviours frequently failed to tap into notions of pride associated with hard, dirty, physical work. With the Polynesian men in this study, there was an acknowledgement of doing ‘what you’re good at’ – jobs which require a great deal of physical strength and endurance. There is also a pride in doing a difficult job well and having your strength praised and recognised:

Poly boys are in demand in the building industry – they [employers] know we’ll just keep working and get the job done. They know we’ll do whatever it takes (Cook Island male, 60).

We have a good reputation in the building industry. They know Maori work really hard. You know if you hire a Maori, he’ll do the work of two men (Maori construction worker, 42).

In the security industry, we [Polynesians] used to have all the security jobs. Now there are a lot of Lebanese guys in it. Their uncles buy the security firms and employ their families. Problem is, they are not good at security – they panic if there’s a fight. Maori and Islanders are great in the business. We know how to prevent a fight. You just talk to them. It’s not all about brawn – it’s about being able to talk people down. We’re physical if we have to be, but we’re good at the job all round (Samoan security guard, 32).

Maori women are also physically strong and take on jobs that may not typically be associated with women, such as driving big trucks in mining camps and shearing. The 2009 World Lumberjack competition in Canada was won by a Maori husband and wife team, where the wife was six months pregnant. Although it would be extremely unusual for a Pacific Island woman to engage in such pursuits, it is not considered exceptional behaviour within Maoridom. Two participants offer their thoughts:

Yeah I know a lot of Maori women doing physical jobs – on the council, in the mines. I’m thinking of going to Western Australia myself. I’m trained as a nurse, but I could make more money driving mining trucks, so I might do that for a while.

My sister went tuna fishing with her husband for years. The Australian men couldn’t believe it, she was so strong (Maori woman, 45).

I remember our cousin was having her first baby. She was driving to work – she worked in the bush somewhere – and got bogged. Next thing, she thought she’d be stuck there overnight. She gets out of the van and heaves it out. Took her three goes but she did it. She was seven months pregnant … (Maori woman 44).

While some Polynesian women may choose to work in ‘non–traditional’ working environments, they are also highly represented in unskilled work such as being chambermaids and cooks. Because of the practices of social and family networking, there is a growing number of Polynesians working in the caring professions:
I’m amazed at the number of Maori and Pacific Islanders working in the hospital system now. When I started 15 years ago, there were a handful, now there must be hundreds in Sydney. Someone will always get their cousin a job, and we’re hard working. It’s good there has been an increase but we need many more. The bad thing is they are shy about getting any qualifications, so they stay at the bottom, doing the heavy stuff and tend not to move up the ladder. Also because we’re so physical, the Polys get asked to do a lot of work that should be done by other people. Like the Asian nurses will often ask a Polynesian nurse to do the lifting and get out of doing it themselves (Maori key informant).

The externalised streaming of Polynesians by body type (racial and class stereotyping), and internalised notions of pride in physical size and strength (cultural ethos) tend to coalesce around sport. In Australia, the tendency to recruit young Polynesian players for school football teams is presenting some problems. Parents of smaller (non–Polynesian) boys are concerned about their children being injured by playing against such heavy and strong players. On the other hand, Polynesian parents are worried that the maturity levels of their children may not match their physicality:

It’s a problem for our kids. Yes we want them to play but the schools put a lot of pressure on them and want them to play for older teams because they’re big. But sometimes they’re just little kids inside, you know? (Maori female, 32).

We’re proud our sons have been chosen to play for their school rep teams, but I hope the teachers put as much effort into their education. You can only play football for so long … then what are they going to do? (Tongan female 45).

They see a Polynesian kid and they’re right onto him – ‘Oh he’s a forward, he’ll do well’, but what if he wants to play guitar, or he’s gay? I think it's got plusses and minuses. Sometimes it’s just out and out racism. If you’re a Poly you have to be a sports jock – you can’t have a brain (Maori male, 28).

Hokowhitu (2004; 2002) argues that the Polynesian body is a ‘racially constructed’ entity. He remains concerned that the ‘myth’ of Maori athleticism has been emphasised to the extent that it has come to be regarded as a traditional characteristic of Maori masculinity and functions to exclude alternative views. Like many working class men, for Polynesians sport is arguably a disproportionate part of their lives. It is more than recreation, and is emblematic of their individual and collective success and well–being:

When the All Blacks win, the whole of New Zealand is happy. Everyone in the Islands is happy. When they lose, it’s really bad. I rang my dad in New Zealand when they lost the World Cup and he said grown men were crying in the streets of Auckland. They were crying at work, crying on the bus. It was terrible (Cook Islands man, 60).

If the All Blacks lose you won’t see any Maori in Bondi. They all go into hiding. They’re embarrassed (Maori woman, 35).
When one of our boys does well, like Fui Fui\textsuperscript{18}, it makes us all so proud. But when they go off the rails in [Kings] Cross or something, it’s a big shame for everyone (Tongan man, 38).

Our boys can think only of football. There is a lot of pressure from their schools and their families to play football and become a star. That’s all very well but not everybody can be an All Black or a Wallaby\textsuperscript{19}. They are not encouraged to think in terms of an alternative career to sport (Samoan woman, 40).

Sentiments critical of these modes of masculinity tend to be more frequently expressed by women and gay men. For adult heterosexual Polynesian men there is more support for the idea that sport is synonymous with masculinity as Hokowhitu’s concerns suggest. Several of the men confirmed this idea:

For us Polynesians, we see sport as the modern form of war. We see ourselves as warriors and are proud of that. We see our men on the field and we think that’s what it means to be a man – a warrior (Maori man, 28).

For Maori and Islanders, to achieve at sport, especially Rugby League or union, is to be a man. That is how they define themselves – how well they play sport. It doesn’t matter what else you’re good at. I remember attending a tangi (funeral) of a family friend. He was a great teacher. He kept so many of our kids off the street. Fantastic, but at the tangi, all they went on about was his football career in a back paddock somewhere. It was tragic (Niuean key informant).

Yeah, I want my boys to play football. They’ll learn to be a team player, to be a man. That’s what it’s about (Maori man, 45).

You don’t want your sons to waste their chance at sport. We all grew up playing sport and it helped us find our way … it’s something all men do. I want them to handle the rough stuff, it makes them strong (Tongan man, 38).

These are examples of the ‘cultural’ pressure young boys are under to perform as elite athletes. There is also concern that sport is progressively being regarded as a short-cut to wealth and security:

Young kids see the football stars and they want to do that. They think of fast cars and lots of money and there’s stars in their eyes. They think – to be a man, all I have to do is play football and I can provide for my family (Maori woman, 32).

Our boys are really successful in sport. It’s their dream and they’re good at it, but I do worry. People think that’s all they can do (Samoan female, mid 30s).

\textsuperscript{18} Fui Fui Moi Moi is a Tongan first grade Rugby League player.

\textsuperscript{19} Reference to the national teams of New Zealand and Australia respectively.
When combined with cultural preferences, class embodiment places the working class Polynesian in opposition to middle class rationality. This position makes it difficult for Polynesians who wish to prioritise ‘brain over brawn’, and also makes the task of the public health message on obesity considerably more difficult.

The problematic body: Obesity

Thinking back, basically Polynesians were fine built people – active fishing and gardening. Only the wealthy were plump like the royal family in Hawaii, so most people would have been fitter – not too skinny, not too fat, just average (Tongan grandmother, 85).

This observation by an eighty–fifty year old woman would confirm that while Polynesians were always ‘big’ people, they were not fat. The physical work of walking to the taro plots, often many miles from the village, gardening, fishing, rowing and dancing kept body weight down to a healthy level. In the modern Western environment, hard physical work performs the same function. It is common in this community that those whose work is physically demanding, have very fit bodies, but upon retirement either through age or injury, the subsequent sedentary lifestyle combined with the enthusiastic consumption of processed foods, rapidly leads to obesity:

All my family – dad, my brothers, cuzzies [cousins], work in the building industry. They’re fit and strong and then they just turn into hulks (Samoan woman 28).

I got such a shock recently. My brother in law – he’s only twenty–eight, and I saw him at a social … last time I saw him he was working as a steel fixer, playing football, then he wrecked his back and now he’s doing security – and well, he must have put on six stone (Samoan woman 28).

It’s sad really. You see these older Polynesians who have worked all their lives, and when they stop – they just blow up. Then there’s all the health problems … obesity is the biggest problem facing our people. It is killing us (Maori male key informant).

The physical complications of being overweight are seldom discussed within the extended Polynesian community, and the high rates of preventable illness rarely attributed to obesity. In summing up the attitude to obesity from within the Polynesian community, a key informant insists that despite the medical evidence, the mindset is still one that rewards a large and overweight body:

Obesity is not questioned in our community. It is the norm. People still believe that you need to be fat to be healthy. Even though they see all the complications around them, and the discomfort, they don’t want to do things differently. They don’t see their obesity as the problem. The thing is that their weight is stopping them from leading full lives, but they don’t care, because they only think of family, they socialise with their families – and they are all fat,
so it gets reinforced. If you are thin, people criticise you and think you’re weird. Not only weird, but probably sick as well. To a Maori or Islander, to be thin is to be weak (Niuean key informant).

This cultural position exacerbates existing correlations between social disadvantage, obesity and chronic ill health. These correlations are circular in nature: statistically obesity is associated with economic disadvantage, and the stigma of obesity furthers disadvantage by diminished job prospects and ill–health (Carr and Freidman 2005; Khang and Youfa 2004). This cycle also compounds the likelihood and severity of co–morbidities for this population group. Two key informants explain:

It’s a catch 22. An obese body tires quicker than someone who is fit. Then it’s a big effort to just get off the couch – so you don’t. Then the legs pack up. A big problem for our people is gout, not just gout, but all the circulatory problems. They have breathing problems. Their hearts give out. They get diabetes – and then they lose a leg. It just goes on – but they just don’t get it – that it is all connected to their weight. Polynesians don’t think in those terms (Niuean key informant).

Polynesians are resistant to the ideas of eating less. Big eating is so entrenched so even though there are all these health problems, people don’t change their ways. It is killing us – we are eating ourselves to death (Maori female key informant).

As nurses, the key informants can clearly see the result of this cultural positioning in relation to consumption of food and lack of physical activity. The oldest participant again observes that as she was growing up, although people were ‘big’ they were not incapacitated with obesity, nor did they demonstrate the range of health problems that is prevalent today:

Probably a difference in those days, people were fit. Even the people who were big. I never saw in Tonga growing up a person so big, so huge, you know…. There would be weight, but not overweight like nowadays where people can’t get off a chair. They’ve got leg problems, I never saw that. Didn’t see anybody with feet problems, or cancer – that was out of the question (Tongan female, 85).

The following participant expressed her frustration with the ‘disconnect’ between the issue of over–eating, lack of exercise and ill–health:

Gout is a big issue now. Samoan, Maori and Tongans … it is very common. It’s what they eat … and then they don’t exercise. You can hear the aunties when they eat. They are so fat, their breathing is over the top. They don’t stop shovelling and they can’t breathe (Tongan woman, 42).
Another concern for this community is related to obesity in pregnancy. For Polynesians, the associations of plumpness and passivity with fertility are widespread and difficult to change. The following quotes affirm a ‘folk tradition’ of women sitting around, eating, as being the best preparation for pregnancy:

When my mum was married, and wanted to have a baby, her sisters would say ‘stay home and sit there and eat’! (Samoan female 25).

My cousin was skinny with big tummy. And the other Tongan women with a ‘normal’ big Tongan body say ‘Oh I feel sorry for that one because she’s so skinny’. My brother was 13lbs 12ozs [6.2 kgs] and my mum was pretty skinny back then …and everyone said she couldn’t walk, just had to sit there while they fed her (Tongan female, 21).

This prevailing cultural practice, particularly amongst Islanders, is supported by notions that the pregnant stomach should be as large as possible to make the baby more comfortable. Western women, in general terms, are regarded as too thin, and therefore not good ‘baby makers’: ‘My brother’s girlfriend is Australian and she’s very skinny and my mum thinks she’ll find it hard to bear children, she’s got no hips. The baby is going to be so squashed’ (Samoan female, 21).

High rates of maternal health complications in Polynesian women (see Paterson, Tukutonga and Abbott 2004) including asthma, gout, circulatory disorders and heart problems are exacerbated by encouraging pregnant women to ‘sit there and eat’. The high birth weights of Polynesian babies is also a matter of concern to perinatal workers in that gestational diabetes is often accompanied by extremely high birth weights of babies. A generation ago, such weights were rarely recorded in any ethnic grouping, but now this is extremely common. As one participant put it: ‘My babies were all elephants’ (Maori female, 35).

Changing perceptions and the Australian experience

Although many younger participants (under 35) appear to be absorbing different influences about body shape and weight and the possible health implications, this was by no means the experience of all participants. Just over half of participants admitted to attempting to modify their food intake and exercise more, for some period of time. For older participants (+35), this tended to be for a short period and discontinued. The younger participants of both sexes, living in Australia, appear to be responding to the media message in relation to weight and attractiveness, rather than associations of
health. Whatever the motivation, there is a heightened awareness of obesity being problematic in this cohort:

In New Zealand, if a girl is too skinny they say ‘Oh you should eat more, you’re not well’. Most Maori are overweight. I don’t want to get that big. I think you’re more aware of it over here [in Australia]. My cuzzies in New Zealand are all huge. No one seems to care (Maori female, 18).

Things have changed now, particularly for women. Island women now are struggling to lose weight, it’s more individual intentions. They see and learn from the TV. They’ve got TVs now and they are influenced by the Western world, overseas, thinking of how a person should be (Cook Island woman, mid 50s).

Many of the younger participants expressed that they had some difficulty in reconciling contradictory messages from the media and from their elders:

It’s very hard to lose weight and my mum doesn’t want me to have a sickness over it. When I’m eating my mum will say: ‘That’s enough’. Or, if I’m still eating she’ll say ‘If you don’t stop you’ll look like me!’ She makes out like she’s huge. ‘You have to be careful what you eat’. On the other hand, my aunties always want me to eat: ‘You don’t look like you’ve had enough’ – and I feel like I have to eat. Any relative gives you food, it’s rude to not accept it. So you have to force yourself so you end up getting big anyway. You don’t have a choice but to eat (Tongan female, 21).

There is a lack of respect to not finish it up [food]. When they serve Island food, they serve a big one and you look at it [and think] that’s not for all of us, it’s just for you. Staring at the plate and it’s like a whole tray of food (Samoan male, 22)

You get pulled from the cultural angle and the media angle. In the Islands, magazines aren’t that popular, but most of them have TV. Some shows are about fashion, but most Island girls don’t get into fashion...but in Australia we can do whatever fashion. My cousins are celebrity mad. They look at, like, Queen Latifa20 – someone with a chubby body, and she is very popular (Tongan female, 21).

While the physicality of Polynesian men is in demand in certain fields, they are also vulnerable to obesity. Some of the younger male participants indicated they are beginning to distinguish between being big, healthy and strong, and being big and unfit:

For men it’s changing. In Australia I think it’s 50/50. Fifty percent want to work out, get the abs. It’s because of sport, the fit look. The other fifty percent don’t care and are happy to just be huge. I noticed a change in Australia – a lot of my cousins are watching their figures, the male cousins. You can see it’s the same with the Islanders – when they see a really fat cuzzie, and say ‘Wow what’s he eating?’ ‘Come play football with us you’ll work it all off (Maori male 32).

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20 African American talk show host
This observation reflects a shift in position from the previous generation and is an indication that awareness about the physical and social implications of obesity is penetrating the male ethos of this community.

**Conclusion**

It is evident from the literature and the data that the Western perception of both Polynesian men and women is primarily socially constructed through their physicality. The Polynesian body continues to exemplify the Polynesian identity for many Australians and for the people themselves. However, while Polynesian men may get ‘socially rewarded’ for their size, the overweight Polynesian woman does not. The ‘visibility’ of Polynesian sportsmen continues to make an impact on the ‘multicultural’ landscape of Australia, while the obese Polynesian woman tends towards ‘invisibility’. The limited employment opportunities for both men and women presents a challenge. Maori and Pacific Islanders will need to be aware and informed, that unless alternative avenues and opportunities are embraced regarding education and employment, they will continue to be defined by their physicality.

For Polynesians there is an inverse relationship contained within cultural understandings of the body, health and illness – strength and appetite are regarded as markers of health, whereas ill–health is associated with a slight body mass. The data indicates that awareness is changing, particularly with younger Polynesians, however the levels of health literacy in this extended community are extremely low. When combined with the dominant cultural mores around food consumption and body size, the rates and complications of obesity will most probably continue to be problematic.
Introduction

In this chapter I will demonstrate how socio-economic factors – education, skill levels and health literacy – combine with certain cultural practices to reinforce the process whereby social disadvantage becomes medical disadvantage. The literature demonstrating the close relationship between social disadvantage and medical disadvantage returns to three agents of predictable health outcomes: socio-economic position, availability and access to health care (including discrimination on grounds of ethnicity or poverty), and ‘lifestyle’ factors which, in turn, are influenced by socio-economic position (Harris et al. 2006; Robson and Harris 2007). This chapter offers accounts of the Polynesian experience of health services in Australia, and examines issues of cultural practice and poverty which hamper compliance with recommended preventative measures and treatments.

There is also a discussion regarding the underlying assumptions of Western health knowledges and practice, which at times, may be mismatched with Polynesian notions of health and wellness. In terms of Cultural Safety, the behaviours of medical and allied health professionals are explored, particularly in regard to the role of the family in relation to the Polynesian perspective of well-being. I will then further examine concepts and techniques suggested by interviewees, that may be effective in inspiring Maori and Pacific Islanders to adopt healthier lifestyle practices.

Reluctance to engage with health services

Every family is worried. I can’t tell you how many funerals I’ve been to just in the last couple of years and often it’s diabetes. Most of them don’t want to go to hospital … and then it’s too late (Maori male key informant).

The widespread incidence of heart conditions and diabetes have contributed to the economic and emotional stress of the Polynesian migrant experience, but few have availed themselves of the tools necessary to combat these trends. In this section, I explore the socio-economic and cultural reasons behind the reticence of Polynesians to have regular health checks, and engage with preventative health measures regarding illnesses afflicting so many in the community.
Social disadvantage and culturally prescribed perceptions and behaviours coalesce around the issue of health literacy. The low level of understanding and factual information about diabetes and other serious obesity–related diseases amongst Pacific Islanders is in itself a concern (Simmons, Kenealy and Scott 2000). The incidence of such illnesses appears high, while awareness of the nature, symptoms or complications of diabetes, for example, is extremely low. Similarly, the Department of Maori Development, found that many Maori were also uninformed about the nature of diabetic symptoms and were further unable to demonstrate awareness of any health or lifestyle interventions that may help this condition (Te Puni Kokiri 2000, p.45). This report indicated that a lack of culturally appropriate health education was a major contributor to the high prevalence rates in Polynesian communities. Health literacy, therefore, is a prerequisite, along with other culturally specific programmes, to build capacity for this community to arrest the disproportionate numbers of Polynesians presenting with obesity–related illnesses.

A key informant for this project, a Pacific Islander nurse, expressed his concern around the poor levels of health information amongst the Pacific Islander diaspora:

Pacific Islanders know even less than Maori about health issues. They live in a small migrant community and only go from home to school, to church and back. I doubt very much they would recognise the early signs and symptoms and if they did, it does not mean they would seek treatment (Niuean key informant).

As another key informant (Maori male nurse) indicated:

In many ways our community is suffering from diseases that are preventable. They just don’t make the connection between their lifestyle – particularly what they eat – and how they get sick. They don’t know what the symptoms are of the early signs of diabetes, or gout, or heart conditions, so they just plod on. It’s really hard to get them to seek medical attention. So it’s the double whammy – they don’t know how to prevent these things happening, and then, even when they get symptoms they really shouldn’t ignore, they won’t go to hospital.

As an example of this, a Tongan participant in his early 50s offered his thoughts:

My wife has sugar diabetes. We’re all trying to cut down on sugar. I think it’s genetic – all of us [Polynesians] seem to get it. My daughters are worried about me but I won’t get tested [laughs] … if I get tested, then I’ll know. I don’t want to know.

This comment brings together several salient issues. Firstly, most Polynesians refer to ‘sugar diabetes’; inherent in this adopted term, is the notion that an excess of sugar causes diabetes. The naming of the condition effectively precludes other influences on the acquisition of type 2 diabetes,
most particularly, obesity caused by a high fat, low fibre diet, and inadequate exercise. The second element is the reluctance to undergo testing. As I have alluded to elsewhere, the inflammatory language surrounding ‘high risk’ populations for diabetes, has the effect of paralysing, rather than motivating, the population to be tested. There is a pervasive idea amongst Polynesians that such ailments are genetically ‘inevitable’, and subsequent mortality from the condition is also ‘inevitable’, therefore testing represents an unwelcome confirmation of this:

Our people just do not want to be tested. They fear the worst and they just don’t want to know. They don’t see it as an opportunity to do something about their health status – it’s the opposite. The only time they find out is when they are being tested for something else, or are in pre-natal care’ (Maori female key informant).

As well as issues of health literacy and education, all key informants cited ‘shyness’, cultural issues, or lack of money, as playing a part in this community not presenting to health services in time for effective intervention.

They are really whakama [shy] and nervous about dealing with anyone outside their community. If I am not there to interpret, they just won’t say anything at all. Sometimes it is pride – they don’t want the doctor or nurse to know they have difficulty following what’s going on, language-wise – or they are embarrassed they might not be able to afford the medicine (Niuean key informant).

Whakama, most frequently translated as ‘being shy’ or ‘shyness’, according to Metge (2004), is a psychosocial and behavioural construct of Maori (Polynesian) culture that has no Western equivalence. Metge suggests feelings of inadequacy, shame, excessive modesty and withdrawal go some way towards explaining the concept. Sometimes this may appear to a Western health worker as misplaced politeness or stoicism. As a Samoan interpreter said:

Maori and Islanders are very shy, particularly the men. They find it hard to talk to a Pakeha [Anglo] doctor. They’ll be in chronic pain, but won’t say anything. Their leg can be black with gangrene and they’ll just be staunch and won’t say anything (Maori female key informant).

I get so frustrated. They [Polynesian patients] just don’t say anything and then the doctor or nurse look at me – well how can I interpret silence? Then I have to go and talk with the family and try and find out what the symptoms are (Tongan interpreter).

Frequently, it is the confluence of socio–economic and cultural factors which prevent Maori and Islanders from accessing health services and complying with medical interventions. Polynesians, as migrants, are often unaware of government subsidies available for medications and therefore, when
instructed by practitioners to get a particular medicine, there is an assumption by the patient they will not be able to afford it; a situation they find ‘embarrassing’ in front of an Anglo health worker. A Tongan participant was obviously distressed when recounting an incident involving a family member which illustrates this:

Islanders are very shy – they just won’t talk. If you push them they’ll shut up even more. It makes it very difficult…. I had a cousin visiting Australia and I was so shocked when I went to say goodbye and my relatives said ‘Did you know he had diabetes? He’s very upset he can’t afford the medicine’. I said: ‘Why didn’t you let me know?’, and he said he didn’t want to bother me because he knows I have family problems and I am so busy. I asked him ‘Did you go to the doctor?’ and he said: ‘Yes I did – but they told me to go and buy this and that’. Sometimes they’ve got the money and they get the treatment and sometimes they don’t have the money and don’t go. Financially they are very poor – they get embarrassed. Now he has passed away (Tongan female, 45).

**Western paradigms of health care delivery and the subjective Polynesian experience**

Language facility is an issue, especially for Pacific Islanders, who enter the health system. For most Maori in Australia, English is their first language. For Islanders it is not, and often their English is basic, and overall literacy poor, particularly amongst older migrants. This affects all levels of healthcare treatment and can contribute to a degree of communication breakdown between participants and health care providers, especially in relation to the ability to understand treatment regimens:

 Mostly they don’t understand what is happening. They are in this strange place [a hospital], they don’t know anybody, they don’t understand why they’re ill in the first place, and they are scared. Often doctors and nurses are busy and just fire off a series of questions or an explanation, but the Maori and Pacific Islander patients usually don’t get it, and then they are more freaked out and I see them just shut down (Maori female key informant).

This provides a profoundly distressing and unsatisfactory experience for the Polynesian health consumer. Most participants reported ‘mixed’ encounters with providers, however, when support staff do take the time to overcome these barriers, their efforts are greatly appreciated. The following account of a hospital experience by a Samoan family contains both an unsatisfactory experience, and the ability of a more culturally attuned staff member to make a difference:

I took my son to the hospital and the doctor wanted to send him home. I said: ‘How can he go home? He is very sick’. My other son tried asking them questions about why can’t they keep him at the hospital. But his English isn’t very good. The nurse started arguing with us, we were all distressed, even my son was crying – and they called security! They (hospital staff) refused
to treat him and wanted us all to go. Then another doctor came in, he was really different. I still pray for that doctor, he’s a good man. He examined my son, and said ‘My God’ – they discovered he had something very serious and they operated on him that night, or he would have died. No one said sorry to us. It was a very sad time (Samoan male, 50s).

This example focuses on the role of family, and inclusion of family, in the patient’s encounters with the Western health system. Cultural Safety, in practice, addresses a range of issues, including attitudes of health professionals, acceptability of the provider, and cultural factors such as food preferences, or the fear of being alone. For Polynesians, as with many indigenous people, to have their family around in times of illness, including institutionalised care, has been demonstrated to be instrumental in their recovery, compliance with a medical regimen, and improved overall well-being (Eckermann et al. 1995). This was the case in my study also: ‘If they have their family with them, they often cope better. Even in a semi-dysfunctional family, there is usually someone who can help them understand what is going on. They need their family, or they just fade away’ (Niuean key informant).

One participant, whose mother had been in a coma, attributed her recovery to the presence of family. His response below articulates the processes he considers to be instrumental in her recovery, and later for her to ‘pass’ in a way that is in keeping with her spiritual beliefs:

Mum brightened up when she saw us all coming – there were like twelve of us. The staff had written her off, but she really just wanted to see her grandchildren. They [the staff] couldn’t believe the change in her. If there’s no family members there, that’s when they die. Mum would have died. The nurse actually asked me the question: do you realise she’s going to die? And I said ‘Not at all she’s got things to do. She wants to get her whakapapa done. I explained to her that’s your genealogy. One of the major things in life for a Maori is your whakapapa. When you’re at the marae [tribal meeting house] people tell you: ‘You’re connected to this ancestor, to that person, this is your waka [canoe]’…her father had a photographic memory. He was known for it. Now his daughter wants to know. When that’s done, she’ll pass. It’s a spiritual thing. The medical stuff doesn’t cover the spiritual, or the children, which is such a large part of Indigenous life… and there’s no answer for that (Maori male, late 40s).

When staff are willing to accommodate a large number of relations visiting, it is often because a family member has successfully negotiated this arrangement by approaching staff beforehand:

Lucky I’m capable enough and articulate. My six sisters have been in and out in the last few weeks. I spoke with the nurses and they let them all in. Eight of the ten of us have all come down. I spoke to the doctor too … for Mum, just having family around who love her….All the attention she’s had. Now the lights are on. No matter how bad she is, she recovers and I’m
shocked – ‘You were so sick just a minute ago’. The doctors are shocked (Samoan female, mid 30s).

However, visits by large numbers of relatives accompanying the patient can also present complications and animosities with staff. Within the Western health system are embedded notions of ‘partner’ and ‘next of kin’ and the importance of their relationship with the patient. In the consocial Polynesian extended family, such relationships are more divergent and contextualised within broader cultural dynamics. As an example, one participant, forced to take extended hospital rest for high blood pressure during pregnancy, recounts her reaction when she was asked to stop all visits from family members with the exception of her husband. The patient herself did not want her husband there, but preferred her sisters. Accordingly, she addressed the health staff with her complaint:

What? You really want me to be stressed out? He drives me crazy … worries about everything. I want my sisters to visit. My blood pressure will go through the roof if my sisters don’t come because they play cards with me and that relaxes me – he’s useless at cards (Maori female, 38).

Family offer ‘awhi’ (support) in times of stress. They are also responsible for bringing in large amounts of food, both for the patient and other visitors, as is the Polynesian custom. Particularly for older Maori and Islanders, the departure from their regular food habits is distressing and cannot be simply be replaced by hospital meals: ‘I was in hospital in Sydney – I’m a diabetic, and my heart’s not good. I thought, if I didn’t have my family, how would I eat? I’d get more sick’ (Tongan female, 55). This last comment raises several issues. Firstly, the woman in question, had arrived directly from Tonga, where, like Samoa, Niue and the Cook Islands, relatives are expected to feed anyone in hospital. The institution itself does not provide proper meals. Therefore, the comment ‘…how would I eat?’ reflects habituated expectations of the hospital experience. Also, the statement: ‘I’d get more sick’ is informed by the notion that her regular diet is keeping her healthy, despite the fact she is hospitalised for obesity–related illness. Thus, it is extremely difficult to monitor the person’s eating behaviour, even in an institutionalized context, as the family and broader community share these positive associations with familiar food. Additionally, in a Polynesian family there are many more people, other than the ‘patient’ who are being catered for, and a constricted diet, such as for diabetics, may be harder to achieve. The relationship to food and its symbology are also, arguably, more entwined. Many participants shared stories of ‘smuggling’ food into hospitals for relatives. This practice is widespread as
reported here: ‘You can always tell the Polynesian visitors to the hospital. They’re the ones with the eskies’ (Niuean key informant).

The following comment is revealing because it contains a hint as to the scale of this issue for patients who have a great many visitors. The participant is one of fourteen children, who presumably, all took in illicit foodstuffs to the father, as well as a number of other relatives who would also have done the same. Again, the emphasis is on well-being, rather than what is medically advised as beneficial:

Dad’s favourite is seafood, we couldn’t see him go without, so all of us would take him a little something – he wasn’t supposed to eat anything with batter on it, but it makes his day. The aunties had cooked up a storm and took it in as well, so he’s not going to make his target weight this week (Samoan male, 22).

Cultural reflexivity of doctors and allied nursing staff

Language and cultural barriers can impede the identification, targeting and delivery of services. It is well recognised that this results in CALD populations experiencing a high burden of disease which results in undue negative impacts on health and quality of life (Bedford et al. 2009; van Driel 2009). Yet as Twigg (2006, p.34) points out, ‘Otherness’ remains a marker of ethnic distinction, and ‘whiteness’ (is) the unexamined body norm’. Issues surrounding race and ethnicity are not only important in regard to CALD populations, but also within the health profession itself. In Australia, forty-six percent of the medical workforce (doctors, nurses and allied health staff) are overseas-born (Hawthorne 2007). This would indicate there are other considerations to be addressed, for example, practitioners themselves may also be in the process of adapting to their new cultural environment in Australia more generally. According to Bedford and colleagues (2009), the Australian health system is largely monocultural, that is primarily Anglo–Celtic, in its vision and delivery of health. These authors argue that the patient demographic is moving quickly away from this and, therefore, there is an urgent need to train health service providers in understanding how best to treat the burgeoning CALD population. The complex ethnic and cultural interplay that is evident in most Australian clinical settings, is an argument for Cultural Safety principles to be employed more widely, and more quickly, than is currently the case. A first step in implementing Cultural Safety guidelines, is for medical staff to become ‘enculturated’ to the extent they are familiar with at least a small number of common cultural ‘touchstones’ important to the ethnic or culturally diverse patients they are treating (Wepa 2003). All key nursing informants reported that this already happens in most hospitals, but not in a structured way. Rather, the exchange takes the
form of health staff from different cultural backgrounds sharing ideas ‘in the tea room’. As an example:

I was doing midwifery and one of the Chinese nurses told me, in her culture, the new mother doesn’t wash straight away, it’s a spiritual thing. We normally bundle them off into a shower five minutes after having a baby. Now I ask the mother if that’s what she wants, and it works. It’s the same for me: if she has a Poly [Polynesian] patient, she’ll come and ask me how to handle this or that. It’s good. We are all learning (Maori female informant).

Most staff want to do the right thing, but if you ask me the biggest problem is that Anglo workers are always in a rush. When our people are shy, or slow, the doctors are very impatient. But some I can talk to at the canteen, or somewhere, and say ‘Just take your time Doctor, I know you’re busy, but if you don’t rush him, he’ll cooperate more’ (Niuean key informant).

Intuitive nurses we can’t get enough of. Just a bit of cultural sensitivity …I try and listen to what nurses from other cultures have to say. We bring food in from all over the world and chat about our own people … and at the end of the day, one good nurse, who is kind and sympathetic can make a huge difference (Maori male key informant).

As the following participant, a carer, also makes clear, what is ‘good care’ for the dominant Anglo–Celtic patient group, may not be optimum for other ethnicities:

We’re different, we’re not Pakeha. Colonialism tried to change us and did change us; that has to be acknowledged. But there’s a beauty to it coming from a cultural angle. If Western medicine could see it through Indigenous eyes what a difference that would make. You grieve for your lost land, your lost child, for years … It’s the spiritual things and connection to community (Maori male carer, 48).

The following exchange between this same carer and a senior renal specialist, is an account of how a decision was reached for the terminally ill mother to return to her home rather than undergo dialysis treatment. For the carer and the extended family, the approach taken by the specialist translated into a more positive experience of a traumatic event:

The specialist said we know that Indigenous people have the worst health statistics in relation to this stuff [obesity–related illness]. I said I am so grateful you know this because not many white people know this stuff. He said: ‘She needs to go home’ and I said: ‘I know – she needs to feed the birds, talk to the neighbours, cuddle the babies. She needs the noise [referring to a large busy household]’ She doesn’t want dialysis. It’s like for Aboriginal people – for Black people going to hospital, they think it’s a place you go to die. They don’t want to die surrounded by Pakeha in a strange place. The specialist gave his blessing. I was so grateful to this doctor for understanding because now we could just get on with supporting our mother in her passing.
The Niuean key informant, while understanding the constraints of operating in a large institution, also supported the idea that it would be ideal to have certain rooms available for cultures with large extended families, who are in cultural terms, loud:

It’s not just the Polys [Polynesians]; the Greeks, Maltese, the Italians – there are other cultures too where it is normal for fifteen people to visit the hospital and all chat and carry on around the patient. I think it’s that philosophy, ‘life goes on’.

For another Maori participant, one of the hardest aspects of visiting her mother in a palliative care ward, was the need to try and keep the other relatives quiet:

Doctors try to keep everyone quiet. There’s ten or more of us there making noise and she [grandmother] loves that. What they do with the ‘shush’ doesn’t work – a sterile environment. Sure it’s required at times but it’s a Pakeha thing. It doesn’t work for Polynesians. They have to realise the ‘shush’ doesn’t work. (Maori female, early 30s).

**Stress on carers**

For someone to become a designated carer, or primary carer, there are usually a series of family factors to be taken into account. Gender may be a consideration but not a determinant. In other words, there are a great many female and male carers. Issues surrounding availability may be more importance. In other words, someone who has been unemployed for a considerable period of time may be a more likely candidate than someone who is already in full–time employment. If someone is to receive the carer’s pension, they also need to be regarded as trustworthy both with the person needing care and with the money ‘earned’ in this way. Age is also not a decisive factor in its own right and some carers are very young. Several carers were involved in this research, both male and female, from teenagers to those in their mid sixties.

Chronic illness and disability are confronting to anyone experiencing these conditions, and also for those close to them, who provide care for their health and wellbeing. In the case of impairment or physical disability, it could be persuasively argued that those in a Polynesian extended family arrangement are better off than those in a nuclear family. It is easier to move a paralysed body, pack wheelchairs, provide tactile support for a visually impaired person, or rotate someone in the night with more people to share the load. A great many of occupational therapy goals of ‘normalisation’ take place organically in a large family. As one participant commented: ‘No one took special notice of me with one arm. I guess that’s why I can do everything’.
Even in the case of serious and/or multiple disability, in a Polynesian family few concessions will be made for such disability. Instead, the person is encouraged to participate in family tasks and maximise any contribution they may be able to make. For example, Maori family (2) have a twelve year old boy who has cerebral palsy and is blind. According to his mother, he is expected to do household tasks to the best of his ability:

I’ve put foam strips around the legs of the furniture so he can vacuum without doing any damage. We’ve put little magnets on the buttons of the washing machine – he can do that, and he can help his brothers and sister with the cooking – they set it up for him, peeling potatoes, whatever …(Maori female, 35).

While such a holistic approach may arguably empower the individual needing care, and thereby reduce the amount of physical assistance required from a carer, there are also instances of people in the carer role who are feeling stressed or frustrated. Cultural expectations of behaviour, such as being a designated child minder at a very young age, or carer for the elderly and disabled, has meant the life opportunities for individual Polynesians may be severely curtailed. Because there may be no time for homework, or because of the disruption of being uprooted from one branch of the family and moved to another, upsetting other personal relationships, education may be disrupted. Availability of ‘free time’ may also be compromised, as indicated by focus group participants: ‘There is always something – if it’s not taking my nan to the doctor, it’s feeding all the kids and getting them ready for school next day. I don’t get to see friends much’ (Samoan female,18). In most Polynesian families there are a myriad of informal caring arrangements in place. However, in the case of caring for someone undergoing a great deal of medical interventions and treatments, an adult is preferred. For those who are caring for a seriously, or chronically ill relative, there is a great deal of responsibility, and frequently, not enough support for the carer at risk of ‘burn out’:

I know what tablets Mum needs. We’ve been doing this for nearly five years now. She has forty–four tablets a day. The doctors have been scratching their heads – and that’s after they’ve cut it down. The money they make out of pharmaceuticals! We had an incident where the hospital missed one of these major drugs, so I’m hunting around for it in her hospital cabinet… I worry about the combination of the tablets – the heart, the diabetes, everything is separate and they are very strong drugs. I think there are a million mistakes going on every day. It just takes me to drop one on the floor – and it’s wrong. There must be an easier way – I’m stressed out (Maori male, 45).
This statement indicates that the social positioning of the carer themselves, in relation to the patient, is often problematic. Young Polynesians are brought up to not question their elders, so it may be difficult for a child, even an adult child, to impose a treatment regime on a parent or older relative: ‘The pills! Too many pain killers and whatnot. Mum holds off – she should have had ten and she’s had three and we don’t want to force her – it’s not our place’ (Samoan female, 28).

Two carers, one who looks after his mother, and another who looks after her grandmother, share the mixed sentiments that many carers describe. They are torn between their Polynesian (and Christian) family values, with inherent social obligations, and their more ‘Westernised’ individualised selves with expectations of ‘having a life’:

My brothers and sisters think it’s OK because I get the carer’s pension, but we have to pay rent in Bondi and food – Mum still thinks there’s fourteen of us for dinner – and it’s a struggle. The shopping! Trying to get the shopping done with my mum in a wheelchair and we don’t have a car… Just getting on and off the bus – painful enough. In the supermarket, she says ‘Son, push me over there and I’ll get the trolley’. I push her in the wheelchair and she grabs the trolley and I’ve also got the backpack. We have heaps of shopping… now we’ve got used to it. But one time, we got to the traffic lights – all the groceries on the wheelchair, ten kilos of potatoes in her lap, I’ve got a full backpack, and I’m pushing her over the road. I’m sweating, sulking, and feeling sorry for myself, and I see this wheelchair coming backwards and it was a white guy with one leg, pushing with his leg, and mum says ‘Quick son, go help him’. I’m hoha [cranky] at the same time but I go. If we see someone struggling on their own, it teaches you a lot. Mum says ‘Aren’t we blessed son’. Now I feel I’m evil to complain, when really I just want some free time (Maori male, 45).

It’s hard to keep up with everything – the blood tests, the sugar levels and the pills, do the washing, clean the place, put her on the toilet, wash and shower her. The others help, but it’s my responsibility. It’s amazing. I’ll always look after her, I’m the eldest moko (grandchild), but sometimes I just want to go to my boyfriend’s place and not come back. He’s an Aussie and doesn’t really understand why I have to do it (Maori female, 35).

The family and social obligations that frame the role of carer arguably extend to those who act as interpreters for their families and the wider Pacific Island community. The interpreters, like the carers, are at the interface of the hospital system and the family. Interpreters themselves are often stressed and feel ill-equipped with the job they do. Most are unpaid. A Samoan interpreter made the following observation:

Our people are shy. They don’t want to cause trouble. I often get called to the hospital. They don’t understand what’s happening to them. I think it’s really important. We need more interpreters, and we need to train the ones we have. I haven’t had any medical training, most of us haven’t. I don’t really understand what the doctors are saying, I just do my best (Samoan female, late 40s).
The report by ECCQ (2009) also identified the insufficient numbers of trained interpreters, or more correctly, medical translators, in these communities. Most families expect a relation with better English than their own to interpret for them, but this is problematic as many do not have a working medical knowledge and are simply translating the words as best they can, without an underlying knowledge of the medical language and processes that are being discussed. Others with more education and experience are highly sought after and are expected to travel, again unpaid, great distances to service their extended communities. As the following comment reveals, someone who is regarded as a good interpreter is also in demand for legal situations as well as in the medical domain:

I’m exhausted. I was called to Sydney in the middle of the night because a Tongan boy was in a car accident and the doctors wanted to turn off the life support and they needed someone to talk with the family. Then the next day I had to drive to Gosford [about an hour’s travel], because my brother’s wife’s family had a crisis – someone in court. I’ve missed so much work lately I’m going to get the sack (Tongan female, 44).

**Cultural safety and increased engagement**

Cultural safety is the need to be recognized within the health care system and to be assured that the system reflects something of you – of your culture, your language, your customs, attitudes, beliefs and preferred ways of doing things (Eckermann et al. 1995, p.167).

Many participants had stories where encounters with the medical system were enhanced by having a Polynesian health worker in attendance, such as in the following example, or a worker who was simply kind:

The nurse who came yesterday to wash mum was a Maori girl. She doesn’t know Mum that well, but it was just that whole thing, it made such a big difference. Mum greets her: ‘Kia ora [hullo] girl, where is your family from?’ She was in pain but she rallied around this girl…and this nurse said ‘I’ll look at the roster and make sure she’s on my shift’. It makes such a difference. Mum is much more comfortable (Maori male, 45).

However, the Niuean key informant who works in a hospital in Sydney, explained that often it is not the junior workers, but rather the senior staff who are rushed, and less willing to take the time to consider the validity of cultural requirements which may improve a patient’s health and well–being:
I used to work in New Zealand, and they understand people’s culture and you’ve got no problem with that. But here they [senior health staff] don’t want to know about that. I’ve got patients here who say ‘Tell them I need my family here’. Here in Australia, you’ve got to spend more time with the doctors and nurses explaining so they understand. It’s about health but it’s also about people’s worth, their values. It’s not something they can just snap out of them, they were brought up that way and you’ve got to be careful what you say to them. You’ve got to find a way to get through to them and not be in a hurry. And Island people have a tendency that ‘everything’s going to be OK’. If you say to an Islander ‘the world is going to end’, they will say there’s still time to party [laughs].

Settings – where the health information or care is delivered – will influence the manner in which programmes are received. A space which is local to where people live and enjoy spiritual or recreational activities, contributes to optimal health outcomes (Ministry of Health 1997; Sobo 2010). Not surprisingly, this report revealed most Maori do not respond well or even participate in settings such as schools and workplaces. The work of Simmons, Kenealy and Scott (2000) found that sixty-nine percent of Maori and seventy-six percent of Pacific Islanders preferred to receive information from a lay educator or a nurse specialist service, rather than a general practitioner. Further, no Islanders in the study listed a preference for a hospital based ongoing education service. All preferred a Polynesian ‘face’. The reluctance to engage with medical practitioners who are overwhelmingly ‘Other’ to the Polynesian patient, indicates that even in New Zealand, there is a critical shortage of Polynesian allied health practitioners – a finding of Cultural Safety practitioners more generally (see Tomlin 2006).

They want a brown face. They want someone, one of their own, to tell them what is happening in a way they understand. They want someone who understands their culture. They pay taxes, they should be entitled to that. And the thing is, if money was spent on training Polynesian health professionals, even at the level of nursing aides, it would save the government money in the long term, because more would get early treatment (Niuean key informant).

Targeted funding of more Polynesian health providers, and the provision of culturally conducive resources, may well reduce the spiralling cost of chronic ill health associated with obesity.

There’s no point telling a Maori ‘Just eat less’ – they would just put it down to being a miserable Pakeha. You’ve got to put it in terms they understand: you need to talk about kai [food] for a start’ (Maori male, 45).

The New Zealand government is starting to get it. If you give out a pamphlet telling Polynesians they ‘should’ have a diabetes or heart test they are not going to do it. But if you put it in terms of ‘Live long for your mokos [grandchildren], get the whole whanau [family] checked’ – you are more likely to get a response (Maori female informant, early 30s).
The idea of prevention is important, yet the message is not being successfully conveyed in a way that prompts action in the most at-risk groups (van Driel et al. 2009). More avenues need to be explored outside of a medicalised setting. For example, in New Zealand, studies show most women claim to get their health information from friends, magazines, newspapers and television, which would appear to be an argument for putting this information out in the popular culture domain (see Dew and Davis 2004).

The Ethnic Communities Council of Queensland (ECCQ) issued a four-part report to help health professionals work effectively with Maori and Pacific Islanders (ECCQ 2009). This had been prompted by figures from local hospitals whereby CALD populations contributed over seventy percent of urban hospitalisation episodes, with Polynesian admissions being the highest (ECCQ 2009, p.13). Concern over health literacy in this population, including poor awareness of chronic disease symptoms and medical terminology, and limited understandings about support networks, led the ECCQ team to embark on new initiatives that embrace cultural practices. Many of the recommendations made by the ECCQ after qualitative interviews with Polynesians in Queensland were also suggested by participants in this thesis. These included physical activities that were close to home and involved the entire family. Other issues were that these activities should be suitable for all ages, fun, and free of cost. Group ‘walks and talks’ were suggested whereby people could encourage each other, and that these should be on weekends. Interestingly, the Tongan focus group which was part of the Queensland study, suggested that exercise might happen once a month, but only if food was offered afterwards. This led researchers to conclude that these issues (over-eating and lack of exercise) may be ‘insurmountable’ in the Tongan community (Bedford et al. 2009, p.28). This confirms the findings of Sutton (2005) that there are a myriad of socio-economic and cultural factors which ‘…are not directly amenable to medical or public health interventions without assaults on culture, tradition and lifestyle which would be ineffectual or incur strong resistance’. Rather, Sutton calls for ‘cultural augmentation’ – acceptable changes to negative or damaging cultural practices. In keeping with this position, participants for this thesis suggested healthy food could be offered as an incentive. It was also suggested community workshops and meetings could be informative and constructive, particularly if they involved story telling, the talanoa tradition, in the Pacific.

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21 Although weekends were suggested as an obvious starting point for community exercise, this would be problematic because of church commitments in Pacific Island communities. Seventh Day Adventists do not play sport or do any physical activity on Saturdays, and the rest of the community will not engage on a Sunday.
Conclusion

As discussed, Maori and Pacific Islanders in this study under-utilise health care services in the early stages of illness and throughout the length of illness. This means a treatable disease becomes more severe, and the effectiveness of treatment is greatly reduced. The reasons include a reluctance to speak of medical issues (lacking the language and confidence to do so), low levels of health literacy and poor compliance with long term health measures. For this to change, the contrast between medical knowledge and lay understandings of health needs to be bridged. Reasons for lack of compliance with public health directives are many and varied, but the pattern that emerges reflects both cultural and class issues.

Interviewees were generally positive about the quality and geographic accessibility of services in Australia, but expressed concern at the high costs incurred for treatments and medication that were burdensome to most families. They also identified a need for culturally appropriate information, in Pacific languages, about availability of health services, prevention of chronic disease, and related issues. It was evident that the concept of preventative testing, and benefits of early diagnosis, remain abstracted: if you do not understand the nature and trajectory of a particular illness in biomedical terms, why would you seek to prevent it?

Print media, television and the internet were suggested as vehicles for accessible information, encouraging participation for different age groups and literacy levels. Community centres and churches were also cited as places for disseminating health information. Participants also suggested storytelling be utilised to help people understand the long term nature of chronic health issues through the stories of others. It was also obvious there needs to be a great many more Polynesian medical interpreters trained, and supported, to help explain concepts of preventative health, the content of medical information, and also the bureaucratic processes required by the health system.
Chapter Nine

Cultural identity, adaptation and belonging: Keys to well-being

Introduction

The correlations between identity and health have been recognised by health workers in New Zealand since the early 1990s (Polaschek 1998; Ramsden 1992) and security of identity is regarded as a pillar of both Kaupapa Maori and Cultural Safety. Over recent decades Maori and Pacific academics, activists and health workers have continued to point out that deculturation and loss of identity has been associated with poor health, low social engagement, increased likelihood of criminal offending and early mortality, while acculturation has been linked to good health, and more successful social outcomes (Durie 2003; 1997; Baxter 2002; Ministry for Maori Development 2000a). It has been argued, therefore, in the New Zealand context, the goal of health promotion in the Polynesian community should encourage on-going cultural involvement. With migration and the associated stress of raising a family in a new country, the question of how cultural practices are retained and strategies adopted to maintain these practices are explored in this chapter. I discuss the social techniques, behaviours and attitudes employed by Polynesians who migrate to Australia in adjusting to a multiplicity of forces shaping their lives at the interface of two (familiar and alien) worlds.

This chapter also examines how young Polynesians who are exposed to Western media influences and are engaged in school and work environments that do not share the same cultural values as their parents, reconcile these influences. The issue of how young Maori and Pacific Islanders see themselves in Australia has not so far been thoroughly researched. With the notable exception of Helen Lee’s work on Tongans in Australia (2006; 2003; 1996), Australian researchers, for reasons explained in the early chapters of this thesis, have shown little interest in the social lives of young Polynesians. For this reason, the research sought to hear the voices of these young people themselves who are attempting to negotiate a range of exciting, frustrating and conflicting value systems. This also includes a discussion of the tensions between first, second and third generations that are engendered by this process.
Polynesian socialities in an individualised world

Indigenous notions of individual autonomy and ‘relatedness’ are mediated through politics, spatial domains and pre-existing social relationships (Turner 2008; Baba et al. 2004; Myers 1979). In the typical Polynesian household this involves manipulation of personal space and concepts of privacy whereby daily life is conducted in close physical proximity to a great many other people. According to Twigg (2006) domestic rituals circulate around the body – the spatio-temporal order, therefore, how the body is manoeuvred in a particular space is also culturally defined.

Maori and Pacific Islanders share a number of protocols regarding the body and bodily deportments both within culturally defined sacred spaces and the domestic sphere. In a marae, or meeting house, there are a range of ritualised practices surrounding the body and cleanliness, and many of these conventions are carried over into the domestic space of a Polynesian home. Shoes must be left outside, only bare or socked feet permitted. When people are seated or especially lying down, one does not step over any part of their body. It is also considered a travesty of tapu22 to sit on a table or kitchen bench. Where the buttocks can and cannot be is also clearly enforced by social sanction and, at times, physically punished. For Polynesians, it is very difficult and sometimes confronting to see an ingrained social taboo flouted in an external context, as with the following example of a Maori woman newly arrived in Australia: ‘I went to a conference recently and this Pakeha academic was sitting on a table while he was talking to us. I couldn’t concentrate on a word he was saying. I just wanted to slap him – how rude! Is it normal for Pakeha to sit on tables?” (Maori female, 32).

As well as a range of cultural practices regarding management of the body in relation to the home, there is also a fundamental difference in attitude towards what constitutes privacy (personal space) in the home. For most Anglo–Europeans, ‘home’ is a private place and the world is left outside (Twigg 2006). Within this view, household economics permitting, priority is given to each person having ‘space’. It is largely taken for granted that, at least as an adult, you will have your own bedroom. This domain (the bedroom) is usually not shared by any other person, other than the partner of choice. However, in Polynesian homes it is not unusual to have ten or fifteen people sharing the same space and facilities. Consequently, bedrooms are regarded in more flexible terms. As an example:

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22 Tapu, contains meanings of both ‘sacred’ and ‘forbidden’ in different contexts.
We had ten kids in a four bedroom house – most Maori families had three bedrooms so we thought we were really lucky. Five boys in one room, five girls in the other. Mum and dad had one room and the other room always had relations in it (Cook Island male, 60).

In a typically large Polynesian household, young babies often sleep with the very old people; the cultural logic being that older people are the lightest sleepers and get up first. Toddlers tend to sleep in ‘packs’ often in a double bed, or share beds and sleeping mats with older children. In many households, a Polynesian teenager is unlikely to have a bed to themselves, let alone an entire bedroom. As one participant complained: ‘My seventeen year old son broke his leg at football. Now he’s got to have a whole bed to himself’ (Cook Island female, mid 40s). Sexually active couples do not necessarily share a bed when they visit relations, and may be allocated separate sleeping positions by an older (usually female) relative. This practice can present tensions and problems when Polynesians have relationships with non–Polynesians who are not used to such arrangements:

My first husband was English. He was not impressed when we went to stay with the relations and we couldn’t sleep together. He said ‘What’s going on?’. I told him to just get used to it, Aunty will tell you where to sleep (Samoan female, 35).

I had an Australian girlfriend and she couldn’t believe she wasn’t allowed to sleep with me when we went home. I said: ‘It’s just the way it is. Anyway babe, think how hot it’ll be when we get together!’ I don’t know if she was convinced. She left not long after that (Maori male, 31).

The logistics of housing and feeding large numbers of people requires different skills and levels of acceptance, and also, a different concept of ‘privacy’. The Niuean key informant reflects on the distinction between his upbringing and that of his Anglo counterparts:

After growing up in a Polynesian household, I realised that this was the fundamental cultural difference between me and my Anglo friends – their attitude to privacy and space. In a Polynesian home, everyone has their chores. How else do fifteen people negotiate one bathroom and be ready for church, school or work by 7.30am? Large families have to work cooperatively. Each member is expected to pull their weight in terms of domestic chores, or to put it another way, to do as they are told. You don’t just do what you want…it’s a different idea of home and family (Niuean key informant).

Another participant put it in the following terms: ‘For Polynesians home is the centre of social life. If you want privacy, you go outside – and probably down the road (Maori female, mid 40s).

Commonly, an individual, particularly a young person, has very little say in determining their own living conditions within the family home. The management of the home as a collective space, rather
than a series of private realms, inevitably affects and shapes what constitutes personal ‘space’ for Polynesians. Frequently, such collectivism also takes precedence over ‘individual’ lifestyle choices as demonstrated by this exchange between members of a focus group discussion:

My sister had three young babies. My mum and dad said I had to go and live with her in Sydney to help out. I was going out with a boy in New Zealand, but I had to leave him, my sister needed me (Samoan female, 22).

Here my Aussie friends are all out getting flats and that. We don’t leave home (Tongan female, 18).

I know kids I went to school with …some are living with their boyfriends, but in a Tongan family that would never happen. I’m expected to look after my grandmother and I do that. I love her. That’s my family – I’ll always look after her (Tongan female 24).

The issue of household overcrowding is one of the areas where the ‘culture gap’ between Polynesians and Anglo–Europeans becomes most apparent. To the affluent post World War II Western mindset, household overcrowding is regarded as a sign of impoverishment, something to be rectified as soon as the family can afford to do so. The growth of the ‘MacMansion syndrome’ (large houses with multiple bathrooms, play areas, home theatres and small yards) is about maximising space between family members. For Polynesians, this is simply not a priority, nor does overcrowding constitute a problem in itself. A typical response in regard to this issue was from a twenty–one year old Tongan female: ‘We don’t think like that. I love living with my extended family. I’d hate to be on my own – and anyway how selfish’. This statement combines several elements affirming the consociality of Polynesians. These include the ‘love of family’ being experienced by being together, and disdain for the notion of living alone that is construed as being ‘selfish’. To be described as ‘selfish’ is a stinging rebuke for Polynesians. The idea that someone would have a house with an entire bedroom per person, and not invite other relatives to live with them is strange, ‘selfish’. The implications are that all parties would save money by sharing, that the domestic load, particularly around childcare would be reduced, and also that the more people (family) who live with you is translated into greater well–being, fun and joy. Therefore, to only pursue one’s own comfort and desire for ‘space’ is regarded as un–Polynesian – at odds with the collectivity of cultural practice. While for some individual Polynesians, there may be stress in relation to personal space, this is rarely expressed. On the contrary, it is far more common for people who are living in more individualised circumstances, to express a longing for the collective lifestyle:
When I first came to Australia, I stayed with my uncle in Sydney. It was just him and me. I was so lonely and missed my brothers so bad. My uncle would pass out [go to sleep] in front of the tele, and I’d be on my own. Sometimes I just cried (Maori male, 20).

These collectivist practices as illustrated here, act to powerfully underpin Polynesian attitudes to the ‘self’ and agency that are non-Western in nature. They also actively inform notions of well-being, as experienced by Polynesians, in ways that are markedly different from the Eurocentric idea that well-being can only be achieved through autonomy and prosperity. As one of the older participants pointed out, in the prevailing economic climate Polynesians may, in fact, be better prepared for the future than many Anglo-Australians:

It’s funny, Pakeha are freaked out by the global financial crisis, but it’s different for us ... Polynesians are used to having no money and sharing everything we have. I think we’ll come out better than a lot of Pakeha if capitalism collapses (Cook Island male, 60).

Relational values of health and happiness

Post-industrial Western societies have moved steadily towards creating smaller, more affluent family units. By limiting the number of children to two or three, the social reward is perceived to be that these children will be well-educated and highly employable, thereby being able to maximise their life opportunities and afford to comfortably reproduce this life for their own children. This idea is allied closely with a rise in consumerism where the acquisition of goods is associated with a high quality of life. In psychological terms, this is yet to be proved. A study by Kasser (in Amichai-Hamburger 2009) indicates a preoccupation with materialism results in greater narcissism, an increased tendency to unfavourably compare oneself with others, to exhibit less empathy and to experience an increase in relationship conflict. Kasser’s conclusion was that those who highly value material goals are less happy than those with lower material expectations.

In Maori and Pacific Islander communities, while socio-economic disparities exist and are widespread, perceived quality of life is not just about money, as pointed out by Durie (1994a). In this section, there are examples of participants’ attitudes to money and material goods and how money is handled in this community. This is accompanied by a discussion of what values Polynesians consider important in the pursuit of a ‘happy’ life: ‘A few weeks ago our next door neighbours [Anglo Australians] had a domestic argument. The police had to come – it was over money. Islanders, we might fight – but I’ve never seen a physical fight over money’ (Samoan male, mid 50s).
The Tongan custom is they will give you everything… if they’ve got something you are welcome to it. If they have nothing, they will do something for you. The best gift for a Tongan is saying ‘thank you’, because they have nothing, that’s why ‘thank you’ is important. That might be a little thing but they will never forget you (Tongan female, late 40s).

Our people always think with the heart. It’s *aroha* [love]. People might have nothing on the table but if there is a fundraiser for someone in real trouble, they give – you wonder where the money comes from…. They will do anything, get a loan at the bank. That’s how they are (Maori female, 34).

My father died suddenly a couple of weeks ago. In times like this you can see how relevant it is to keep the custom. It was a Saturday. We had so many people … they came with food, they came with money. They loaned us cars and vans. Some relations paid for the funeral. In everyday life I can’t afford this, but when it comes to the real crunch you know why your family is important. Everything we needed just appeared! I was so happy (Tongan female, mid 40s).

This last response brings together a combination of emotional responses – sadness, relief and happiness – in the context of a sudden and tragic event. The reaction of family members allowed the woman in question not to be burdened with unexpected financial strain and also gave her comfort. The relief that this provided enabled her to feel ‘happy’ under difficult circumstances, and affirmed her cultural expectation of being supported by family and community.

Social and cultural constructionism has concentrated on structures of meaning and formulation of social order around complex systems of symbols, meanings, models and schema, but far less work has been done on the individual emotional world of highly relational societies (Lyon 1995). However, authors such as Lutz and White (1986) and Strathern (1988) have explored how emotional states such as grief, happiness and compassion, often theorised as a universal experience, are mediated by socialisation. For Strathern (1988), the individual is not the locus of relationships; rather she talks about the consocial person as a ‘pivot of relationships’. Strathern (1999, p.272) describes the dividual or composite person as ‘the plural and composite site of the relations that produced’ him or her.

The cultural polarities of ‘egocentrism’ and ‘sociocentrism’ are also explored by Derne (2009). Derne’s work discusses the implications for well-being when the consocial, or sociocentric construct of identity and belonging is disrupted: ‘… in a sociocentric social milieu, humans experience well-being when guided by others and may feel a loss of well-being when forced to rely

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23 In this context, ‘nothing on the table’ does not mean there is literally no food, but rather that there is a shortage of money at that particular time.
on their individual selves to control a situation’ (Derne 2009, p.131). This was confirmed in the qualitative findings from Heil’s work (2009; 2003) in a rural Aboriginal community where, like other consocial groups, being with your relations is synonymous with perceptions of well–being. It is within the presence of family that the social meanings of engagement are generated and affirmed. For Polynesians, if family members are absent, this can cause a disruption to other people’s well–being. In relation to health, this helps to explain why Polynesians prioritise family (and togetherness) over individual health issues. Therefore, exploring subjective notions of well–being for Polynesians requires an understanding of how the health and well–being of an individual cannot be divorced from broader family relationships. An example of this was given by a Maori male carer (aged 45) in the cohort for this thesis:

That old school era, you know the over sixties … they don’t see themselves as sick, even if it is really bad. Mum would say to the doctor ‘I’m just a little bit out of breath’ – no mum, that is ninety percent kidney failure. But as long as she has her family around her she’s happy.

For Polynesians, a sense of happiness, well–being and belonging are directly attributable to membership of a large extended family. In Maori language, the word whanaungatanga encompasses relationship, kinship, and a network of family connections. It is a relationship based on shared history and experiences and working together that provides people with a sense of belonging. In this way, the ‘family’ relationship develops as a result of kinship rights and obligations that also serve to strengthen each member of the kin group:

It’s every family member, it’s not just you. If there is a wedding … or if your child is sick and taken to hospital, you ring up everyone … So if you’re working and can’t get to the hospital, you tell them [the relatives] and they organise the others, even aunties, uncles… Everything in your life operates as a family, you are part of a unit. Your nephews and nieces all pitch in to help – money, looking after the other kids, whatever (Maori female key informant).

Like my mum … my sister looks after her, but mum gets around so she doesn’t experience just one little family24. We all help with her. She doesn’t feel lonely. We take turns. She sometimes says ‘Go away all of you’ [laughs]. You can see it helps her live longer. I think the most damaging thing for Maori and Islander people is sadness, when they are away from their family (Tongan female, mid 40s).

The following contributions from participants further highlight the extent to which family relationships impact on what constitutes ‘happiness’ in the Polynesian context:

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24 ‘Little family’ refers to marital partners and their immediate biological and adopted children.
Like my mum, she will sit down and talk and help each of us … each other’s little family, about their health or money worries, and if there’s any downfall [problem] she will talk about how we can reach out and help. Do what you can. Maybe not money but you can help in some other ways. You know there is always the support there. Mum says: ‘You know it is very important, don’t look at the money, or how much food you’ve got, look at your family, that’s your happiness … [Laughing]’ (Tongan female, mid 40s).

Be happy with yourself. You have to be happy within yourself before you can share your happiness. In my family, we live by that. We have disagreements sometimes but we never let the problem go too long. If you are unhappy, you can have all the money and the things but if you don’t have happiness … it is very important to us (Cook Island grandmother, mid 50s).

You don’t feel that pressure of being lonely and left out and struggling with your life within yourself: ‘Which way should I go? Why am I unhappy?’ I guess I watch my mum and everything about her. If mum is unhappy that is the worst killer you can ever have. If she’s happy, we’re all happy. Of course there is something special in my heart, she’s my mum (Maori male, 43).

What is shared by each of these participants is that personal happiness is regarded as directly relational to other family members. The collective notion of family and extended family provides stability and a sense of belonging that underpins the happiness and well-being of its constituents. These examples illustrate the point that anything that is important to Polynesians, such as their health, needs to be addressed in terms of family. They also serve to explain how a community comprised of many families who are not wealthy, and in fact may be struggling in financial terms, perceives the strength and solidarity around them as an invaluable asset. This forms the basis of the social capital that is available to community members.

‘Polycultural capital’: How forms of social and cultural networking are employed in this migrant community

While I explore the use of ‘Polycultural capital’ in relation to youth issues below, in this chapter I wish to utilise the concept across the broader Polynesian migrant community. For Polynesians, social capital centres around the support inherent in close family and community relationships that are reinforced by an array of cultural practices. In this sense, ‘Polycultural capital’ acts to bring together social and cultural capital in the form of Indigenous knowledges, skills, language and values that become a repository of social good that is activated through networking. In turn, these can be used to generate other forms of economic and social benefit in the migrant context: ‘The ability to function successfully in multiple contexts [is] a valued skill, perhaps even more relevant and important for … Pacific peoples in diasporic locations’ (Mila–Schaaf and Robinson 2010, p.1).
In the Maori/Pacific Island community a great deal of Polycultural capital is generated around the sharing and exchange of food. These reciprocities are enacted to provide support for extended family and community members. In this context, social capital results from an interaction of social processes – where the personal intersects with the community – and this produces a positive, affirming outcome for the community as a whole, as well as the individual. By continuing these processes of socially instituted reciprocity, cultural practice and identity are reproduced. As an example, such social networking in and around the extended family and community, works actively in terms of generating employment opportunities:

A lot of Polynesian women are involved in the hospitality industry. We’re good at jobs that involve institutional cooking – we’re used to cooking for a big mob. It’s no sweat to us. Everyone will get their relations a job if they can. So those of us who work for the churches or a hospital or something, will try and get other relatives a job (Samoan female, 55).

I know a lot of Maori and Islanders working as carers. It works because we’re strong and can do the lifting. We also don’t have an issue with washing people and that. There are quite a few Polynesians working … not well paid … but have a high presence in the helping professions. We always try and get our own people a job if we can. Older women in particular are reliable and good at this stuff (Maori female key informant).

This recruitment of younger Maori and Islanders to the jobs their parents and other relations are engaged in, particularly the hospitality, security and the building industries, helps young people find employment in an often inhospitable economic climate where youth unemployment is high:

My husband works as a scaffolder. Every few years we bring over one or two of the nephews [from New Zealand] and give them a start. They live with us, and we know they’ll get to work every day because they go in with him. They’re better off here because the money’s better and they can make something of their lives over here. There’s no work in New Zealand and they’d just be sitting around on the dole (Maori female, early 40s).

The other resources and outcomes that flow from these practices, such as financial and emotional support, as well as ‘in kind’ assistance in finding employment, sustain and re–iterate strong family and social networks. For example, strong social cohesion in Polynesian families and communities acts in many ways to offset other aspects of socioeconomic disadvantage:

If you’re poor and have nothing, at least you can have a big family. A big family is firstly prestigious, and secondly it is practical. There is always someone to look after you. It the opposite of the Pakeha view of the world (Cook Island male, 60).
This statement encompasses many of the meanings contained in the Polynesian view of family and community. Well-being and security are perceived to emanate from being part of a large family. ‘There is always someone to look after you’ reflects the assumption that no matter what your economic situation or life situation, you can always turn to a branch of the extended family and be housed and fed, and where possible, assisted in practical ways should your own health, or that of your children require it. The idea that a large family is ‘prestigious’ encapsulates an understanding for Polynesians, that if family is the source of comfort and acceptance, to have a particularly large family is a greater insurance against hard times, and also provides a greater likelihood of economic success. Within this framework, a large family constitutes increased community influence. For example, if a land claim is to be negotiated, greater numbers in a particular family may translate into more votes or capacity to influence favourable outcomes. The last sentence contains the observation that as Western society moves inexorably towards smaller families and institutionalised care of the elderly, the collectivism of Polynesian family life remains a polar opposite. Wealth is people – not money, therefore the larger the family the greater the Polynesian perception of ‘richness’ and a ‘good life’.

While Polynesian consociality provides many areas of support for community members, there is also a need for the cultivation of relationships with the wider non–Polynesian community. As described by Mila–Schaaf and Robsinson (2010) this is the basis for acquiring ‘Polycultural capital’. In order maximise potential for these relationships the concepts of Bridging and Linking (Baum 2007) are useful. Given the high rates of sporting participation in Polynesian communities, networking between sporting organisations and other institutions is one way for this to be achieved. As an example there has been a spate of newspaper articles extolling Pacific Islanders as ‘super athletes’ in the Australian press and cited elsewhere in this thesis. While individual players may be offered contracts for enormous sums of money, they are acutely aware their cousins are playing barefoot in the Islands (literally), and many decide to support small community action groups in their home islands. Similarly, Maori sport stars have lent support to campaigns to reduce domestic violence and other community causes.

The relationship between Polynesian athletes and their families and communities is complex. They are acclaimed by the community, but also expected to contribute a great deal. Maori and Pacific Islander sports stars are expected to financially support a great many people as they are so financially well–rewarded for their work. As Heil (2009) points out, for those brought up in a socio–centric environment, the purpose of ‘work’ is that it allows you to look after your family,
other relations and yourself. This conforms with the view of Myers (1979) that family responsibility and social prestige are associated with looking after others, or as Strathern suggests, the consocial person is one who ‘… from his or her own vantage point acts with another’s in mind’ (Strathern 1988, p.272). As the following participant observed:

All the [Polynesian] boys I know would like to do well in sport. It’s not just for themselves, it’s because they want to help their families and relations. They want to make their lives easier – they see how hard their parents work (Samoan male, 32).

The sentiment underlying this comment was echoed by other participants. As so many Maori and Pacific Islanders are involved in blue collar work, the children are aware that their parents have usually worked extremely hard physically, experienced difficult working conditions and have still struggled to ‘make ends meet’. Sport, therefore, represents an opportunity to reward the parents with an easier life as well as making them proud of the success of the sporting person.

**Inter–generational tensions: Between two worlds**

The premise (and promise) of globalisation was that it would bring a greater prosperity to all participating nations and social inequalities would be reduced through increasing affluence. This would be accompanied by affordable internet usage that would allow egalitarian access to the world of ideas (Giddens 2004). Instead, in many cases, it has led to a new wave of cultural imperialism whereby Western, market–driven ideology has permeated more countries in the quest for maximising the number of consumers and promoting individualism (Ovortrup 2008). More communal concepts of being and sharing are misunderstood, ignored or invalidated within this paradigm. Arguably, these processes have made it harder to keep reproducing the cultural values that are important to Polynesians and other socio–centric communities. However, as Durie points out, this is not a new situation: ‘Maori, like other indigenous peoples in developed countries, live in two worlds – an indigenous world where one set of values, customs and expectations prevail, and a global world where there are other norms’ (Durie 2007, p.12).

The metaphor of living ‘between two worlds’ is frequently employed by Polynesian academics, writers and artists in relation to discussions of post–colonialism, migration and identity. It is also a useful analogy of inter–generational mis/understandings in this diasporic community. A great concern of many participants who are parents and grandparents, is the commitment of teenagers to existing family and community values. Polynesian teenagers have traditionally been active
contributors to the family and are brought up to not question their elders. In these interviews, some older family members expressed the belief that their young people are becoming more ‘Western’ as a result of migration to Australia, and commented they were worried about signs of social dislocation, depression and the up–take of criminal behaviours:

They’ve got a lot of influences – being a teenager from a different culture. Like my husband and myself, we look at parenting from different perspectives: we were brought up in the strict traditional way, and he thinks our children should grow up that way. We argue about this, especially now we have four more children [her sister’s children have come to live with them]. Now, there is a lot of pressure on them to go to school and do well. When my daughter was in Year 11 she was getting mostly As, but in her last year she isn’t doing as well. She’s crying a lot. I’m worried about her (Tongan female, 43).

We don’t have as many whanau [family] here in Australia. Everyone has to work, so the kids are left on their own a lot. Who is going to guide them? Some handle it, others get into trouble\(^{25}\) (Maori male, early 40s).

My older son is working for the Justice services, he is looking after people who are struggling and he’s looking for ways to help the kids, especially the Island kids. Big numbers of them are in jail at the moment. Sydney is worse. They don’t go to school, they roam the train stations and form gangs … only a minority, mind you, and people like mum and my age group, hang on to tradition but it is fading. In Sydney most of the parents are working from when the kids are small, so when they come home there is no one to supervise them so they go with their mates for companionship …then they get into trouble [with police] (Samoan female, late 40s).

A Samoan youth worker explains what he sees as the reasons for some Polynesian teenagers to rebel against some of the more cloistered cultural practices:

I see both sides [parents and children]. For Islanders, it is a belief that discipline starts from home. We stress and emphasise the [corporal] discipline of children. The children here … don’t always follow the Island custom, they want to change to the Western world because the Island way has is so restricted in the dress code and so on. It’s hard for those kids who live here [in Australia]. They see Palangi [Anglo] kids have all this freedom. They retaliate. They think [physical] discipline is old fashioned and think the Western way of life is better than what they have at home. Then they play up [commit a crime], they get arrested, they don’t have a lawyer – then they’re in jail, but really they are just kids. Their parents don’t understand. They are just worried their kids aren’t going to keep the old ways (Samoan male, early 30s).

When talking with Polynesian youth, many of these issues were raised by them, for example, the extent of corporal punishment, not feeling ‘understood’ by senior family members and in the case of Pacific Islanders, not having the freedom of their non–Polynesian peers.

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\(^{25}\) Euphemism for being cautioned or arrested by police.
For us Maori it’s the same – as a kid, you don’t really have a voice. You’re brought up to do as you’re told, but hearing you guys [Islanders], I think it’s probably not as bad (Maori male, 22).

At home there’s no communication. So when young men are upset and frustrated, they fall back on the violence (Samoan male, 22).

The girls over–eat. They live in the kitchen (Tongan female, 18).

Issues that are important to young people are personal freedom (or lack of it), lack of communication with older family members and the weight of cultural expectations of conformist behaviour. The last comment related to over–eating also offers an insight into how young Pacific girls relate to food as both refuge and reward when they spend so much time at home, or continually supervised in some way.

While many parents are concerned with the perceived deterioration of cultural and family values, there are others who expressed an understanding that their children are under the stress of competing social forces. The following responses demonstrate empathy for the difficult issues faced by young Polynesians in Australia:

Like my niece – she went to another cousin’s presentation. Then afterwards we went out to a club and she goes ‘Oh I’m going to get a hiding when I get home’, and I said ‘Why?’ and she said ‘Because I’m out so late – mum will know the presentation’s over and we’ve gone somewhere else’. It’s frustrating. The mother’s a social worker and she’s on committees talking about youth, and yet her youngest daughter is afraid to go home. She wasn’t doing anything bad, she just wanted to do what the others were doing (Tongan female, mid 40s).

I feel that our kids are coming away from our church. I still feel that strong connection with the church…but it’s diminishing in the next generation. I’ve allowed them to have friends outside the church, but at least they have the church as well. They have to make their own decisions (Samoan female, late 40s).

It’s a problem for our youth. No one listens to them and this is how they learn to react if something goes wrong – they will use aggression. Then the families are shamed because they go to jail. They really don’t see how they contribute to the problem (Samoan male, early 30s).

In Australia it is different. I want my kids to be able to communicate with me. I won’t hit them like we used to be hit and I won’t let my husband hit them. He’s old school and is likely to lash out. I stop him. I do give them a smack if they are really misbehaved though. Pakeka [Anglo Australians] just let their kids get away with anything – no respect (Maori female, mid 40s).

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26 In this context, ‘presentation’ refers to having gold inserts in the teeth, a common practice for Tongans in the home islands and New Zealand.
A commonly held sentiment amongst most participants is that Anglo Australians are too tolerant as parents, and for reasons which are mysterious to Polynesians, do not hit their children even when they are lazy or rude. This is best summed up by a Maori mother of seven:

For *Pakeha* it’s different. They let their kids get away with anything. They answer back. They don’t do chores. They just lie around with TVs and computers. You don’t understand why we hit our kids, and we don’t understand why you put up with that (Maori woman, 55).

**Offshore identity: Sites of identity formation for young Maori and Pacific Islanders in Australia**

The social context of forming, shaping or changing identities is a personal journey, an ‘inward’ search, however, it is also influenced from without by our social interactions. Charmaz and Paterniti (1999) identify three ways in which this search is influenced: the individual’s definition of identity, the views and wishes of significant others, and the interaction and negotiations between these elements. Using this framework, I will first address how parents and older community members see the identity of Polynesian youth – the views and wishes of significant others. This will be followed by a discussion informed by comments of youth themselves and the strategies they use to reconcile these influences.

When talking with parents about how they see their children’s identity, there was a mixed response reflecting the complex interplay of factors around ethnicity, nationalism and transnationalism. For example, the Australian–born children of New Zealand–born Island parents are now twice removed from their country of ‘ethnic’ origin. As one parent put it: ‘Sometimes I wonder what they’ll tell their children. But for me, I tell all my children – you are Islanders [Cook Islanders]. Nothing will change that; it’s your blood’ (Cook Island female, late 40s). The complex double displacement from country of ethnic origin is frequently dealt with, particularly by older respondents, by reverting to ethnicity as a sole marker of identity.

A mixed family in this cohort, a Maori husband and Samoan wife, both born in New Zealand, discussed their views on their children’s identity in Australia. They use the description ‘*hula–hakas*’, a term that has gained ‘traction’ in the last decade in both New Zealand and Australia. It can also be reversed, as in ‘*haka–hulas*’. Used in a jocular way, this term is used to describe a child of one Maori and one Islander parent:
Interviewer: How do you think of your children in terms of their identity?
Mother: They’re hula–hakas alright [one Maori, one Island parent].
Interviewer: Does ‘Australian’ come into it?
Mother: Oh it does at school and that, and they get all fired up about this team or that team and following Australia… I’m teaching them traditional siva [Samoan dancing] and they speak a bit of Samoan, bit of Maori – all with Aussie accents!
Interviewer: Do you think they identify with New Zealand as you were born there [and the eldest child]?
Father: When it counts they’re All Black supporters.

This exchange demonstrates a typical acknowledgement of being in Australia via the school culture of their children, but outside of school, ethnicity is referenced as the dominant identity marker. The ubiquitous intergenerational support for the All Blacks was brought up by virtually all participants, and appears to function as a unifying agent in Polynesian/New Zealand identity formation. A Maori participant described this phenomenon in the following terms:

I think the Maori identity is still really strong. I’m amazed how strong it is. Every Polynesian kid in Australia or anywhere in the world wants to play for the All Blacks. There’s the odd exception who are proud they’ve got family members in this team or that team but really at the end of the day, they all want to be All Blacks and they all follow the All Blacks. That is a stronger affinity than any other because it bonds Maori and Islanders, it bonds the old and the young, those at home [New Zealand], in the Islands or in Australia.

Outside of the All Blacks, many parents were aware of a growing pan–Pacific identity related to and emergent from broader globalised transnational youth cultural mores, specifically Hip Hop and rap music. A Maori mother of five teenagers expressed how she saw her daughters’ relationship to this genre of music and the accompanying ‘gangsta’ clothing and mannerisms. On the one hand she does not particularly like music itself, yet can see that it fulfils another role for the teenagers, particularly ‘Pacific rap’ rather than the more ‘hardcore’ American version:

I worry about my [teenage] girls; they are so into rap and Hip Hop. I don’t like the hardcore stuff [American ‘gangsta’ rap]; I prefer when they listen to some of the Maori and Pacific versions. I see it gives them a sense of identity and belonging – to be with other kids who are also into it. Also in the wider Pakeha [Anglo–Australian] society… it’s given them power. When they walk around the shopping centres, the look, the language… I tell them not to bring the ‘attitude’ home, to leave it out there, but it is a sense of identity (Maori female, mid 40s).

The rise in popularity of ‘Pacific rap’, as distinct from its American roots, is a source of identity for young Polynesians who are now part of a diaspora throughout the Pacific (Zemke–White 2005).
The language and imagery associated with Pacific rap therefore provides an identity marker which links those Polynesian teenagers who share an interest in it, whether they live in Australia, New Zealand or the home islands. The mother’s observations convey an understanding that the music itself and the associated ‘look’ offer her children a way to identify with other young Polynesians whose experiences they share. Her reference to ‘attitude’ is that, although Pacific rap and Hip Hop is arguably not as narcissistic and aggressive as American rap, there is an element of being ‘cool’ or distant to older people that is not conducive to Polynesian family cultural values.

Shopping centres in this context reflect the globalised experience of the shopping mall that is a complex mix of consumerism and social activity. Writing of Pacific youth in New Zealand, Macpherson (2001) acknowledges these as sites of identity creation: ‘Pacific heritage and local New Zealand upbringing …. Creating an identity shared with other Pacific young people which was built around their experiences in playgrounds, schools and malls of urban New Zealand’ (Macpherson 2001, p.75). For Polynesian youth in New Zealand and Australia, schools, mass media and the shopping mall offer exposure to Western values of individual prowess and consumerism, while their home lives and participation in community cultural activities, represents more traditional collective values. The ability to bridge these two worlds successfully is optimised by being able to function effectively in both. Mila–Schaaf and Robinson (2010) regard this bicultural experience as a merging of ‘hybrid synergies’ that has the potential for positive outcomes. Their definition of Polycultural capital, while oriented towards a New Zealand audience, is applicable here: ‘…a theoretical construct which describes the potential advantage Pacific second generation [New Zealand–born] may experience from ongoing exposure to culturally distinctive social spaces’ (Mila–Schaaf and Robinson 2010, p.1).

Within Pacific social spaces, cultural knowledges and language provide a source of counter–discourses that allow alternative ways of seeing, interpreting and being in another world. In other words, it is not about being caught between these worlds but proficient operators within both. A way of achieving this is when migrants are able to de–territorialise their new space and replicate and re–enact more familiar social spaces as suggested by Gupta and Ferguson (1997). Below is a brief exchange between members of a group consisting mainly of university students:

Our Polynesian night at uni went off! We began with a traditional welcome. The dance floor was packed. A local group went traditional with four dancers, then the Sydney ones were contemporary. The band were all young – under twenty–five – someone’s cousins. They
played Island music, old school soul, R & B, Michael Jackson….Everyone starts singing old school stuff. (Samoan male, 22).

I think the church should support this – most of us don’t drink. PIs [Pacific Islanders] have a licence on having fun. Islanders in the club – dancing. Palangis don’t dance …’ (Tongan female, 25).

These comments reflect many issues. Despite parental anxiety about their children ‘losing their culture’, these young people hosted a social event with strong cultural overtones. They managed to organise a traditional welcome that was encompassing of Maori and Pacific Island protocols. Additionally their choice and enthusiasm for music that bridged their own contemporary tastes and music they had obviously listened to with their parents was evident. They had successfully negotiated a predominantly Anglo space – a university – and enacted a version of their parents and grandparents social events.

Migration to countries such as Australia present new challenges for adolescents who are conservatively raised, especially girls. They are often torn between wanting to be regarded as ‘cool’ and ‘normal’ by their peers and not wanting to offend their parents and other relations, as the following comment illustrates:

If I’m going swimming with Palangi [Anglo Australians] or my Australian–born cousins, I’d wear a singlet top and sarong. But if I go with my other cousins [brought up in Tonga] …I’d cover up… long outfits down to there [indicating the knee]. When I buy clothes I think – long – ‘what if I see my cousins?’ – and I’m worried about my family. They have high expectations for me. I don’t want to let them down (Tongan female, 21).

In terms of broader issues of self–defined identity, these adolescents and young adults are influenced by notions of ‘home’ expressed by their parents and grandparents, but are gradually incorporating an ‘Australian’ aspect to their complex identities. For example, there is a tendency for adult Maori migrants to regard themselves as ‘temporary’ visitors to Australia with sixty percent of New Zealand–born Maori stating they intend to return to New Zealand (Hamer 2007, pp.151–152). However, this conviction is reversed for their children. Most young Maori born in Australia regard this country as their home and they have no intention of moving back to New Zealand, whether or not their parents choose to return. Typical of these responses: ‘Mum and Dad say they’re going back [to New Zealand] but I don’t want to go, I’m a Mossie now’. The use of ‘Mossie’ has changed over the last decade to variously mean a New Zealand–born Maori brought up in Australia, Australian–born Maori, or a child of Maori and Anglo Australian parentage. It is both a designated
and self-identified term. For example, sometimes the parent of the child will use it where the child or young adult may not. In other cases, the child or young adult will use the term and be corrected by a parent saying: ‘You’re Maori and that’s that’. Although used in a joking fashion, the term ‘Mossie’ has come to reflect a nuanced, multiple identity that locates young Maori in Australia.

For both Maori and Islanders they are exploring identity options that encompass variations such as ‘Mossie’, ‘Aussie Tongan’, ‘Samoan Aussie’ or ‘Kiwi Aussie’. However, most young participants also volunteered that if they were meeting other Polynesians they would revert to their cultural and, for Maori, tribal identity. For example:

If I meet other Maori, I’ll always say I’m Tuhoe27 – I’m proud of that. But if I’m talking to an Australian I’d probably just say ‘I’m a kiwi’ – they know I’m Maori (Maori male, 22).

Other Islanders and Maori know I’m Samoan because of my tattoos. If I’m talking to another Samoan, we would yak yak [talk] about which village we come from (Samoan male, 23).

To the parents and grandparents, it may appear that their children are ‘pulling away’ and taking on more complex multiple identities. However, there was also a caveat evident in the focus groups that despite these flexible cross-cultural self-descriptions, their core identities retained resonance with their parents’ cultural specificities.

Cousin peer relationships

‘I thought the cousins that lived with us were my brothers and sisters. It wasn’t until years later I realised… not that it makes any difference’ (Cook Island male, 60).

This is an example of the profound nature of the cousin relationship for most Polynesians. A generation later, for both Maori and Islanders, their peer group is almost exclusively formed by cousin relationships. These may be biological first cousins, or more distant cousins who are close in age and geographical proximity during the childhood years. In large families where your siblings may be many years older or younger, it is typical to socialise with cousins your own age, share houses and even jobs. Peer cousins are very important for Polynesian youth as friends and confidantes and these ties frequently continue through adulthood. As people mature, the cousin peer of the parent is referred to as ‘uncle’ or ‘aunt’ by the children in deference to both age and closeness of the relationship.

27 One of the main tribal groups in New Zealand.
While most Maori families expect older males to ‘keep an eye’ on younger female siblings and cousins, the morality surrounding acceptable behaviour is far less constrained than it is in Islander families. This role can be more complicated for Islanders, as male cousins are held accountable for the behaviour and well-being of the female cousins. As the following focus group exchange demonstrates, there is a variation in how these cultural mores are interpreted by individual male cousins:

I go everywhere with my cuzzies [cousins]. If it wasn’t for them I wouldn’t have a life! I’m lucky the boys cut me a bit of slack (Samoan female, 22).

If we [girl cousins] go to the beach, we try and head off a bit early and lie around in our bikinis, but we have to have a lookout for the older cuzzies. Once the boys come down, it’s on with the sarongs and long t–shirts’ [everyone laughs] (Tongan female, 20).

The first speaker was grateful for the freedom she is allowed by her male cousins, while the second response is indicative of the reverse: that the male cousins are policing the behaviour of their female cousins. In the following example, the participant gives an example which was also common; that the relationship between the cousins is negotiated outside the cultural paradigm of male protection:

I love my cuzzies. The boys are supposed to look after us, but half the time it’s us girls who have to get them out of scrapes (laughs) (Tongan female, 18).

Although individual Maori families may have different expectations of the role of the male cousins as ‘protectors’, it is less reliant on gender determination and is illustrative of the comparative freedom of the Maori cousin relationship:

It’s the best thing about going back to New Zealand – all the cousins! I love my cuzzie bros28 here, but there are just so many over there. You can pick who are the coolest to go out with (Maori female, 18).

As most Polynesians still socialise primarily with their cousins, it is evident this relationship helps affirm identity – both for the individual and for the family. In turn, it becomes part of a range of fluid, contextualised and multiple identities expressed by the younger members of this cohort.

28 ‘Cuzzie bro’ is used interchangeably with ‘cuzzie’ or ‘cuz’ meaning both literally blood relations and in certain contexts, other Polynesians.
The extent to which young Polynesians choose to adopt ‘Australia/n’ as part of their identity structure will continue to evolve over time (George and Rodriguez 2009). However, there is also the issue of how Anglo–Australia will perceive and accept the next generation of Polynesians. In the case of visible minorities in Australia, Ford (2009) suggests there is a process of ‘racialised practice’ whereby Anglo–Australians regard non–Anglo citizens differently, forever ‘Other’, regardless of length of time spent in this country. Ford’s study found school teachers in the Northern Territory did not regard those of visibly different ethnicities, even Aboriginal students, as ‘Australian’. This could help explain why Hamer (2008a) noted that second generation Pakeha have become ‘white Australians’ and are accepted as such. By contrast, Hamer found Australian–born Maori remain strongly linked to New Zealand in terms of identity. For Maori and Pacific Islanders interviewed for this thesis, this was not construed as problematic, but rather considered a point of pride and distinction. Data for this thesis indicates Polynesians do not wish to ‘disappear’ into post multicultural Australia. As one participant offered: ‘You learn a lot and you value the culture. It is a necessity to hold on to it. Because once you lose that, you lose respect for what is most special in your life’ (Maori female, 20).

**Social engagement and perceptions of well–being in Australia**

It is clear that for all ages represented in this thesis, civic engagement in the form of taking out citizenship and voting are low priorities. Hamer’s extensive qualitative study (2007) and his follow–up work on demographic movements of Maori (2008a) both reveal that most adult Maori migrants maintain a strong New Zealand–focused outlook and have minimal participation rates in Australian polity – seventy–five percent do not become citizens. The Maori male key informant for this thesis sees this continuing for young Maori. When asked ‘Do you think young Maori vote in any significant numbers?’ his response was:

[Laughing] No way. They have this thing about government. Same with the census. Polynesians like to fly under the radar! The older ones say they are going home [to New Zealand] and the young ones don’t see the point.

As intimated by the key informant’s comments above, this is partly due to a reluctance to interact with government agencies generally, and also due to an on–going allegiance to New Zealand in particular. Reflecting these attitudes and the ambivalence many Maori feel about staying in Australia is the following exchange between the interviewer and a Maori family consisting of husband, wife and the wife’s sister:
Interviewer: Are you intending to stay in Australia?
Wife looking at husband: Yep! [Her husband has an expression that says ‘no – we’ve had this fight before’].
Husband: I’d like to go back …
Sister: Yes, we’re staying. I couldn’t leave my sisters.
Interviewer: Has anyone here taken out Australian citizenship?
All participants in chorus: Nup.
Sister: Couldn’t do that.
Husband: Having the operation! [A slang expression used by New Zealanders to describe taking out Australian citizenship].
Interviewer: What about the kids?
Wife and sister [nodding]: Ours were born here so they are OK.

The inference in this last comment is that their children automatically have Australian citizenship and will not have to make this decision in the future. The response of the sisters is a commonly held position both amongst those Maori who wish to return to New Zealand permanently and those who do not. Most Maori do not consider taking out Australian citizenship.

Low rates of civic engagement, however, should not be readily interpreted as disinterest in long term residence in Australia (Hamer 2007; George and Rodriguez 2009). The majority of participants reported being ‘happy’ in Australia, although many experienced some degree of culture shock on arrival. In relation to the migrant experience, most Polynesians tend to gravitate to the larger cities of Sydney, Melbourne, and more recently, Brisbane and the Gold Coast. To be suddenly living in a big city, with large schools of varied ethnic makeup, and having to negotiate complex workplace arrangements, exposes people to many more experiences than they would necessarily have at ‘home’. For many Polynesian migrants, the Australian school or workplace often represents their first experience of spending extended periods of time out of the company of their relations, and extended kinship group as illustrated in the following response:

It’s great for our kids. We grew up and went to school with people we grew up with, mostly family and cousins. The kids sometimes find it strange, they often haven’t talked to a Palangi [Anglos] before (Samoan female, 18).

Most informants of all ages had a positive reaction to being exposed to people of other ethnicities and religions, such as suggested below:
I got such a shock when I went to work. Some people thought I was Lebanese, or Greek, I guess because of my colour. In New Zealand you’re either Maori, Pakeha, or PI [Pacific Islander], that’s about it. I really like it, eh? I’ve got mates who are Serbian, Irish, even one, he’s Egyptian … (Maori male, mid 40s).

In the Islands it’s all Christian. Coming to Australia, I met Muslims for the first time, and I thought ‘What’s Islam?’ We are so ignorant – well we only usually get to meet our own (Tongan female, 23).

In Tonga I didn’t see any overseas people so there was no choice! You meet someone from the main island like Levau, or the outer islands – it’s not like Australia. Here you meet people from everywhere. That’s fantastic, but you know, the biggest buzz for me is meeting other young Polynesians – we identify, we gravitate together in a way that our parents don’t (Tongan female, 25).

The observations by the last two participants who grew up in the Tonga (as opposed to New Zealand and Australia) reveal the extent of insularity common to Island communities. Outside of those working in the tourist industry, it is rare to meet people of other ethnicities. Also the comment about meeting and socialising with other young Polynesians ‘… in a way that our parents don’t’, is suggestive that older members of each Island community tend to bond together exclusively.

One of the most common points of integration into Australian society for Polynesians remains sport. As discussed in earlier chapters of this thesis, it is in the sporting arena where Polynesian men have the most pronounced visibility, acknowledgement of prowess by others, and success. In Rugby League, Maori and Pacific Islanders constitute thirty percent of rostered premier players, and a full forty percent of the code’s elite teams under twenty years of age, reflecting the growing number of Polynesians born in Australia and therefore eligible to play for Australian teams (Pianella 2007). In much the same manner as sporting excellence is perceived as a way out of poverty for African–Americans, the statistics of Polynesian participation in sport indicate that the perceived rewards of professional sport are a major life goal for young Polynesians and their families. David Lakisa is Samoan and head of the national body looking after the well–being of Polynesian players in League:

The Pacific and Maori community is very small and they feel when one achieves, we can all achieve … in what’s generally a low socio–economic demographic, of course that’s leading to more ‘Plan As’ – planning a career in sport (Lakisa in Stevenson 2008, p.5).

This quote contains several key points. What is evident in this statement is the consocial rewards experienced by the community when a sports star achieves success. There is also the growing
expectation of many Polynesian families that if they can produce a sporting super–hero, the
economic struggle in their daily lives will be reduced. This results from the knowledge as described
above in the discussion on social capital, that the young sportsman will use any wealth he acquires
to help his family and extended family. Further, the sporting success of a family member confers
prestige not just for immediate family, but for Polynesians more generally.

A dramatic example of pan–Polynesian bonding outside of sport, was when Stan Walker, a nineteen
year old New Zealand–born Maori won the highly publicised singing competition ‘Australian Idol’
in 2009. As Walker moved through the elimination rounds, the Polynesian communities (including
Pacific Islanders) galvanised throughout Australia, New Zealand and the Islands to support him.
When it was announced he was in the final to be held at Sydney Opera House, an estimated 300
relatives flew in from New Zealand. When it was announced he had won, these relations then did a
massive, spontaneous haka. When asked by a television journalist: ‘Is it true you had 300 relatives
in the audience?’, Walker responded: ‘Oh yeah, they [relatives] were everywhere, my gosh…
Millions! When they did the haka it was amazing. I got goosebumps. I was so proud’ (Walker
2009). In the media frenzy following his win, Walker described himself both in the Australian and
New Zealand media as a ‘Mossie’ (Maori/Aussie), thereby securing the previously slang term as a
hallmark of identity.

These two examples may indicate that famous footballers and singers are now the ‘face’ of
representations of the extended Polynesian community that was once defined by place. For many
decades, Bondi Beach had the reputation of being a ‘Maori’ suburb. As the cost of living pushed
many more Maori and Islander families to Sydney’s western and southern suburbs, there are now
only a small number of Maori families left in Bondi. As one participant who still lives in Bondi put
it:

It’s sad really. If you had a social [event] in Bondi ten years ago, hundreds of Maori would
turn up. Now there’s just a few of us left. We can’t afford to live here anymore. A flat costs
$450 a week. Now the community has been split up all over – out west, down south … lots
have moved to Queensland. It’s harder to keep everyone together (Maori female, mid 50s).

There was a prevailing perception amongst regional participants that a smaller city such as
Newcastle is more conducive to the preservation of cultural and family values than Sydney. This
was summed up by a Tongan participant (female, 44) who is a social worker in Newcastle. In her
view Tongans in Sydney were not only losing ‘Tongan’ values, but were more isolated from the other Polynesian groups:

Sydney has too many people. Many have grown up in Sydney with different Western ideas more than Tongan ways. It has affected how they assess their life, whereas here [Newcastle] people are helping each other. So that’s why Tongans, Samoans and Maori have never had a fight here. In Sydney it’s different, they can stay in their own community and everyone else is an outsider.

Another participant, a Samoan university student (female, 22) agreed:

The connection between the Polynesians is stronger here in Newcastle, and at the same time the traditional is more kept here. In Sydney there are many Island people, here we are a tiny minority… just a few Samoans, Maori and Tongans. Here in Newcastle people socialise as a family, even little babies. In Sydney they don’t. To me the lifestyle there has a bad effect on the people. Here they still have family values, Sydney is starting to lose that. Family is pulling sideways and it doesn’t get better. In Newcastle we go to each other’s events.

Overall, participants agreed that Australia offered them a ‘good life’ for themselves and their families. Although some of the older participants (over fifty) expressed nostalgia for returning to New Zealand or the Islands, even amongst this age group, many expressed a preference for living in Australia:

I love it here. The health care’s better and cheaper than New Zealand. I love being with my mokos [grandchildren]. I can help them learn their Maoritanga [cultural knowledge] and I can see they will have more opportunities here (Maori female, 60).

This sentiment confirms the findings in Hamer’s work (2007) that older Maori feel that their grandchildren in New Zealand have access to many cultural opportunities and te reo (Maori language), whereas in Australia they do not. The role of cultural custodian to their own families and the broader Maori community in Australia makes them feel useful and valued.

The majority of participants, aged twenty–five to fifty – the economic migrants who came to Australia for improved work prospects – were pleased with their decision to move countries:

The pay in New Zealand is stink compared with here. I earn four times what I’d earn at home for the same work (scaffolding/steel fixing). My wife earns at least twice what she was back home (Maori male, early 40s).

There’s just no work in the Islands. The only choice is do we go to New Zealand or Australia? Now there are more Samoans in Australia, it is much more attractive. But houses are expensive! (Samoan male, 36).
For the second participant, there was clearly no option of staying in Samoa; if he wanted work there was only the question of which migration destination he would choose. His comment about the increasing number of Samoans in Australia is reflective of the ‘beaten path effect’ described in the Introduction to this thesis. This was the case for many of the Islander participants: ‘We thought about New Zealand but it’s too cold! But there’s too many gangs over there too, especially in Auckland. I’d be worried my boys would get into trouble’ (Tongan female, 43).

The concern about unemployment and gang behaviour for youth in New Zealand was frequently cited as a reason for choosing Australia by both Maori and Islanders. Another issue that was raised was health care. In the home Islands the quality and availability of health care is very low, and although much better in New Zealand it is expensive. While it was acknowledged that culturally appropriate health care was more accessible in New Zealand, the cost of medicines and treatments are considered prohibitive. As an example:

I was amazed once we got through all the paperwork ...I could get all mum’s medicines subsidised. Culturally they would handle her better in New Zealand, they would understand the whanau [family] would be there in force [laughs] and be able to talk to her in Maori, but it still costs a lot (Maori male carer, 45).

This comment sums up the duality discussed throughout this thesis: that for Polynesians to experience improved health statistics regarding preventable illness, the issues need to be addressed both culturally and in terms of the working class realities that face most Maori and Pacific Islanders relating to education and income.

**Conclusion**

This concept of Polycultural capital, as defined by Mila–Schaaf and Robinson, works well with the socio–centric ethos of Polynesian socialities. The interplay between class, social disadvantage and culture, acts on the one hand to reduce the possibility of accumulation of wealth, but alternatively, it can provide stability and comfort in difficult economic times and offer support for those who have recently migrated to another country. Migration is stressful, therefore, the embedded nature of networks and reciprocities enacted in the extended Polynesian community are particularly important to how people adjust to being in a new country and inform their feelings of ‘belonging’. These practices serve this community by creating links (bonding) with other Polynesians who have been here longer and who are more adept at making connections with the broader Australian
multicultural community. Such cultural practices also function to reinforce identity for the next generation.

True ‘oranga’ or well-being requires security of identity – and identification – with place, family and wider community. The challenge to define personal and cultural identity is made more complicated by increasing migration and dispersal of individuals and families. It is such a layered issue, that there are now diverse identities expressed within families. Most first generation migrants, adhere to their primary cultural/ethnic identity. However, those representing the next generation of Maori/Islander/Kiwi/Australian Polynesians indicated they were not necessarily locked into a single identity, but prefer a more pluralistic expression of their social realities. Many of the younger participants commented on feeling very connected to other Maori and Pacific Islanders. In turn, this enables these young people to experience ‘belonging’ in another country by identifying with each other.

Overall, participants do not regret their decision to migrate to Australia and are in the process of inhabiting a cultural position within the broader Australian multicultural landscape. The qualitative interviews suggest there is significant variation in interaction inside and outside the communities, with Pacific Islanders interacting less than Maori with those outside their discrete church and familial groups. Despite this disparity, Pacific Islanders were equally enthusiastic about moving to Australia. Both groups have an extremely low incidence of civic engagement in terms of bureaucratic processes such as registering to vote. However, this pattern does not reflect on their commitment to making their lives in Australia.

While it is inevitable that some young Polynesians will ‘lose’ or replace their cultural identities and be subsumed within the mainstream Anglo–Australian culture, the cultural practices that sustain these communities appear to be resilient, and there is a strong commitment to continue these activities. This is crucial to future well-being of young Polynesians in Australia as a ‘visible’ minority. Both the literature and the data suggest that if the next generation are able to retain strong cultural identities, reiterate and/or adapt unifying cultural practices, and operate successfully between the ‘two worlds’, they will be well placed to maximise their opportunities in regard to better education and employment prospects, which in turn will help reduce the rates of preventable illnesses afflicting their communities in the future. However, if a significant number of second and third generation ‘Mossies’ do not acquire sufficient Polycultural capital to inhabit both worlds successfully, the incidence of preventable illness in this community will continue to be problematic.
Conclusion

The importance of this research and its findings

This thesis is a unique contribution to Australian research understandings in sociology regarding the specific health concerns of Maori and Pacific Islander migrants. With the exception of ethnographic studies in relation to Melanesia, mainly Papua New Guinea, Australia has largely confined itself to sporadic strategic and ‘development’ interventions in the South Pacific. The Australian government and academic researchers have largely ignored Polynesia and Pacific studies more generally is in decline. Now Polynesians are one of the fastest growing immigrant groups to this country, Australian researchers and health workers need to be apprised of the social and cultural factors that influence the health of this migrant group. The diverse elements that contribute to this overall picture need to be interrogated via a range of sites and factors requiring a transdisciplinary approach. This requires a specialised literacy that involves a mix of critical, cultural, political and place-based understandings. For this reason, the findings of this thesis provide a basis not just for health professionals, but also teachers, social workers and policy makers. Maori and Pacific Islander community workers will also benefit from having this body of work from which to build their own research models and enable implementation of those undertakings.

As discussed, it has been demonstrated repeatedly that social disadvantage plays a significant role in both the acquisition of many preventable illnesses, and how the individual approaches their health status. This correlation has been largely ignored in the prevailing climate of neo–liberalism that has encouraged the devolution of government responsibilities for welfare, health and education. When coupled with poor employment strategies, this strategy has meant the socio–economic position of Maori and Pacific Islanders in New Zealand has not improved, and has in some instances, declined. This has been a major contributor to the escalation of Maori and Pacific Islander migration to Australia.

Maori and Pacific Islanders are arriving in Australia in greater numbers, staying longer, most permanently, giving birth to their children here and bringing relatives from overseas to live here. Maori/Pacific Island ‘economic migrants’ may appear fit and healthy, however, statistically, the incidence of type 2 diabetes, hypertension and cardiovascular disease and other forms of obesity–
related illness is extremely high. When this profile is coupled with family reunion migration of older relatives who are arriving in greater numbers to be near their grandchildren, it represents an escalation of current and potential financial outlays for Australian mainstream health services. As demonstrated throughout this thesis the issue of how to most effectively treat these patients with an awareness of Cultural Safety, and finding ways to avoid the onset of such serious preventable ailments in the future, is becoming more pressing as the number of Polynesians permanently resident in Australia continues to rise.

Discussion of findings

Food rituals reinforce cultural practice, effectively preserving cultural traditions in a way that people enjoy. The participant statement, ‘That’s what we do, that’s who we are’ makes a clear assertion that Polynesians are indeed a ‘gastro identified’ group and reflects the inextricable nature of the relationship of food and culture in Polynesian communities. However, traditional eating practices have been distorted through the uptake of excessive amounts of commercially produced foods. Combined with a progressively sedentary lifestyle, this has played a significant role in the exacerbation of declining health in relation to obesity. The pleasurable and historic associations of certain foods can lead many Polynesians to assume a ‘cultural resistance’ to suggestions they should abandon such foods and radically modify their eating practices. This position is compounded by the majority of families being working class, thereby joining working class Australians who are also not responding to the current health campaigns around food and lifestyle modification. This apparent resistance should not be construed as Polynesians being disinterested in improving their health. Rather, the ‘problem of obesity’, and inherently its solution, lies in the examination of forms of cultural and class resistance to transitioning away from food and lifestyle practices that are contributors to high rates of obesity. This research has explored in detail the nexus between class and culture in regard to Polynesian obesity, and its prevention and treatment in Australia.

The preparation and ceremonial exchange of traditional foods has a particular and inviolate place in Polynesian cultural practice. It is the medium through which major social interactions are conceived and played out. In a modern wage–labour economy like Australia, Polynesians continue to work together to feed the extended family, and it is around food exchange rituals that the community sustains and affirms its socio–centric identity and sense of well–being for community members. For the Polynesian diaspora, the processes of traditional food preparation and ways of eating are continuing, although accompanied by a dramatic increase in the consumption of commercially produced, highly processed foods. There is not a total shift from one type of food, that is,
traditionally grown and prepared, to another that is commercially produced. Rather, there is evidence of a broadened Polynesian experience of food in a globalised, transnational world.

The role of food–based exchange and ritual re–enacted in the diasporic population retain their significance, especially for first and second generation migrants. In this way, food practices act to affirm a Polynesian collective identity and are integral to social and cultural cohesion and well–being. Nonetheless, the burgeoning demand and consumption of processed foods in daily practice, and the incorporation of these foods into ritualised feasting, contributes to concerns regarding the long–term health risks associated with obesity for this population group. As a cultural group who value and celebrate signature events by eating large, arguably extreme amounts of food, there are cultural considerations that need to be integrated into any future health promotions aimed at this population. These eating patterns are underpinned by cultural notions encouraging the large and substantial body. I have endeavoured to explore these associations, because without incorporating such cultural understandings, research enquiry as to why Polynesians are obese, in such numbers, would be incomplete. For Polynesians, a large body speaks of mana (dignity and power), generosity, and health. Conversely, a slim body connotes weakness, illness and lack of social appeal or attractiveness. Given these cultural referents, the current paradigm of mainstream Australian health promotions around weight loss in the interest of good health, has little relevance for this community. Conceptual systems reflect how people see their own bodies, therefore Western health professionals need to be aware of alternative social constructions, or cultural schema, that inform perceptions of the body, health and wellness for their non–Anglo patients. It is evident, therefore, that there is a need for more culturally specific programs, especially when working with CALD groups, for these differences to be mediated.

For Polynesians, the complex social meanings around the role of food and food rituals, and the cultural preference for a larger body, outweighs appeals to this community to eat significantly different foods, in reduced quantities. There were, however, indications from the younger participants, under twenty–five years, that this may change to some extent in the future. They suggested that an inundation of Western imagery and associated values of ‘slimness’ being preferable to ‘fatness’ were beginning to influence them. It was unclear if this was a desire to appear attractive to the broadened peer group of multicultural Australia, or driven by health concerns. It, therefore, remains to be seen whether these motivations, singly or in combination, will translate into significant changes in individual, family and community foodscales over time. At present, however, Polynesians remain in the highest risk categories for obesity–related disease due
to the convergence of social disadvantage and certain cultural practices that impact on health and health literacy.

In the data collection phase of this thesis, it was affirmed repeatedly that chronic obesity–related illness and premature mortality were major issues for this community. However, the correlations between obesity and a range of life–threatening conditions is poorly understood in the community. The fact that type 2 diabetes can be prevented or managed by modified food intake and an increase in daily exercise is not well understood (Ferreira and Lang 2006). Frequently, in the Maori/Pacific Islander community, the preventable nature of type 2 diabetes and other obesity–related illnesses, is subsumed by a fateful resignation generated by genetic labelling. This would appear to be an internalisation of the biomedical view that Polynesians are inherently predisposed to obesity itself, heart disease and diabetes. As the lay public have little understanding of the predictive limitations of genetic research it is difficult to allay genetic determinist views. Most Maori and Pacific Islanders remain convinced they are genetically programmed to experience these diseases, and most regard premature mortality as inevitable. Without addressing this issue, public health messages regarding obesity–related illness are unlikely to gain traction. It is most important that health workers and policy makers are aware of this in order to more effectively intervene in the prevention or early onset stages of illness.

With the application of the theory of Kaupapa Maori and the framework of Cultural Safety it becomes apparent that the residual impact of colonialism underlies subsequent social disadvantage. This has implications in relation to social positioning and income that impact on health, education, employability and rates of civic participation. The literature reveals that those citizens who have a ‘comfortable’ level of disposable income are more able to participate in society, have a choice in forms of work and recreation, have access to both private and public health care and information, and are more likely to exhibit better health and provide better health care for themselves and their children. Conversely, for a visible minority who do not occupy such a socio–economically secure space, and are marginalised for reasons of post–colonial poverty, racism and low educational achievement, the cycle continues in reverse, manifesting in lower civic engagement, poor primary health care and resultant premature mortality.

Most of the Polynesians in this study exhibited a working class habitus, whereby the coded behaviours associated with this status, including low levels of education and poor health literacy, serve to reinforce negative lifestyle choices that are not commensurate with long term good health
and well-being. At the same time, the socio-economic pressure to feed big families affordably has led to a dependence on poor-quality foods to supplement traditional foods and food experiences. As a consequence, it is very difficult for individual Polynesians to ‘rationally’ influence external factors impinging on his or her own health. When these factors are combined (the post-colonial experience, low socio-economic status, and the diasporic experience) they form a concentration of risk in relation to obesity-related disease. It is only by examination of these complex and intertwined issues, that sense can be made of the intransigent nature of the poor health status associated with Polynesians.

Another dimension to the findings of this thesis, and borne out by my long-standing personal involvement in this extended community, has been that the consocial formation of family, extended family and community lies at the heart of all social relationships. It is within this socio-centric construct that ideas about the body, self and identity are formed. In this thesis it has been argued a strong sense of cultural identity is essential to achieving positive outcomes in health and education. Further, the embedded consociality of cultural ‘belonging’ frequently expressed by participants needs to be aligned with a national sense of identity to form a broader idea of ‘belonging’ and place, in order to maximise health and social outcomes. This requires a transitioning of identities for migrants, and more particularly, their Australian born children.

For first generation migrants, their primary identity is culturally specific and in the case of Islanders in particular, allied with their church affiliations. Although the relationship between educational level and religious affiliation is complex, for many first generation participants, their relationship with their church is regarded as an affirmation of cultural identity. The cultural profiling of congregations continues to be employed, for example, ‘Tongan Mormon’. At this time, the interwoven nature of social, filial and church obligations act to reinforce and maintain the ties between families and the extended community in Australia and the home islands. The focus group discussions with younger people (under 25 years) indicate religious identification as an identity marker may diminish over time as a result of the ‘diluting’ influence of migration and with more community members entering further education.

Second and third generation Polynesians are acquiring aspects of an ‘Australian’ identity, however, this is only a partial picture. Whatever individual identity descriptions may be given such as ‘Mossie’ or ‘Aussie Samoan’, young Maori and Pacific Islanders are in the process of also cultivating a new collective hybrid identity, that is Australian–born Polynesians. In this formulation,
their place of residence is shared with their main, core identity as Polynesian. It would appear such hybrid identities will continue to evolve. While young Polynesians continue to live as part of an extended family structure, they are likely to retain their consocial cultural identity. For those who leave the family home at a young age, live with non–Polynesian friends and ‘marry out’, their perception of identity may include a broader ‘Australian’ component. Also at issue is the degree to which young Polynesians, continuously exposed to Western individualistic values via the media, school friends and the workplace will be able to maintain the non–materialistic value system of older family members. In time, this may well impact on levels of happiness, feelings of belonging and ultimately well–being. It remains to be seen how this impacts on their general health, body awareness and whether they are subject to different concentrations of risk, or if the present pattern is reproduced.

**Implications for government social and health policies**

As a still relatively small migrant group of approximately 160,000 people, it is unlikely the cultural needs of Polynesians will be a priority of health services in this country in the foreseeable future. However, the increasing numbers of Polynesians in Australia who are now presenting in the health system with long term complications of preventable illness, underlies the need for a greater understanding and utilisation of the practice of Cultural Safety in this country. Attempts by medical practitioners and allied health staff who employ simple Cultural Safety measures were acknowledged and appreciated by extended family members in this study. While many individual patients and their families commented that they were receiving ‘good quality’ medical care for their ailments, there are still many social, cultural, political and economic factors to be addressed if clusters of ill–health and diminished well–being, are to be reduced in this community.

Health care providers are also advocating for better interpreting services and improved recruitment and training of health care workers from Polynesian CALD communities (Wepa 2005). Individual bilingual members of these discrete communities are stressed by trying to service families and provide a bridge for health workers. Such unpaid pastoral care leads to interruptions in their own working lives, and several participants reported that being a cultural resource for allied health staff and an advocate for the community is exhausting. They also suggested they feel distressed by having to convey and explain technical medical information without sufficient training.

A growing number of health care providers in Australia have also indicated they would benefit from more cultural awareness training themselves (Bedford et al. 2009). The reflexivity accompanying
Cultural Safety training and skills acquired in helping Polynesians and other CALD patients, provides health care workers with a more substantial ‘tool box’ for working towards better treatment and delivery of services. The issue of resources for improving health in marginalised populations reflects the political will of elected governments and has other implications in regard to the total picture of Cultural Safety. As the paradigm of Cultural Safety becomes more widespread in Australia, the lessons from New Zealand may prove valuable. While New Zealand has been at the forefront of culturally targeted nursing practice, with particular regard to Polynesian health, it has not adequately resourced this endeavour. Cultural Safety practitioners have experienced ‘burn out’ in the wake of budget cuts and inadequate training, while demands for their services have increased.

In the overlapping literatures which bear upon the social analysis of health, there has been a great deal of discussion and recommendations for empowerment of individuals and communities, and rectifying social inequalities and power imbalances in relation to health. In order to shift policy direction and implement these recommendations, changes would be required to embedded practices of governments and institutions and the short-term time frames within which they operate. These political determinants continue to undermine the full potential of Cultural Safety measures that may otherwise promote a significant improvement in Polynesian health.

The demand for an ethical and urgent response to the crisis in Indigenous health is, of course, not unique to Polynesians. The multi-sectoral determinants of health, well-being and social engagement are issues familiar to those working in other Indigenous communities. These issues include the need for greater mentoring of Indigenous students in education, acquisition of life skills, reducing disparities in income and chronic household overcrowding. The key social determinants of health remain unaddressed as they exist in the domain of different government departments and portfolios. This piecemeal approach is an obstacle to genuine attempts to arrest inter-generational disadvantage in Indigenous, migrant and other socio-economically deprived communities.

This has a particular impact on CALD groups. For many Polynesians, access to healthcare is a balancing act. In some cases Polynesian migrants under-utilise services because of cultural inhibitors such as shyness or unfamiliarity with the ethnicity of the service provider, low health literacy regarding the need to attend treatment and financial strain. However, like many CALD groups, they are more likely to over-use comparable services because of anxiety regarding the health status of family members and perceived high quality of services compared with the country
of origin. The problem then becomes one of compliance with treatment regimes when the immediate health crisis has passed – in other words, building health literacy in the community.

Frameworks of health care ultimately determine and characterise the contexts within which professional health care practice occurs. The move away from institutional hospital care to ‘super clinics’ in a community setting appear to offer a more localised, responsive approach to care for the chronically ill. However, when introduced without adequate infrastructure, staffing or training, and lacking cohesive and transparent benchmarks of success, the model is ill-equipped to produce consistently positive outcomes for the client base. Indeed, devolving federal and state government responsibility to local providers can be an attempt to off-load national responsibilities for health care that may, in turn, disadvantage communities because of under-funded, under-resourced programmes that are conducted in highly medicalised, inappropriate systems.

**Limitations of this research**

This qualitative study gathered in–depth data from sixty–seven people. These were comprised of nine family groups together with individual and focus group participants. Although I interviewed a cross–section of participants, in terms of age, marital status, length of time in Australia and employment there is a limit to the generalisability of the findings. There is scope for more extensive surveys to be carried out with both family groups and individual participants on a larger scale. In addition, the nature of this thesis did not allow for specific health details of participants to be gathered. Future research linked to health records might examine ‘baseline’ weights for Polynesians that would inform further discussion on whether the heavier muscular–skeletal structure of Polynesians discussed in the literature should be factored into BMI calculations. It would also allow a longitudinal study of weight gain (or loss) in the diasporic community and relate this to the incidence of obesity–related illness and cultural change. Further research could also explore ways in which young Polynesians may be motivated towards adopting healthier lifestyles. Qualitative interviews would reveal the extent to which these young people may be influenced by having a broader multicultural Australian experience than older family members, or whether their health literacy matures to an extent that they seek out the health benefits of different eating and exercise patterns.
Implications and suggestions for further research

As obesity continues to attract concern amongst health professionals, there is likely to be a proliferation of programmes and campaigns designed by medical specialists and allied health scientists to address the issues. However, Polynesian communities, with their cultural associations of obesity as ‘normal’ and even desirable, are unlikely to respond to directives to radically change their eating habits. At present local delivery of type 2 diabetes education is limited, and among Pacific Islanders grossly inadequate. Programs based on qualitative research findings carried out within a Kaupapa Maori framework such as these might be more successful. This thesis, therefore, offers a culturally relevant methodology to explore research opportunities in regard to identifying gaps and points of tension between Western and Polynesian understandings of health and inform the shape of experimental or pilot intervention programmes.

In order to maximise the impact of such programs they would ideally comprise ‘transformative research’ techniques as a foundation for capacity building in the extended community. This requires researchers who understand the cultural factors that are enacted around issues of the body and health to be able to direct and ‘interpret’ responses. Programs should also be ‘localised’ to encompass Polynesian perspectives and specific issues relating to migration to Australia and be carried out in a culturally appropriate fashion; for instance conferences and forums held at weekends do not attract Pacific Island participants who have church and family responsibilities then. This is why qualitative data collection, allowing people to speak with their own voice, participate in a process they understand, and achieve goals they have identified makes for better long term results. Recognition of the strengths, resilience and knowledges that are employed by diasporic Polynesians to support one another, as set out in this thesis, should inform such programs.

The findings of this research suggest wide-ranging goals to raise levels of health literacy, increase places in training and work experience for Polynesians, improve cultural training for non-Polynesian health workers, and create more accessible ‘family friendly’ primary care outlets. A dialogue needs to be established aimed at building strategic alliances within and between sectors. Such an inter-sectoral approach involving researchers, health practitioners, policy makers and community advocates would enable better co-ordination of programmes. In terms of community involvement, the prioritising of issues to be addressed, co-ordination between community leaders and health professionals and the training of young Polynesians in related fields is essential. The strengthening of public health infrastructure should be inclusive of new and innovative methods of delivery of health information and services, such as story-telling and mixed media messages in
English and the various Island languages. The role of interpreters is also at issue here. Dual accountability to the community and the medical institution is demanding in terms of time and energy outlay and these voluntary contributions should be acknowledged. It is important that more people with these language skills are identified within the community and at least a proportion of these volunteers properly funded for the work they do. There is also a need for more language training for community interpreters in relation to health as many struggle with the complex and alien medical terminology they are asked to convey between practitioners and patients.

Australian medical staff and health care professionals cited in this thesis understand that to be successful, strategies must to tailored to individual CALD populations, in this case Maori and Pacific Islanders. This requires a ‘culturally sensitive’ approach rather than ‘general multicultural approach’ to population health that would improve outcomes. For example, culturally mediated eating practices for Polynesians may not resonate with other migrant communities’ food habits where people eat more moderate proportions of food. Ideally information regarding cultural proclivities around notions of the body, eating, health and well–being would be part of increased exchange between health researchers in Australia and New Zealand. This would also contribute to the body of knowledge on Cultural Safety in Australia.

These and related recommendations can be undertaken in such a way that is not inordinately expensive, nor duplicate existing services. Well–designed pioneer models could be introduced that are largely interchangeable with quite simple localised adjustments, particularly in relation to language. These mini healthcare models could be implemented in the future throughout the South Pacific. This would, of course, be of great benefit to the region that is presently under–serviced because of being part of individually small populations, geographic isolation, and poverty. In this way, best models of practice can contribute to the international body of literature on optimum healthcare for Indigenous peoples more widely.

If hauora (health) and oranga (well–being) are to be achieved for this population group, issues of social equity and cultural reflexivity of health care providers need to be addressed simultaneously. This is both in the area of research and health care delivery. Without remedial actions that reflect cultural paradigms relevant to the population group, significant improvements will remain elusive. It is a recommendation of this thesis that culturally specific programmes and strategies that are inclusive of community values from their inception, are encouraged and resourced, even if certain individuals do not engage. The lack of investment in culturally targeted preventative measures
could be described as a ‘false economy’, as the cost of treating these conditions soars when left untreated.

It is also evident that macroeconomic policies and social infrastructure conducive to healthy lifestyles must be initiated alongside health promotions and pharmacological interventions to control diabetes, heart disease and other obesity–related illness in working class communities more generally. It is indeed ironic that it may well be the spiralling costs of chronic disease and disability that may prompt the Australian government to support a more preventatively–based approach to the problem of obesity. Such an economic imperative should increase the demand for prevention strategies in the short and long term future, which is why this research will assume greater importance in the coming years.

There is a need to address and counteract the impact of billions of dollars spent on attracting consumers to the global marketplace of fast food. Additionally, a commitment needs to be made towards improving the quality of food, more generally, that is available to consumers. In the current situation, both Australia and New Zealand have done little to limit the problem of large export corporations selling poor quality meats and groceries, particularly in the Islands. This directly contravenes advice by health researchers that these products disproportionately contribute to obesity in the Pacific, and defies warnings by health economists about the escalating costs of treating obesity–related illness.

Finally, this research has specified the cultural context in which Maori and Pacific Island migrant health must be viewed. The many health afflictions, complications, disabilities and premature deaths associated with obesity that are of paramount importance in this community clearly emerge from a confluence of socio–economic and cultural factors. The pathologising of obesity in biomedical terms and insistence that it be viewed as an individual health issue will not further understandings of the high incidence of obesity and related illness for Polynesians. Rather, the relatively high degree of social capital evident in this community needs to be drawn upon to design and promote alternative health messages and programmes relevant to this group. With the application of both Kaupapa Maori and Cultural Safety principles, further research into the health of Polynesian migrants in Australia may lead to more positive outcomes in the future.
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246


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GLOSSARY MAORI/PACIFIC ISLANDER TERMINOLOGY

This glossary is intended as a guide to the non-Polynesian reader of this thesis. These are, therefore, not dictionary definitions as such, rather they explain the terms as they were described in the original academic source or in some cases, the meanings as commonly used in conversation. These terms are in te reo (Maori) unless otherwise stated. For further advice on meanings and pronunciations please see: Te Aka Maori/English dictionary online:
http://www.maoridictionary.co.nz/index.cfm?dictionaryKeywords=arohanui&n=1&idiom=&phrase=&proverb=&loan=

Ako Maori – the principle of culturally preferred pedagogy
Aroha – love
Arohanui - affectionate way to ‘sign off’ on letters and other communications
Ata - encompasses ideas of effort, discipline and the ability to plan
Fale – traditional house in the Islands
Hapu – extended family
Hauora oranga – health and well-being
Iwi - tribe
Kai - food
Kia ora - greeting and salutation
Kia piki ake i nga raruraru o te kainga – the principle of socio-economic mediation
Kaupapa Maori – the Maori way: for Maoridom to be able to debate, conceive, shape and create its own aspirations and goals. The name of the theoretical model for this thesis. Kohanga reo - literally ‘language nests’ – the name given to Maori run kindergartens in New Zealand
Matauranga Maori - knowledge and understandings of both the visible and invisible that exist and interact in the Maori worldview.
Pakeha – Anglo New Zealander. Also progressively being used to describe Anglo Australians
Palangi/Palagi – Pacific Islander version of Pakeha
Pito – umbilical cord
Tamariki – children
Tangata whenua – people of the land/Indigenous people

Taonga tuku iho - the principle of cultural aspiration

Te reo - Maori language

Tikanga – collective name for cultural practices

Tino rangatiratanga reflects concepts of sovereignty, self-determination and the right to independence for Maori

Wa - time

Wahi - the notion of ‘space’

Wananga - gatherings, or institutes of higher learning institutions based on Maori principles

Whakama – shy, self-conscious

Whakawhanaungatanga - acknowledges the need to incorporate the concept of whanau into government policies and initiatives and to cultivate relationships between whanau and government agencies.

Whanau – family

Whare – house

Whenua – land/placenta
APPENDIX A

Summary of family participants’ household densities and migration histories

Code
- Adults – over 18
- Dependent children – under 18

Maori Families

Eastern Sydney 1 – 2 adults with 2 dependent children
Two adults born in New Zealand, two children born in Australia. Migrated to Australia twenty five years ago.

Eastern Sydney 2 – 3 adults with 5 dependent children
Mother, father, their own three children, mother’s sister and her two children.
All adults born in New Zealand, five children born in Australia. Migrated twelve years ago.

Eastern Sydney 3 – 4 adults
Disabled mother, her three sons, one of whom is her primary carer.
Three adults born in New Zealand, one in Australia. Migrated to Australia twenty five years ago.

Southern Sydney – 7 adults, 5 dependent children
Mother, father, their two adult children, (one with partner and child), three teenage nieces, mother’s sister, her husband, and their dependent child. All adults born in New Zealand, all children born in Australia. Migrated to Australia twenty years ago.

Southern Sydney 2 – 1 adult (single mother)29, 1 dependent child
Single mother born in New Zealand, child born in Australia. Migrated five years ago.

Tongan families

Newcastle 1 – 8 adults and 1 dependent child
All adults born in Tonga, with exception of sister and partner born in New Zealand. Main family migration around twenty–two years ago to New Zealand. Migrated to Australia seventeen years ago. Child born in Australia.

29 There were other unpartnered women with children in this cohort, but they had chosen to live with their extended families, and were therefore interviewed as part of the broader household context.
Newcastle 2 – 7 adults and 3 dependent children
Mother, father, their three dependent children, two grandparents, father’s two sisters, mother’s niece. Two oldest participants born in Tonga, remaining family members born in New Zealand. Migrated to Australia five years ago.

**Samoan families and Samoan/Maori family**

Lake Macquarie – 6 adults, 8(+) dependent children
Mother, father, three sons, four daughters, father’s sister, two nieces, one nephew, one grandmother and assorted grandchildren (infant to 10 years) also live with them.
Parents born in Samoa moved to New Zealand as newlyweds (1979). Their six children were born in New Zealand. Grandchildren born here. Migrated to Australia ten years ago.

Sydney – 8 adults, 2 dependent children
Mother, father, their own four children, mother’s brother, mother’s niece, father’s sister and her child. Five related adults born in New Zealand, two eldest teenage children born in New Zealand, youngest teenage child and two dependents born in Australia. Migrated to Australia eight years ago.

Sydney Samoan/Maori – 5 adults, 2 dependent children
Mother, father, their two children, father’s sister and her husband, mother’s adult niece. Maori husband and Samoan wife both born in New Zealand. Eldest child born in New Zealand and youngest in Australia. Migrated to Australia six years ago.

**Cook Island family**

Sydney – 9 adults, 3 dependent children
Mother, father, their three teenage children, their adult son, his partner and their three children, mother’s aunt, grandmother. Two primary adults born in the Cook Islands, eldest children born in New Zealand, grandchildren born in Australia. Migrated to Australia ten years ago.

**COUNTRY OF BIRTH**
The majority of respondents were born in New Zealand, including Islanders. Age of migration was typically mid to late twenties. Most children in the household studies were born in Australia. Average length of time since migration 13.5 years.
APPENDIX B

Summary of individual and focus group participants

**INDIVIDUAL PARTICIPANTS**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Age</th>
<th>Gender</th>
<th>Country of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maori</td>
<td>Mid 30s</td>
<td>Male</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Maori</td>
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<td>Male</td>
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</tr>
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<td>Maori</td>
<td>35</td>
<td>Female</td>
<td>New Zealand</td>
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<tr>
<td>Maori</td>
<td>Early 50s</td>
<td>Female</td>
<td>New Zealand</td>
</tr>
<tr>
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<td>New Zealand</td>
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<td>Cook Island</td>
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<td>Male</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Samoan/Maori</td>
<td>18</td>
<td>Male</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Tongan</td>
<td>22</td>
<td>Female</td>
<td>Australia</td>
</tr>
<tr>
<td>Tongan</td>
<td>Mid 40s</td>
<td>Female</td>
<td>Tonga</td>
</tr>
</tbody>
</table>

**FOCUS GROUP PARTICIPANTS**

**FOCUS GROUP A (Newcastle)**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Age</th>
<th>Gender</th>
<th>Country of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maori</td>
<td>22</td>
<td>Male</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Samoan</td>
<td>22</td>
<td>Male</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Samoan</td>
<td>22</td>
<td>Female</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Tongan</td>
<td>18</td>
<td>Female</td>
<td>Australia</td>
</tr>
<tr>
<td>Tongan</td>
<td>24</td>
<td>Female</td>
<td>Australia</td>
</tr>
<tr>
<td>Tongan</td>
<td>25</td>
<td>Female</td>
<td>Australia</td>
</tr>
<tr>
<td>Tongan</td>
<td>20</td>
<td>Female</td>
<td>New Zealand</td>
</tr>
</tbody>
</table>

**FOCUS GROUP B (Sydney)**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Age</th>
<th>Gender</th>
<th>Country of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maori</td>
<td>22</td>
<td>Female</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Maori</td>
<td>20</td>
<td>Female</td>
<td>Australia</td>
</tr>
<tr>
<td>Maori</td>
<td>19</td>
<td>Female</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Maori</td>
<td>24</td>
<td>Male</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Maori</td>
<td>18</td>
<td>Male</td>
<td>Australia</td>
</tr>
<tr>
<td>Samoan</td>
<td>22</td>
<td>Female</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Age</td>
<td>Gender</td>
<td>Location</td>
</tr>
<tr>
<td>-----------</td>
<td>-----</td>
<td>--------</td>
<td>-----------</td>
</tr>
<tr>
<td>Samoan</td>
<td>22</td>
<td>Male</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Tongan</td>
<td>23</td>
<td>Male</td>
<td>Tonga</td>
</tr>
</tbody>
</table>
APPENDIX C

Education and employment histories of individual and focus group participants

INDIVIDUAL PARTICIPANTS

Samoan/Maori male, 18, born in New Zealand, employed in unskilled work
Cook Island/Maori male, mid 30s, born in New Zealand, studying at TAFE part time
Cook Island male, 60, born in New Zealand, studying at university full time
Maori male, mid 30s, born in New Zealand, studying at university part time
Maori male, 22, born in Australia, unemployed
Maori female, 35, born in New Zealand, employed in unskilled work
Maori female, early 50s, born in New Zealand, employed in unskilled work
Tongan female, 22, born in Australia, studying at TAFE full time
Tongan female mid 40s, born in Tonga, employed in unskilled work

(TOTAL: 9 individual participants)

FOCUS GROUP A (Newcastle)
Seven young people aged 18–25 years: 1 Maori male, 4 Tongan females, 1 Samoan female, 1 Samoan male. Four born in New Zealand, three in Australia

1 Tongan female, 18, born in Australia, studying TAFE full time
1 Tongan female, 24, born in Australia, sole parent beneficiary
1 Tongan female, 25, born in Australia, unemployed
1 Tongan female, 20, born in New Zealand, employed in unskilled work
1 Maori male, 22, born in New Zealand, employed unskilled work
1 Samoan male, 22, born in New Zealand, unemployed
1 Samoan female, 22, born in New Zealand, studying at university full time

(TOTAL: 7 participants)

FOCUS GROUP B (Sydney)
Eight young people aged 18–25 years: 3 Maori females, 2 Maori males, 1 Tongan male, 1 Samoan female, 1 Samoan male. Five born in New Zealand, two in Australia, one in Tonga.

1 Maori female, 22, born in New Zealand, employed unskilled work
1 Maori female, 20, born in Australia, employed unskilled work
1 Maori female, 19, born in New Zealand, studying at TAFE full time
1 Maori male, 24, born in New Zealand, employed working musician
1 Maori male, 18, born in Australia, unemployed but has occasional paid music gigs
1 Tongan male, 23, born in Tonga, employed unskilled work
1 Samoan female, 22, born in New Zealand, studying university part time
1 Samoan male, 22, born in New Zealand, employed unskilled work

(TOTAL: 8 participants)

Summary:
Studying full–time 5
Studying part–time + working 3
Unemployed 4
Employed in unskilled work 10
Benefit recipient 1
Employed professional musician 1

TOTAL PARTICIPANTS: 24
Greetings to your family and community,

You are invited to participate in the research project which is being conducted by Lena Rodriguez, lecturer in health sociology from the School of Humanities and Social Sciences at the University of Newcastle. This research is part of Ms Rodriguez’ studies at the University of Newcastle supervised by Professor John Germov and Dr Ann Taylor from the School of Humanities and Social Sciences.

Research in New Zealand has identified significant health problems for the Maori and Pacific Island populations, and many of these diseases are preventable. New Zealand has tackled these problems with a whanau/family-based approach to health care, but in Australia there has not been a great deal of work done on Polynesian health. As more Maori and Islanders are living permanently in Australia, it is necessary to find out what is happening here and how we can work towards supporting more Polynesians as health professionals to work with their own communities.

Why is the research being done?

The purpose of this research is to find out:

- What is the importance of food in Maori/Islander culture?
- How do cultural eating practices determine what and how much you eat?
- The cost of feeding big families.
• Are Maori and Islanders concerned about the health issues caused by obesity, such as diabetes, heart disease, gout and asthma?
• If people are aware of how their eating habits affect their health.
• Whether Polynesians change their eating habits when living in Australia.
• How do Polynesians see their bodies?

Who can participate in the research?

Lena would like to talk to people who are Maori and Pacific Islanders over the age of 18, resident in Australia.

What choice do you have?
Participation in this research is entirely your choice. You are welcome to consider this Information Statement and have time to talk with your family members and think about whether you wish to participate. You can also withdraw from the project without having to give any explanation.

What will you be asked to do?

If you agree to participate, an interview time will be arranged. An interview with an individual will last for approximately half an hour and in the case of family groups this may take one to two hours. The interview will be tape recorded if this has been agreed and separately indicated on the Consent Form. The meeting can be done at a time that is convenient for you and/or your family. It can be at a place of your choosing – including your own home if preferred.

What are the risks and benefits of participating?

Any degree of risk would be low because this project will gather only general responses and not probe into particularly sensitive areas. This is NOT a medical study and you will not be asked any specific questions about your health status or medical record. Hopefully, you will enjoy talking about your culture and knowing that the results of this project may help to improve services in the future.

How will your privacy be protected?

Once I have transcribed all the interviews, and the analysis completed, the original tapes will be destroyed and full transcripts will be held by the senior researcher in a locked, secure location at the University of Newcastle for five years. Interviewees will be de-identified and the transcripts password protected.

For the purpose of this study, I will not be using names as people will be given pseudonyms. In the case of group discussions, these will be in the context of family groups, so confidentiality should not be an issue in a way it might if a random collection of people were put together.
How will the information collected be used?

The information collected will be analysed by Ms Rodriguez and presented as part of her thesis to the University. Part of this work may also be included in an academic paper. However this work will not be published outside of an academic context. You would not be identifiable in this process.

Audio taping. If you agree, the interview will be taped onto cassette. Ms Rodriguez will ask you at the end of the interview if there was anything discussed which you do not want to be included or mentioned in any form. Also you can request at any time after the interview, that part or all of your interview be removed or erased, up until Ms Rodriguez completes her thesis.

If you agree to an interview you will be asked to sign a Consent Form. The Consent Form allows the informant to decide whether they wish to be quoted or not. If quoted, the person will be de-identified.

If you wish, once the information is collected and analysed and written up, you may receive a summary of the results of this research.

What do you need to do to participate?

Please take your time to read this Information Statement before you consent to participate. If there is anything you do not understand, or you have any further questions, please contact Lena Rodriguez. My contact details are on this form.

Thank you for considering this invitation.

Student Researcher
Lena Rodriguez
School of Humanities and Social Sciences
Callaghan Campus
University of Newcastle, 2308
Lena.Rodriguez@newcastle.edu.au

Project Supervisors
Prof John Germov
School of Humanities and Social Sciences
Callaghan Campus
University of Newcastle, 2308
Ph: 49216315
Fax: 49216902
Complaints about this research
This project has been approved by the University’s Human Research Ethics Committee, Approval No.…
Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, the Chancellery, the University of Newcastle, University Drive, Callaghan NSW 2308, Australia. Ph: (02)49216333, email: Human-Ethics@newcastle.edu.au

Ethics Number: H6171007
APPENDIX E

Consent Form

Study on
THE SOCIAL CONSTRUCTION OF OBESITY AND ITS IMPACT ON THE
HEALTH OF MAORI AND PACIFIC ISLAND MIGRANTS IN AUSTRALIA
conducted by
Lena Rodriguez

I, ________________________________ have read the information letter provided. Any questions I have asked have been answered to my satisfaction. I agree to participate in an interview, realizing that I may withdraw at any time without reason and without prejudice.
I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand that all information provided is treated strictly confidential. I have been advised as to what data is being collected, what the purpose is, and what will be done with the data upon completion of the research.

I give my permission for the researcher to audio-record the interview. YES/NO

I agree that data gathered in the study may be published provided my name or other identifying information is not used.

I consent to being identified by a pseudonym in the report with quotes from my interview. YES/NO

Quotes from my interview may be used in the report. YES/NO

I would like a summary of the information obtained in this project: YES/NO

I ________________________________ agree to participate in the above research project and give my consent freely.

Signature: ________________________________ Date: _______________________

☐ A tick in this box indicates that the Information Statement and Consent Form was read to the participant due to literacy concerns, before consent was given by the participant.
TABLE 1

Summary of family household economic profiles

<table>
<thead>
<tr>
<th>Name</th>
<th>Ethnicity</th>
<th>Number of Adults</th>
<th>Number of Children</th>
<th>Housing</th>
<th>Estimated household income p/w</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Sydney 1</td>
<td>Maori</td>
<td>2</td>
<td>2</td>
<td>Renting</td>
<td>$1,900</td>
</tr>
<tr>
<td>Eastern Sydney 2</td>
<td>Maori</td>
<td>3</td>
<td>5</td>
<td>Renting</td>
<td>$2,000</td>
</tr>
<tr>
<td>Eastern Sydney 3</td>
<td>Maori</td>
<td>4</td>
<td>0</td>
<td>Renting</td>
<td>$1,530</td>
</tr>
<tr>
<td>Southern Sydney 1</td>
<td>Maori</td>
<td>7</td>
<td>5</td>
<td>Mortgage</td>
<td>$2,700</td>
</tr>
<tr>
<td>Southern Sydney 1</td>
<td>Maori</td>
<td>1</td>
<td>1</td>
<td>Renting</td>
<td>$650</td>
</tr>
<tr>
<td>Newcastle 1</td>
<td>Tongan</td>
<td>8</td>
<td>1</td>
<td>Mortgage</td>
<td>$3,480</td>
</tr>
<tr>
<td>Newcastle 2</td>
<td>Tongan</td>
<td>7</td>
<td>3</td>
<td>Mortgage</td>
<td>$2,880</td>
</tr>
<tr>
<td>Lake Macquarie</td>
<td>Samoan</td>
<td>6</td>
<td>8+</td>
<td>Renting</td>
<td>$4,680</td>
</tr>
<tr>
<td>Sydney 1</td>
<td>Samoan</td>
<td>8</td>
<td>2</td>
<td>Renting</td>
<td>$4,200</td>
</tr>
<tr>
<td>Sydney 2</td>
<td>Samoan/Maori</td>
<td>5</td>
<td>2</td>
<td>Own home</td>
<td>$3,200</td>
</tr>
<tr>
<td>Sydney 3</td>
<td>Cook Islands</td>
<td>9</td>
<td>3</td>
<td>Mortgage</td>
<td>$3,800</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>60</strong></td>
<td><strong>32+</strong></td>
<td></td>
<td><strong>$2,820</strong></td>
</tr>
</tbody>
</table>

\(^{30}\) Average of estimated weekly family household income