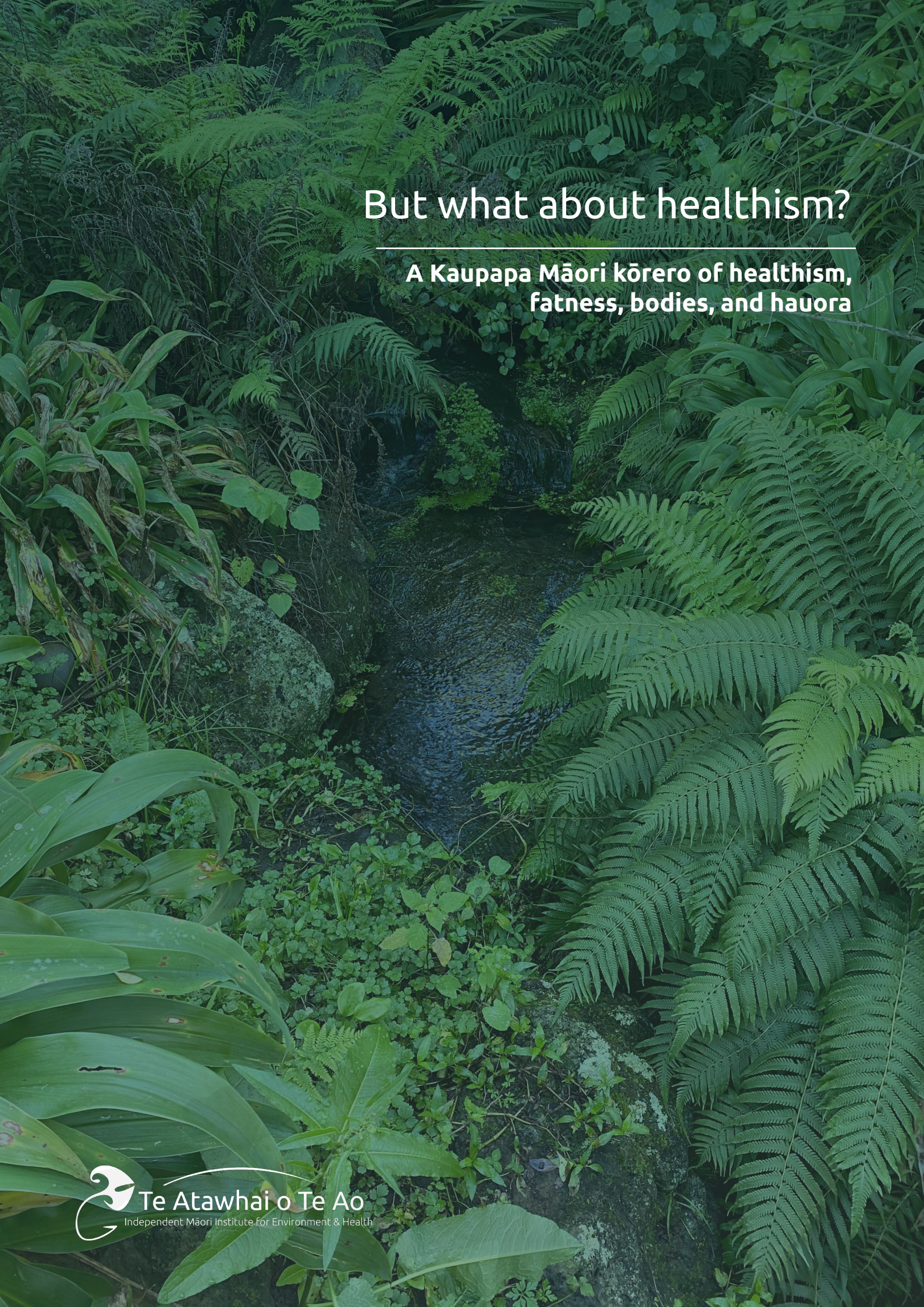

But what about healthism?

A Kaupapa Māori kōrero of healthism, fatness, bodies, and hauora

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ABSTRACT

Healthism, like racism and fatism, influences the ways in which we conceptualise bodies and understand and perceive notions and pursuits of health, bodies, and worth. Kaupapa Māori and mātauranga Māori perspectives offer alternative insights from colonial, hegemonic views on health, fatness, and bodies. Neocolonial perspectives often perpetuate restriction, inaccessibility, and structure deservedness. Healthism presents itself in a number of intersecting ways that ultimately structure and assign access, desirability, and palatability to bodies that are deemed worthy and morally good. These social constructions can manifest through the production of particular bodies and a medicalised gaze that reduces explanations to lifestyle choices, morality, and meritocracy. When thinking about this stratification of bodies, inaccessibility is then exacerbated when systems of oppression based on race, ethnicity, and fatness converge. This paper explores healthism and bodies from a Kaupapa Māori perspective utilising the pūrākau of fat wāhine Māori.

KEYWORDS

healthism, Kaupapa Māori, health, hauora, fatness, racism, fat

Karakia tīmatanga

Karanga mai e ngā manu
Karanga mai e iwi
Karanga mai e ngā pīwaiwaka
Nau mai te Kaupapa
Nau mai te take
Nau mai te hauora
Haumi e hui e taiki e

He tīmatanga kōrero: Introduction

He aha te pito o te kaupapa (hau) ora[1]? He aha ēnei mea, ko mōmona, ko hauora, ko tinana? He aha ngā kawekawe o ngā pūnaha aupēhi i a tātou, i tō tātou ao Māori, i ō tātou whakaaro Māori hoki? He aha te whakaaro Māori i ēnei kaupapa? Ko tēnei pito kōrero he tautitotito o ēnei kaupapa.

Te ao Māori[2], mātauranga Māori[3], and Kaupapa Māori[4], our ways of being, knowing, thinking, and understanding offer a multiplicity of perspectives on how we conceptualise bodies, health, and fatness. In centring our epistemologies, we can both be critical of the ways in which colonisation and the imposition of colonial systems of oppression restrict our access to our knowledge systems, axiologies, and ontologies, and we can privilege our mātauranga[5]. In seeking to prioritise our mātauranga Māori, we challenge and disrupt these colonial, hegemonic discourses around health, fatness, and bodies that so often convey punitive, negative connotations (Gillon, 2020; Gillon et al., 2022). The moralisation of health, bodies, and fatness has intricate and oppressive consequences, which further perpetuate negative perceptions that lead to the racialisation of healthism, impacting Māori[6] at both individual and collective levels.

This paper explores hauora[7], fatness, bodies, and the nuances in te ao Māori that provide powerful alternatives to the dominant westernised and neocolonial systems that structure our understandings of our bodies, health, and fatness in racialised, healthist, fat-biased ways that impact and restrict our realities. This paper draws on established work about Māori understandings of fatness by Gillon (2020; 2024), Gillon and Pausé (2021), and Gillon et al. (2022).

1. The use of hypens, brackets, de/re-capitalisations within this paper are purposeful, critical practice. They do so as to challenge the ways in which westernised, colonial worlds seek to weaponise English and the nature of simple categorisation. Here, they offer expansive meanings.
2. The Māori world
3. Māori knowledge, wisdom, ancestral understandings, skill
4. Māori approach, Māori principles, Māori agenda, Māori ideology, theories, methodologies, and epistemologies
5. Knowledge
6. Indigenous people of Aotearoa
7. Wellness, vitality, in good spirits; calm, peace, tranquil

He aha tēnei mea, ko 'health'?[8]

Health, and the ways in which we understand it, are social constructions based on our realities of occupation and choice. From a westernised understanding, the World Health Organisation defines health as "a state of complete, physical, mental and social wellbeing and not merely the absence of disease or infirmity" and that "the enjoyment of the highest attainable standard of health is a fundamental right of every human being without distinction of race, religion, political belief, economic or social condition" (1948, p. 1). While this definition attempts to provide insights into the complexities of health, it fails to include and accommodate different understandings, enactments, and variations of health. These include the wider systems that inhibit those who are unable to financially access health and those who are excluded from health, due to race, class, gender, and ability (Harrison, 2021). This has been exemplified more recently with COVID-19 responses, as tāngata whaikaha [9] or those with physical disabilities, mental illnesses, and chronic illnesses were further restricted to health access (Jones, 2020, as cited in Johnsen, 2020; Pausé et al., 2021; Tinirau et al., 2021a).

Harrison (2021) argues that the lack of breadth in the definition of health is purposeful in the colonial establishment of health as an institution that centres and privileges Eurocentric and westernised views. Understanding and enforcing health in this way, it makes those assigned ill, unhealthy, or undesirable vulnerable to being repositioned as forms of social contagion that must be confined and eradicated. These definitions of health demonstrate how processes of colonisation have moulded health theory and practice into a narrow western and white perspective, which has been interrogated by Black, Indigenous, and Māori scholars through discourses on fatness, anti-Blackness, eugenics, genocide, healing, and historical trauma theory (Duran & Duran, 1995; Gillon, 2019; 2024 ; Harrison, 2021; Pihama et al., 2021; Smith, 2004). Smith (2004) reiterates these discussions on those that are deemed fit and unfit by examining eugenics specifically on Māori in Aotearoa, summarising that,

> *there are many power politics to this distinction and to the actions that societies or groups take to assert power and to marginalise, criminalise or to exterminate the 'unfit' […] Colonisation was in itself an assertion of eugenics, in that power was asserted over 'unfit' populations. (pp. 1-2)*

Understandings of health are socially constructed, contextual, and ultimately shaped by those in positions of power. Assignment and access to health, then, is often structured by white supremacy, colonisation, and capitalism (Gillon & Pausé, 2021; Smith, 2004). In this way, health is laden with value, judgment, hierarchy, and biased assumptions that illustrate the ways in which power and privilege occupy more space than notions of wellfulness within health. Health focuses largely on disease and dis-ease, centring pathology, morbidity, and morality over flourishing and wellfulness . The hypermedicalised gaze in this way is one that reclassifies everything as an illness; to cure via medicalisation is one of our most dominant explanatory modes (Gillon & Pausé, 2021; Metzl, 2010). In conceptualising medicalisation as the ways in which behaviours and conditions are renamed and categorised as medical issues, hypermedicalisation can be understood as disease-mongering and repositioning

8. What is this thing called 'health'?
9. People with disabilities

the selling of sickness as an important component of health. Health consumerism in this way highlights the ways in which healthcare consumerism practices reinforce the idea that healthcare is "a product to be purchased by informed, empowered consumers, rather than a service bestowed upon a patient by a paternalistic provider" (Arney & Menjivar, 2014, p. 519; Blasco-Fontecilla, 2014).

Societal understandings of health are primarily disseminated through public health that seeks to focus on population-level health in preventing illness and disease as well as health promotion, which frames health as a need for individual behavioural change (Chrisler & Barney, 2017). The individualisation of health stems from colonial, neoliberal, and capitalistic structures that are resistant to acknowledging the impact and power of social determinants of health. Therefore, these restrictions stifle access to power and policy to create effective system-level change (Gillon & Pausé, 2021; Jecker, 2008; Johnsen, 2020; Mcleod et al., 2020; Smith, 2004; Tinirau et al., 2021a).

Public health excludes those who are fat from any definition or categorisation of health and wellness. This results in fatness becoming a problematised and individualised moral failing, rather than a series of colonial eugenic pathologisations and biomedicalisations of fat bodies that seek to eradicate these bodies and people. This structure of power is able to stigmatise and simultaneously render socially invisible the people who do not fit public health definitions of 'healthy' or morally 'good' (Gillon & Pausé, 2021; Parker et al., 2019). While public health often acknowledges the harms of fat stigma, it also perpetuates and encourages these harms and perspectives, without critical acknowledgment that it does so. Public health in this way, recognises fat stigma as a social determinant of health, while it weaponises fat stigma to restrict fat people accessing health, healthcare, and their human rights under the guise of a 'war on 'obesity'', as opposed to a war on fat people. (Gillon & Pausé, 2021; Ivancic 2017; Lyons 2009; Pausé, 2017). The fatness of the body and the individual morality of the fat person is continuously pathologised and placed as the primary focal point in health settings, which positions fat people in liminal spaces of both requiring a saviour in the health system, as well as being a victim of the hierarchical- and value-based system. This results in the simultaneous and often contradictory under- and over-surveillance of fat people, excluding via structural, policy, and denying our humanity, while highly pathologising and scrutinising our bodies that are categorised in ways that disadvantage and misposition us as up for public consumption, input, and control (Ivancic, 2017). Further, the moral blame of fatness is misplaced onto the fat person as an individual failing, stemming from colonial and neoliberal policies (Parker et al., 2019; Smith, 2004).

Colonisation and its introduction and expansion of white supremacy continue to create and perpetuate inequities for Māori and Indigenous peoples globally (Tinirau et al., 2018; 2021a). These narrow definitions and structures of health fail to acknowledge Indigenous peoples, relationality, and Māori and Indigenous expertise, perspectives, and practices in these complex spaces. Further, these definitions do not ask the critical questions about the health experts who define these concepts and categories, and, ultimately, structure accessibility (Cram, 2014; Durie 1999; Gillon & Pausé, 2021; Smith, 2012).

Te ao Māori and our ways of being and knowing offer much insight into our relationships with notions of health and the ways in which we can conceptualise and enact this. Māori health involves expanding our thinking and engaging in critical thought around how human and non-human capacity and relationships within te ao Māori can look. These customary definitions of te ao Māori health, trauma, and well-being are discussed extensively in Smith's (2019) Kaupapa Māori publication *He Ara Uru Ora: Traditional Māori understandings of trauma and well-being* and central to this is our mātauranga that prioritises connectedness and relationships to hauora (Cram, 2014; Smith, 2019). Kaupapa Māori offers the means to engage in critical, structural, and cultural examination and insight into the complexities that shape our understandings, definitions, and enactments of health and hauora[10]. Kaupapa Māori, in this way, simultaneously acknowledges and critiques the ways in which colonisation shapes our access to health and what health we can access. Moreover, Kaupapa Māori methodologies offer culturally-relevant ways of conceptualising health that honour our relationships, land, culture, language, sovereignty, and self-determination (Pihama et al., 2021; Smith, 2019; Smith et al., 2021).

What about health(ism)?

Healthism functions by repositioning health as a moral, personal responsibility and achievement (Crawford, 1980; Hokowhitu, 2014). Therefore, healthism positions health, disease, and the pursuit of health and wellfulness at an individual level, which is rooted in colonial and neoliberal thinking (Smith, 2004). In elaborating on healthism, Seher (2020) highlights it as a "moral and political ideology that shapes the aims of our profession and, more acutely, the motivations of the food, diet, and weight-loss industries" (p. 94). However, healthism opens up individual bodies for public scrutiny and opinion, and subsequently delineates who is able to access and not access resources rather than examining wider social determinants of health, which perpetuates the idea that health-seeking is a personal preoccupation that influences assigned worth and humanity (Crawford, 1980). Crawford first articulated healthism, noting that, as a process and system, it creates the "illusion that we can as individuals control our existence, and that taking personal action to improve health will somehow satisfy the longing for a much more varied complexity of needs" (1980, p. 368). In this way, healthism shifts the responsibility of health-seeking behaviours to the individual, while failing to prioritise human rights to healthcare and wellfulness. Structuring bodies and health in this manner ensures that the failure of the state to meet obligations and responsibilities for access, through healthism then "reinforces the privatization of the struggle for generalized well-being" (Crawford, 1980, p. 365).

10. Wellness; vitality; in good spirits; calm; peace; tranquil

In the context of healthism, fat bodies are received and perceived in various ways based on the colonial and hierarchical value systems within which we occupy. These systems influence the contradictory ways in which our bodies are understood, represented, racialised, and biomedicalised, which can be illustrated through the following moral labels and (re) inscriptions :

- (un)deserving
- (un)well
- (un)(re)liable
- (de)/(re)valued
- (under)/(over)-surveilled
- (hyper)(in)visibilised; and
- (un)assigned rights (Gillon 2020, 2023; Harrison, 2021).

These re-inscriptions of fat bodies create negative individual expectations in health settings and, alongside other harmful categorisations that are racialised and sexist, fatism produces body sizeist and healthist reactions that maintain and perpetuate intersectional systems of oppression (Harrison, 2021). These negative individual expectations around health are reinforced through their binary states: health is often perceived as a fixed state, however, health is also positioned as a desired, prescribed state. According to Metzl (2010), we often illustrate our understanding of this dichotomy in situations where,

> *we encounter someone whose body size we deem excessive and reflexively say, "obesity is bad for your health," when what we mean is not that this person might have some medical problem, but that they are lazy or weak of will (p. 2)*

Metzl (2010) goes on to note that in these interactions we also realise our own health in the viewing and judgement of others. In these moments of judgement,

> *appealing to health allows for a set of moral assumptions that are allowed to fly stealthily under the radar. And the definition of our own health depends in part on our value judgments about others (p. 2)*

Perceptions of health and health behaviours then become currency in the discourse of power that is health (Foucault, 1976; Metzl, 2010). Healthism, then, illustrates the ways in which being perceived as a moral failure becomes a means to legitimise oppression against fat people.

The pathologisation of bodies is not limited to occurring through healthism; this policing, pathologisation, and hypersurveillance of bodies has a "genealogy in discourses of class, race and colonialism underpinned by the relationship between morality and cleanliness" (Hokowhitu et al., 2022, p. 109). Healthism, in this way, is rooted within the colonial, white supremacist reality of New Zealand (Gillon & Pausé, 2021; Pausé et al., 2022). Hokowhitu explores these notions of biopolitics and healthism through a Foucauldian lens and examines the ways in which these intersect and intertwine with racism, and notes that "the relentless language of madness, has become ensconced and taken up by Māori themselves. The devotion to be healthy, to live a long and privileged life, has meant forgoing the pleasures and hierarchy of fatness" (Hokowhitu, 2014, p. 39).

Ideologies of healthism are often perpetuated through the stories that are retold about our people and bodies—our fat Indigenous bodies. This continuation of oppression ensures that we are over- and under-surveilled and simultaneously experience enforced medical intervention, negligence, and inaction. In this way, healthism pathologises our genealogy; it pathologises our ancestral bodies of knowledge and repositions fat Indigenous in ways that result in the hypermedicalisation and moralisation of our fat Indigenous wāhine[12] bodies. While the stigmatisation of fat Black, Brown, Indigenous, and coloured bodies tends to be gendered and more prevalent towards bodies read and assigned as girls or women (Di Pasquale & Celsi, 2017; Gillon, 2020; Parker et al., 2019), tāne[13], ia weherua-kore[14], and tamariki[15] experience this also, however, these systems and pathologisations operate differently, in particular noting the focus on the fat Brown child seems to have such a deleterious impact. Parker et al. (2019) discuss the intersectionalities of fat wāhine Māori by drawing on Smith's (2004) colonial and eugenic research within the context of fat pregnancy in who is deemed to mother and who is not, stating,

> *Fat pregnant people have therefore been placed at the very epicenter of contemporary anxieties about the chronic population health problems (and costs) facing Western societies leading to unprecedented opportunities for their discipline and control. (p. 98)*

While not all birthing Māori people are exclusively fat wāhine Māori, this exemplifies the production of the perceived healthy body, which ultimately impacts all Indigenous peoples. At the centre of these intersecting systems of oppression is power and privilege of who categorises, and therefore who places the categorisations over who accesses health, illustrating that health and access are symbols of this power and privilege similarly captured in the historic relationship between colonisation and eugenics (Smith, 2004).

Through the systemic and biopolitical positioning of health through healthism and the state, specifically through the Crown, these institutions absolve themselves of the responsibility in ensuring our rights and that our rights to health are accessible. This preoccupation with and the pursuit of health, then becomes positioned as a meritocratic individual obsession, which then poses the question: What about those who, within the westernised world and systems we are forced to occupy, will never be provided with equitable access to health and never be defined as healthy?

12. Womens', women
13. Male/s, men
14. Non-binary
15. Children

Whakaaro Mōmona16 6 March 2020

I can remember my specialist for my ovaries telling me given my weight she really should have given me two IUDs and laughing about it instead of treating my issues, instead of listening, instead of doctoring. I was fat when she met me. She also told me to tell my family to all spend $25 on me for Christmas to buy me SureSlim. Lol, I left her and had my IUD removed after 3 years of intense anxiety and pain among other new things I hadn't experienced before that were simply ignored.

But again, if I was thin, I would be seen as valid and treated, my concerns heard, my pursuits of ease, of hauora, supported. How fucked up nē[17]. I don't think I hate my body; I hate society, I hate healthism.

Nā[18] Ashlea Gillon (Gillon, 2024)

Understanding the ways in which colonisation imposes upon Māori health, access to health, and how it defines health is complex (Reid & Robson, 2007; Tinirau et al., 2021a). There are further layers and intersections of assigned health and ableness which perpetuate access to more systems of privilege, illustrated through affording time, land, resources, wealth, and food security (Gillon, 2023).

Pēhea te hauora?[19]

Through colonisation and racism, our Māori ways of healing practices, relationality, and understandings of wellfulness and hauora have often been represented and relegated to that of superstition, myth, or inferior (Reid & Robson, 2007; Smith, 2019; Tinirau et al., 2021a). This violence and denial of our truths and realities is purposeful and enabled through racist legislation, policy, and "the confiscation and misappropriation of Māori resources through colonial processes impacted both by historical trauma […] and by impoverishment" (Reid, 2018, as cited in Waitangi Tribunal, 2019, p. 20). In this way, we recognise colonisation and the new and imposed value systems that repositioned Māori as other perpetually dehumanise Māori and restrict Māori from being autonomous and self-determining (Gillon, 2020; Gillon et al., 2019; Reid et al., 2019; Reid & Robson, 2007; Tinirau et al., 2021a).

From a te ao Māori perspective, we embody relationality, particularly between humans and everything else, and this connectedness is central to our hauora (Cram, 2014; Hoskins & Jones, 2017; Tinirau et al., 2021a). Kaupapa Māori enables multiple critiques, analyses, and understandings of health, therefore acknowledging the spectrum of kōrero[20] that happens from 'critical to cultural'. In this way, we recognise that colonial structures influence and restrict our wellfulness, and access to enactments of this, as well as access to culture and cultural understandings of wellfulness and hauora (Reid & Robson, 2007; Gillon, 2020).

16. Fat thoughts
17. Right?
18. Written by; belonging to
19. What about hauora?
20. Dialogue, conversation

Māori are often not acknowledged or included within western ideologies of health which presume universality (Cram, 2014; Durie, 1999; King et al., 2018). Durie (1985) interrogates this by asking who defines health and who the experts are. Hauora provides a Māori philosophy for understanding health, wellfulness, and life within an Aotearoa context. When exploring the etymology of hauora, we know that while hauora signifies wellness, health, vigorousness, and good spirits, the word *hau*[21] conveys vitality, essence, and breath, and ora[22] conveys wellness, safety, to live, to recover, to be healed, to survive, and to revive. Ora is then vitality and life. As Māori, when we greet people, we wish for vitality, healing, and wellness in saying 'kia ora'[23]. Hauora Māori[24] is encompassing of all things interconnected, particularly whenua[25], moana[26], whānau[27], hapū[28], iwi[29], hinengaro[30], wairua[31], and tinana[32] (Gillon et al., 2022; Smith, 2019). Smith (2019) draws on whakapapa kōrero[33] to explain the meanings of hauora, stating,

> *In whakapapa kōrero narratives and the creation of the first human being, the lungs were provided by Tāwhirimātea[34], atua[35] of the wind. The hau, or first breath of life, was transmitted by Tāne[36]. The hau is associated with atua from the creation of the world and human beings, and this essence represents an individual's connection to atua. It is directly related to an individual's mana[37] (power, status, prestige) and tapu[38] … (p. 20)*

Smith (2019) says that hauora is a term for fresh air and goes on to cite a chant given by Te Matorohanga (c.1910), which describes how integral hauora was for the creation of the first human being:

Purangi to hiringa — *Your persistence comes to life*
Purangi o mahara — *Your thoughts awaken*
Purangi to hauora — *Your breath breathes*
Purangi to haumanawa — *Your heart pulsates*
Ki taiao nei — *For the dawning day (p. 76)*

21. Vitality, essence; breath
22. Wellness; safety; to live, to recover, to be healed, to survive, to revive
23. Command to keep well, or keep good health (utterance)
24. Māori health
25. Land
26. Sea, ocean
27. Family, relations
28. Kinship group; descended from an eponymous ancestor
29. Tribe, nation
30. Mind
31. Spirit
32. Body, real, actual, self, person, reality
33. Traditional Māori knowledge
34. Atua of the winds
35. Ancestor of ongoing influence, divine
36. Atua of the forest and birds
37. Ancestral power; agency, authority; spiritual; indestructible power from the atua
38. Sacredness

In this way, our conceptualisations of health and wellfulness are intricately complex and extend beyond the westernised, public health definitions within which we are continuously categorised and defined. Kaupapa Māori conceptualisations of hauora through kōrero tuku iho[39] reinforce the importance of an Indigenous version of balance between individual hauora in terms of tinana, hinengaro, wairua, whānau, and meaningful, cultural, and environmental connection, identity, and access to resources (Gillon & Pausé, 2021; Smith, 2019).

Mōmona[40]

Māori understandings of bodies and fatness are complex. Te reo Māori[41] provides insights into alternative pre-colonisation understandings and explanations of the ways in which fatness and bodies can be understood. Fatness is perpetually pathologised and has racial and colonial origins (Warbrick et al., 2018) which represent and reposition fatness, and ultimately fat people, as inherently negative or a problem requiring removing or fixing (Gillon & Pausé, 2021; Harrison, 2021).

Te reo Māori can illustrate many conceptualisations of pleasure, fatness, and joy that Hokowhitu (2014) alludes to (Gillon et al., 2022). The complexities of relationality and Māori theorising can be demonstrated by kupu mōmona[42]. In expanding our understanding of fatness, Gillon (2019), Gillon and Pausé (2021), and Gillon et al. (2022) highlight the multitude of meanings within the word mōmona, for instance, noting that fatness is conveyed as good condition, bountiful, plentiful, fertile, nourishing, and nourishment. *Tuawhiti*,[43] *matū*[44], and *ngako*[45] all convey fatness as substance, richness, and quintessence (Gillon et al., 2022). Moreover, te reo Māori offers insight into the ways in which anti-fatness did not come from Māori, it comes from coloniality (Gillon et al., 2022; Hokowhitu, 2014; Hokowhitu et al., 2022).

39. Oral traditions handed down from ancestors
40. Fat, in good condition, bountiful, plentiful, fertile; nourished
41. The Māori language
42. Fat-describing words
43. Fat, thick, fleshy, of good quality, of substance, succulent
44. Fat, gist, substance, richness, sense, point, spirit, quintessence, matter
45. Fat, essence, gist, substance; to be ever ingrained

Tikanga[46]

Whakaaro Mōmona 28 November 2020

There's so much to say i tēnei wā[47], engari[48], I'll start with today and where I'm at.

Kua hikina te mate Māori, e heke ana ngā roimata[49]. There's been a block on me being able to listen to my research kōrero, not necessarily anything that I've done wrong, more so the taumahatanga[50] and the tapu of all that has been spoken about, all that has happened, all that I've experienced since I began this kōrero September 2019. I listened to 10 minutes or so of the first kōrero I had, and the tears came. Not good, not bad, just tears. This is such important work, to be able to have these wānanga[51] with fat wāhine Māori, to be a fat wahine[52] Māori and share in these spaces. I feel so privileged, and the weight of this work is not lost on me, the weight of responsibility I place upon myself as a friend, a whanaunga[53], a researcher, a wahine Māori, a member of these communities, an insider. There is so much mamae[54] and so much taumaha[55] in this and in their kōrero, our kōrero, there is just so much to say. And I know that there is so much beauty, resilience (even tho I hate that kupu[56]), so much mana. I just want to ensure that I treat this tākoha[57] (West, 2022) in ways that are tika[58] and pono[59] and am careful to protect these wāhine from harm. I know these are Future Me problems, but Future Me is worrying about them too. I feel the clock ticking. I know I have a short amount of time left, not by choice, but by institutional restriction. I can't help but feel robbed of the last year because of measles, because of my cognitive issues, and now because of covid, it's giving healthism vibes. I wish I had that year back to really have the time to process more of what's going on, more of the importance of these kōrero. Heoi anō[60], engari, ka mahi tonu[61], kia noho puku[62].

Nā Ashlea Gillon (Gillon, 2024)

46. Research methodologies
47. At this time
48. But, however
49. The Māori sickness has been lifted, the tears are falling
50. Heaviness, burden, weight
51. Discussions
52. Woman
53. People who engaged with the research who have ongoing relationships with the researcher.
54. Pain, hurt, suffering
55. Weight, heaviness, burden
56. Word
57. Gift
58. Correct
59. True
60. However
61. Continue working
62. To sit with and come to know through contemplation; reflection; silence; meditation

This is a Kaupapa Māori, qualitative study that utilises Indigenous theory, methods, and methodologies to undertake 'good research'[63] that is critical and restorative (Smith, 2012). Kōrero were undertaken with thirteen research whanaunga. These kōrero had a semi-structured schedule of questions, however, these were guided by the research whanaunga.

The hauora of the research whanaunga was paramount within this study and, under a Kaupapa Māori theoretical approach, conceptualisations of sovereignty are intertwined with research, the ways in which research is approached, and the methods utilised to engage in 'good research' (Smith, 2012). Therefore, this study drew on body sovereignty discourses discussed by Rao (2016) surrounding informed consent. Rao (2016) touches on ways in which issues around informed consent can perpetuate discourses around ownership of bodies and bodily samples and reiterates that people,

> *should not only possess the power to contribute their biological materials, but also the right to help control the course of research, and to share in the resulting benefits or profits. Conferring body property might enable research subjects to regain power and a measure of self-sovereignty (p. 440).*

This project aims to privilege body sovereignty with the research whanaunga and, in this way, recentring their unique lived experiences, intersections, and stories of healthism and hauora.

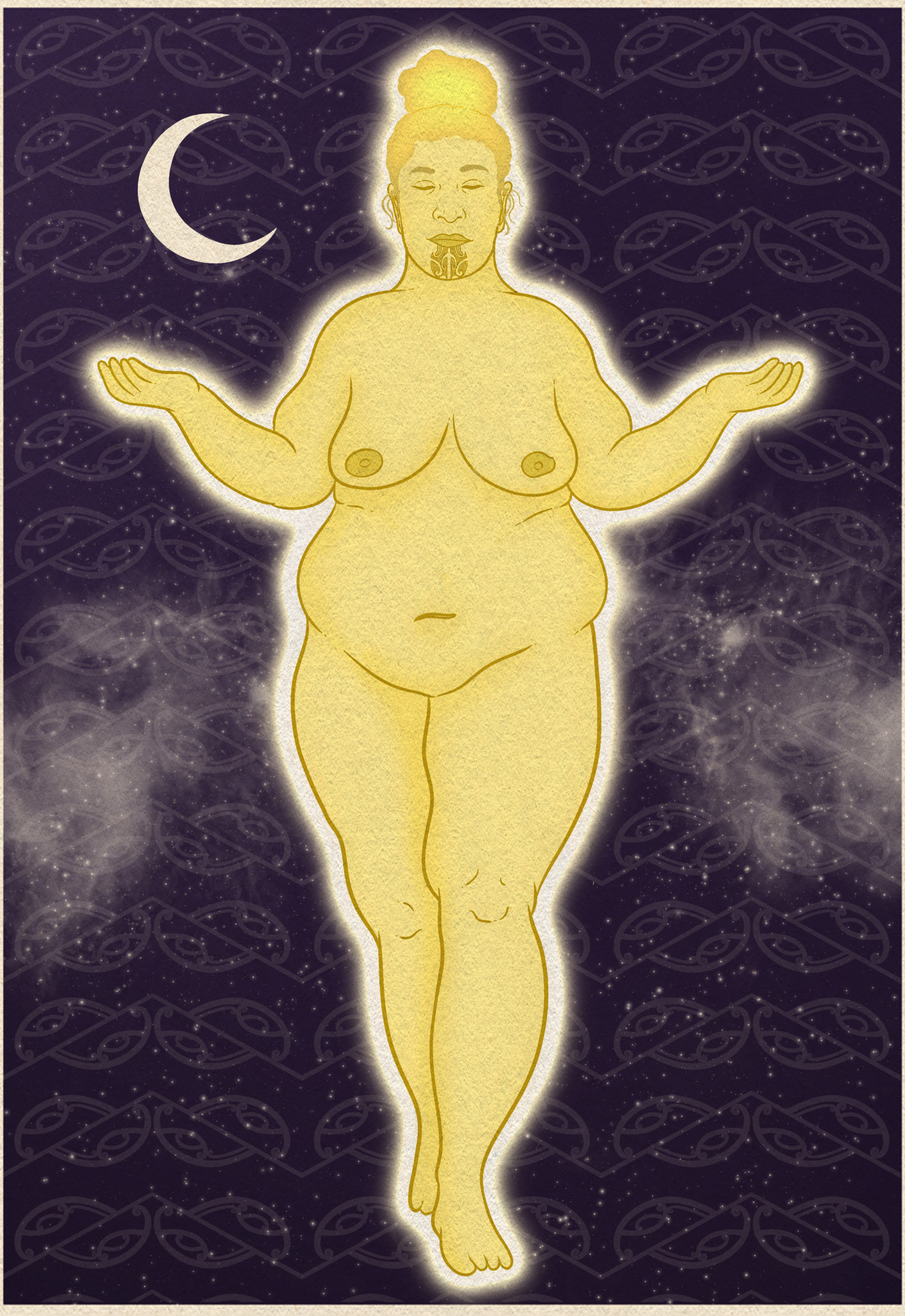
Whakawhanaungatanga[64]

This research project involved discussions with fat Indigenous wāhine about body sovereignty. The inclusion criteria for this project were guided by the research whanaunga and included:

1. self-identifying as a fat wāhine Māori;
2. be willing to share space to kōrero with the researcher; and,
3. be willing to share photographs and images with the researcher.

Research whanaunga self-identifying as fat, Indigenous wāhine ensured the research whanaunga retained autonomy over their multiple identities and that the researcher was not socially assigning people to identities they felt they did not belong (Gillon, 2016). Additionally, ensuring research whanaunga comfortability with identifying openly as fat was a consideration for the self-identification process, as identifying as fat or 'coming out' as fat is a process of agency that allows a renegotiation of the "representational contract between one's body and one's world" (Segwick, 1994, p. 230) as opposed to being identified as fat which can be a contested space for some people due to harms caused by fatism and healthism (Murray 2005; Pausé, 2012).

63. The notion of 'good' as a value is often assumed morality from a westernised perspective and the idea of 'good research' to Māori and Indigenous peoples is different
64. process of establishing relationships



Māramatanga[65] mōmona: Māramatanga hauora

Three themes under the overarching umbrella of healthism were identified within the kōrero shared by research whanaunga. These pūrākau[66] speak to the ways in which healthism is utilised to conflate perceived health status and fatness with rights and accessibility. In speaking back to how unsafe these health spaces and health interactions can be, whanaunga highlight the denial of effective diagnosis, treatment, and humanity. Failure to align to the 'perfect body' within the westernised hierarchical systems is a barrier that perpetuates inaccessibility and stigmatisation, and assigns value and normality to thin white bodies as the default standard. This racialised, sizeist default categorisation then becomes the primary focus within health interactions which continues fatphobic, racist health interactions that lead to negative outcomes (Gillon, 2019; Harrison, 2021; Hokowhitu, 2014). The ways in which medical expertise and ultimately assigned authority and power are weaponised to dehumanise and silence fat wāhine Māori can be seen throughout the use of discursive heuristics at the expense of their own medical tests, data, and treatments. These interactions reflect the complex ways in which health spaces and those within them medicalise and dehumanise fat wāhine Māori through the erasure and problematisation of our fat bodies.

There are three themes that have been identified, which include:

1. tunuhuruhuru o te whare tangata67 (disregard of the womb and reproductive sensitivities)
2. lose weight or lose access; and,
3. what about healthism/pēhea te hauora[68]?

The next section will discuss these three themes within the context of fat wāhine Māori perspectives. While paying tribute to their research offerings, the aim is to privilege, recentre, and reorient their hauora, positionalities, and lived experiences, which are purposefully neglected within current health spaces and systems.

Tunuhuruhuru o te whare tangata

Identified within the kōrero of research whanaunga was the explicit ways in which health professionals and opportunities for healthcare were routinely denied for fat wāhine Māori. Fat wāhine Māori experiences related to whare tangata[69] and sexual and reproductive health are often complex and can be unsafe (Parker et al., 2019). There is a level of deliberate disregard for wāhine Māori pain and the sensitive nature, both culturally and sexually, of reproductive-related healthcare (Pihama et al., 2021). The false idea that Black and Brown bodies have a higher tolerance to pain is reiterated globally and is historically tied to medical racism as well as the field of gynaecology (Hoberman, 2012; Tinirau et al., 2021b).

65. Understanding
66. Stories; Māori narratives with philosopohical epistemological thoughts centring around relationships
67. Disregard of the womb and reproductive sensitivities
68. What about healthism?
69. Womb; uterus; house of humanity

Further, tunuhuruhuru o te whare tangata, the disregard of the whare tangata and reproductive insensitivities highlight the lack of acknowledgement and weaponisation of power, mana, and tapu. In conceptualising the importance of mana and tapu in relationship to reproductive wellfulness, Smith (2015) expands on the ways in which genitalia were understood as sacred and powerful in relation to their influence over life and death. Smith notes,

> *The ritual use of genitalia and references in incantations and chants highlight the degree of sanctity attached to sexual organs. Sexual violence or any other type of physical or psychological assault where a powerful individual violated and/or humiliated a less powerful or powerless victim, was initially responded to with whakamā[70] (pp. 256-257)*

The perpetual silencing, reassignment of shame and blame, and enforcement to conform through the victimisation of Indigenous wāhine (Le Grice, 2017; Smith, 2015) is evident throughout research whanaunga experiences shared here.

Chanz notes her experience in the ways in which her health issues were exacerbated by a long wait and fatphobia prescribed through forced weight loss and not providing general anaesthetic:

> *Fucking horrible I had to go through a process where I would have my period for 3 months at a time kind of bullshit, like fuck. It took them 3 years to put a mirena in. And then when I did, fucking whole new lease on life. I love this shit. You know, I know it doesn't work for every wahine, but it has worked for me.*
>
> *But that whole process, because of being bigger at the time, I lost 40 kilos to be able to go under the general anaesthetic for a procedure, and because I'd had the flu twice within a month, they didn't put me under because my lungs wouldn't have taken it. I was wide awake, while they're scraping out the inside of my womb. That shit is fucking horrible. They don't listen to big Māori women because you should be smaller than that. And I'm like, 'how about you fucking increase my income so I can afford the kale', you know? It was fucking horrible. Not to mention little white nurses walking around and you're just like, really?*
>
> *Really? I'm hanging out here, surgeons in there doing some things. You know what's bullshit about this? You didn't even buy me a piña colada. I mean, humour is my natural defence system, and then I went home, and even though yup, the process is good I'm done, I'm healed up but I felt so violated. And humiliated. And you know, if someone had bought me a drink and my legs all wide open and my ankles up behind my ears, fucking sweet as! But there was no reason for it to feel like it did. You know? It was just so damaging. (Chanz)*

70. embarrasment, shame

As noted, Black and Brown bodies are often assigned a perceived pain tolerance that is racialised and rooted in biological determinism and reflected in the ways in which early gynaecological practices enacted harm and enslavement upon Black bodies (Skloot, 2010; Tinirau et al., 2021b). The ways in which pain and pain severity are minimised and often punished then become exacerbated by intersecting systemic oppression of racism, sexism, and fatism.

Chanz goes on to discuss how both Pākehā[71] and tauiwi[72] doctors have been unable as well as unequipped to socially and politically understand her hauora needs, and noting that when she found a wahine Māori doctor, her experiences dramatically and positively changed, stating,

> *The first gynaecologist was fucking horrible. All the fat comments. The second on, life-changing woman, incredible. Wahine Māori, OB-GYN, she looked at me, she understood, 'oh fucking, paying eighty bucks a week for pads, fuck right off'. And she changed my life. And now I'm doing like, illustrations and shit for her around all this whare tangata stuff so that she gets the resourcing, the resourcing we need. (Chanz)*

Issues around accessing comprehensive and safe healthcare that did not cause discomfort or pain was a prevalent discussion for research whanaunga. Within health spaces, fat, Black, Brown, and Indigenous peoples, much like those with chronic health issues and disabilities, are required to engage in extensive levels of self-advocacy and illustrate their knowledge of their own condition in attempts to be assigned humanity by health professionals (Andrew, 2020; Lee & Pausé, 2016; Strings, 2019). Natasha discusses her experiences of seeking reproductive healthcare from Pākehā and tauiwi male doctors, specifically her preparedness in bracing for conversations and potentially harmful interactions, as well as her self-advocacy with doctors, which was ultimately dismissed:

> *The one doctor I chose because he said something about diversity, he was white. So maybe he's quite liberal, so I chose him. And I took my list because I feel like they're related, because it was about period stuff, he just would not listen to my list because it was itemised, you know? He was like, 'oh no, I won't cover this in one session.' But I'm just, like, can you not see that they're all related things, they're all the same region.*
>
> *So, I went to another doctor and he seemed pissed off at me. Because I complained about my smear, and he just seemed really to have dis[d]ain for me. And I was just, like, you can't be my doctor 'cause you're just blaming everything on me being fat.*
>
> *[…] the smear was terrible because they had to have three or four nurses. And the nurse was new so, you know, when you're a bigger woman as well, it's harder to get the, what's it called, the clamp thing. And now the clamp is plastic as well, so it kept slipping and I was just, like, this is violating I'm just traumatised here. And then my complaint was relayed back to me by this man who was just mad at me for telling them what my experience was. Maybe you have never had strangers in your junk on the table, but it's not a sexual experience and it's not one that you wanna have.*

71. European settlers of New Zealand
72. foreigners


Hīrairaka
Hīwaiwaka
Pīrairaka
Pīrakaraka
Pīrangirangi
Pītakataka
Piwaiwaka
Piwakawaka
Tīrairaka
Tīrakaraka
Tīwaiwaka

> *Doctors are yuck and I really need to go back for my smear, but my last smear was the one where they couldn't keep the prong thing in. I also was made to feel like, 'oh, okay, it's because I'm fat that I can't keep, that I somehow failed, I can't keep this piece of equipment inside my vagina'. Or I'm sitting wrong and I'm doing something wrong which I know is not the case because people have done it. I've had a smear before obviously. But I'm always scared that I'm gonna have something that I don't know about. Because I've had people in my extended family have similar things like that and they die. (Natasha)*

Within healthcare settings, healthcare professionals often "rely more on body size to judge physical health than other diagnostic tools or even their client's own information and perceptions" (Perksy & Eccleston, 2011, p. 730). This policing of bodies, particularly, fat wāhine Māori bodies, and the utilisation and weaponisation of power to restrict body sovereignty and the ways in which wāhine Māori are able to enact this over our whare tangata highlights the colonial nature of control and stigmatisation that has its origins within medical racism as well as Christianity (Mikaere 2011; Parker et al., 2019; Tinirau et al., 2021b). Emma shares her experiences with family planning:

> *I go to Family Planning for birth control which I take […] not that it matters, you can take it for any fucking reason it doesn't matter, but I specifically take it to manage my hormone levels which impact my anxiety, and then also I get hormonal migraines. I've chosen to go to Family Planning because it's usually better than the doctor, it's usually women, they're usually pretty cool. Usually, my body doesn't come up in a negative way, but it was just horrific. I wrote a massive complaint straight away and named her [the nurse] in it. I was like "This is unacceptable." So, basically my blood pressure was elevated, and I refused to be weighed which I always do as a rule, and so she was saying that they could refuse me my contraception if I refused to be weighed and my blood pressure was blah blah blah. But that wasn't the bad thing, the bad thing was as soon as I questioned her, she was defensive, defence, defence, defence, and it ended in her basically being like "If you wanted to do something about it you'd just do it, you'd just lose weight it's easy", like that kind of shit. "I really don't wanna have to go through with this, but I'm gonna follow through with my complaint." (Emma)*

Andrew (2020) notes for fat Black women within health-seeking spaces,

> *the accommodations and the resistances we consistently undertake, and the pain of having our lived experiences questioned, minimized or otherwise erased. Fat Black womxn who dare to be bold, opinionated, and difficult, who ask too many questions and demand accountability especially from those with authority, and who take up plenty space in with and through our fleshy bodies are exactly what we need in place (p. 225)*

In seeking accountability, Emma goes on to discuss her efforts of self-advocacy as resistance to the violence she experienced. In having a meeting with practitioners, she questions them further after outlining the harmful denial of body sovereignty:

> *In the actual meeting I said: "So what other things affect blood pressure?" She's like "if you're stressed or in a hurry."*
>
> *"So, like … the stress that you just put me under by telling me that I had to be weighed? Maybe that kind of stress."*
>
> *I have this real false hope/false belief that Family Planning is meant to be one of those places that's a little bit […] I said that "I choose to come and spend my money here, it costs more than my GP, because I see it as an advocacy service for women of all backgrounds and you've just proved me wrong, this one person." That's why I was so disappointed because at the GP I'm kind of ready, ready to fight.*
>
> *I mean it's not okay to be treated that way and to be basically told that you're gonna be stripped of your body sovereignty if you don't conform to whatever. (Emma)*

In regard to complaints, Ahmed (2021) delves into the ways in which spaces can be structured for specific purposes and ultimately for specific bodies. She states that,

> *you might have to make a complaint because of how a space is occupied. When you challenge how spaces are occupied, you learn how spaces are occupied […] Spaces can be occupied by being intended for specific purposes. When spaces are intended for specific purposes, they have bodies in mind. Perhaps we can more easily tell whom spaces are intended for when those for whom they were not intended turn up. (p. 137)*

Lose weight or lose access

The weaponisation of access to healthcare was identified within research whanaunga kōrero. The ways in which healthism is perpetuated through the enforcement of perceived health-seeking behaviours was extensive for research whanaunga. Health-seeking behavious such as actively and purposefully pursuing weight loss, engaging in food restriction, and punitive approaches to occupying fatter bodies in the fatphobic world within which we occupy were experienced as a method of dehumanisation and scapegoating. These instances are succinctly summarised by Emma, stating:

> *The denial of access just because you're fat and you're refusing to be weigh[ed].*

This notion of erasing difference (Walsh, 2020) in relation to fat wāhine Māori can be seen as a mechanism of control and compliance. Siobhan discusses her issues of access in regard to requiring surgery for a health issue spanning years and the ways in which her pain and discomfort were minimised (Skloot, 2010; Tinirau et al., 2021b) and disregarded due to failure to comply until the issues were reclassified as urgent by those in power:

> *I'd had issues with my gall bladder for 2 years, but I hadn't scheduled any surgery. They pretty much said that they were waiting for an emergency. The emergency came, I was at my mother's for dinner, and I was trying to eat corned beef and I just couldn't hold it down and I vomited, because the bile duct was blocked. So anyway, go to hospital they're like yes, your gall bladder stone has moved and it's dangerous. Before I go into my surgery, the anaesthetist says to me, "so, because you're obese, you have a higher likelihood that you could die on the table."*
>
> *I'm like, cool, thanks, for wording it like that. So, it was very callous. She was just for like really hitting home that I was fat and I was a risk, but she said "oh, you need to sign this sort of waiver or something to say that like, if you pass away it's not our fault, it's because you're fat", it was some sort of documentation. And I remember as they were wheeling me away to the theatre, and I was holding my mum's hand and I was kind of crying, and I was like, "I love you", and she's like, "don't do this, you're going to be fine" and I'm like, "but they said that because I'm fat I'm going to die". I was being dramatic, but it felt really real at the time. It is real, because you have a medical professional telling you at the time that because you're fat, you're likelier to die. That was not nice.*
>
> *Because I had asked them previously, can I get a surgery date and I had to go through all of these appointments for these doctors or surgeons to tell me that "oh, we want to put you on this for weight loss." They told me to do Optifast, which is expensive, but also that I had to eat things that were 5 percent fat or less, 5 percent sugar or less. And that was what I was meant to be eating. And they were like, if you stick to this you should lose enough weight for us to be able to take it out. For them to tell me that they literally cannot give me a surgery, it's an infringement on human rights that they cannot give me a surgery because I'm too fat. It feels so weird that they can use their power to influence individual bodies like that and play God with who gets a surgery and who fucking doesn't. (Siobhan)*

The unnecessary display of callously suggesting death is caused by fatness and to weaponise that value-based assumption against a patient who is unable to advocate for themselves in an emergency and because they will be vulnerable under anaesthetic highlights the punitive nature of anti-fatness (Andrew, 2020; Pausé, 2020). This weaponisation of weight and fatness is a means of control to restrict access to procedures until fat people conform to social norms around health-seeking behaviours, or it becomes a life-or-death emergency. Biological determinism here highlights how certain bodies are assumed to be more

tolerant of physical, emotional, and psychological pain (Harrison, 2021; Strings, 2019). This perpetuates the idea that fat wāhine Māori bodies can, and more evidently, *should*, suffer and take any pain that is forced upon them (Le Grice, 2017; Mikaere, 2011).

The lack of privilege often reinforces healthist, discriminatory behaviour. Within health spaces, so much of perceived health status and opportunities revolve around privilege and access, Siobhan goes on to highlight that often this genetic and intergenerational privilege influences healthcare:

> *Health privilege usually breeds health privilege. And access to good healthcare, access to affirming healthcare. (Siobhan)*

The health system is often an extremely unsafe space for Māori, particularly when we are infantilised and positioned as needing education to comply with said education. Camilla experienced this attempted forced compliance in relation to pursuits of weight loss in order to regain access to a service she had been previously utilising. The focus on fatness and weight over access and her own understanding of hauora and being an expert in her body and condition (Andrew, 2020) was recurrent throughout her healthcare interactions, serving as a site of many intersections. She notes that the health system is a dangerous place for her:

> *The public health system I don't feel like that's a safe space for me.*
>
> *Especially after I had my baby, not just being told that I'm overweight and I need to not be overweight. They didn't care about if I was feeling healthy, not one of them asked me if I was fit, if I'm active, it was all about my weight and nothing else. Not one of them asked me about my mental health, I was just really appalled. Not being listened to, especially when I was in pain, which I feel like is all connected not just with my body but my who I am, because I'm a wahine. I feel like the health system is the least safest space for me. Especially when I went to one, and I was asked to go and talk to the counsellor, this was at Family Planning, and I talked to the counsellor about my mental health and she was like, 'oh, is it okay if I tell CYFs what we've talked about' and I was just like, 'wow', that really made alarm bells go off for me about that probably being the least safest space for me. This space that was supposed to support me and help me to feel healthy. Instead of fat shaming me. (Camilla)*

The prevalence of enforcing weight loss and subsequently dismissing wāhine Māori concerns has been prevalent within the kōrero shared and present since colonisation (Mikaere, 2011). We can see this in the ways in which wāhine Māori have been dismissed and ignored within colonial historical recounts (Yates-Smith, 1998).

Ahmed (2021) discusses the process of complaint noting that "you might make a complaint because you are in an intense and difficult situation. What a complaint is about is a situation the person who complains is still in. You might make a complaint because you do not want to remain in that situation; a complaint can be an effort to get out of a situation you are in. Trying to get out of a situation can sometimes make that situation even more intense and difficult." (p. 103). This effort of change can be seen in Meagan's experiences of having health concerns ignored, attributed to weight without any health investigation, and subsequently denied access to diagnostics and treatment until she laid a formal complaint:

> *I had something wrong with my leg for a really long time, didn't know what it was. Had to go through the hospital and many doctors, I kept dislocating my knee which was very painful.*
>
> *And I'd been to the doctor on a few occasions and eventually they were like, "you know, it's not really that normal that this keeps happening, so we'll refer you to have a look at it to see if there's something else wrong". And the specialist said, "have you tried losing weight?" Which is the standard response that we all hear. And by that point I was like "you know what? I've been the same amount of fat for ages, for some years now. I've been the same weight, the same size. Pretty sure it's not that. You haven't physically examined me at all, you haven't touched me to examine me. You haven't sent me for any imaging. I feel like you can't really just say it's 'cause you're fat without doing any aspect of your job."*
>
> *And also made that complaint to the District Health Board and then I was magically referred for imaging, surprisingly. And they said, cool, so it turns out you've got a tumour in your knee and that's why it is dislocating because the tumour has grown and pushed your kneecap out.*
>
> *And I felt like the people who are trained to look after our bodies didn't care enough to help but then luckily eventually, had this imaging done. Was referred to a doctor who said, 'wow, this is something I've never seen before', and suddenly my weight wasn't a thing that was discussed. It was hey, this is something that's actually not that common, I don't know anything about it so I'm going to refer you to this other guy, who referred me to another guy. And, but eventually I ended up with somebody who specialises in joints and specialises in tumours and he took it out.*
>
> *I was on the waiting list for a couple of years, three or four years.*
>
> *And okay, we're gonna do your pre-op thing. "Oh, have you thought about bariatric surgery?" That's not going to help the situation so how about we just remove the tumour, right? Or what, are you wanting me to have bariatric surgery now before you remove the tumour so then you can put me under anaesthetic?*
>
> *That was implied, that I should lose weight beforehand, and I was like, well, what do you want me to do that? You want me to exercise? Well, cool, I can't walk to my fucken bathroom without being in pain. I can't drive, I can't go grocery shopping, I can't do normal people things. (Meagan)*

What about healthism/ Pēhea te hauora?

Healthism and fatism as systems of oppression, perpetuate the dehumanisation of people who do not conform to the categories at the top of the hierarchy. The proximity to privilege, in this case, identities of privilege such as white, thin, able-bodied archetype is the basis of which health is defined and therefore the metric of healthism (Tinirau et al., 2021a, 2021b). This deviation from what is classified as human and de-human highlights the ways in which notions of body supremacy are perpetuated in moralising, punishing, and assigning deservedness, humanity, and mana (Gillon et al., 2022; Harrison, 2021). Fatness in this way becomes problematised and individualised which enables healthcare to be gate-kept and weaponised. Emma highlights the complexities and contradictions within health spaces that often centre the preoccupation of health behaviours which continues oppressive, restrictive, ideas and pursuits of health that are both moralised and utilised to restrict access to human rights:

> *"Hmm, what could my biases be?" It's around educating yourself and fucking take some time. But then the other side of it is to do with being part of humanity, and compassion and kindness and every person, and it comes under the thing of healthism, one of the biggest arguments against fatness is 'it's okay as long as you're healthy', but if I was unhealthy would that then mean that it would be okay for you to abuse me? And I would not be deserving of basic respect and dignity? If you have power you have a responsibility to connect with your base level humanity, and think about other people as human beings regardless of if you don't like the way that they look.*
>
> *Fatness is still perceived as an individual problem and like you did this to yourself, so there's a choice in that, whereas if you have an illness or are born with a disability […] or are injured and have a disability as a result then you didn't choose that, but we chose this, so we deserve to be sick and hurt. (Emma)*

The kōrero within this research illustrates that the intersectional layer of fatism alongside racism and sexism further perpetuates dehumanisation. The Whakatika Research Project, which examined racism as a health determinant for Māori, Black, Indigenous, and People of Colour through its literature reviews, exposed that proximity to whiteness was closely related to humanness (Tinirau et al., 2021a, 2021b). Using these findings within the context of fat wāhine Māori stories, it can be surmised that cis-gendered white male and thin bodies are the colonial archetype of humanness and is, therefore, the metric of healthism. This can mean that a body that veers away from that archetype is measured on a spectrum of humanness (white, cis-gendered male, thin) to dehumanness (Black, cis-gendered female or gender non-conforming, and fat). These tie into wider ideas about white-body supremacy denoting what body is deemed the correct body and is therefore deserving of humanity (Menakem, 2020; Tuwe, 2022). The research kōrero exemplifies that not only are these deeper systems interplaying, but that these critiques are deflected by neoliberalist conversations by medical practitioners who continually problematise and individualise fatness (Gillon & Pausé, 2021; Hokowhitu, 2014).

Tūī expands on their experience of weight being the focus and blame for every issue they have had and the ways in which this enforces the inaccessibility of healthcare. In examining the moralisation of certain types of bodies, they highlight these ideas of healthism and biopolitics, and the focus on and pursuit of perceived health behaviours over humanity and evidence-based health experience.

> *My weight was mentioned whether I had a mental health problem or a UTI or anything, there'd always be some conversation around my weight or how my body looked. My body has always been commented on. I have so much distrust for the doctors, because being an Indigenous person, and now a fat person, having a uterus, non-binary, wahine, so I feel like I've never been listened to and always been gasli[t] into somehow it being my issue, like what I eat or how much exercise I do or my lifestyle or whatever.*
>
> *My mental health being related to the fact that I'm fat, 'if you lose some weight then your mental health will be better' or somehow my weigh[t] is equated to giving me depression, for some of us the suicidal shit that comes with that just reinforces the idea that society teaches us that our bodies are bad. (Tūī)*

Fatness is often assigned synonymous with poor health; we see this within the ways in which society discusses fatness and the hypermedicalisation of our fat bodies. At times, this results in the idea that individuals need to be educated about weight-loss behaviours and practice in order to become healthful. This education can be illustrated through fat shaming and dismissal of actual concerns (Aphramor & Gingras, 2009; Ioannoni, 2020) expressed by wāhine Māori. It fails to take into account any sort of evidence-based practice, hauora, intersectionality, and the ways in which racism, classism, and sexism intersect with fatism and healthism. Camilla shares her experiences of seeking a referral to a physio for an issue known by the health practitioners and how it was extremely challenging and harmful:

> *And going to my doctor about going to physio, because my back pain from when I was pregnant never went away. I was like 'can I have a referral to the physio?' And then she was like, 'how much do you weigh?' And I was like, 'what's that got to do with going to the physio?' I've told you I went to physio during pregnancy and it's the same thing. And then she made the whole consultation about my weight, instead and she ignored the part where I said I want to be active, not trying to fat shame myself or hate my body, I just want to be active, but when I do that, I get back pain. And then she was like, 'oh, how much do you weigh? You're gonna need to do more exercise.'*
>
> *I was really upset about that as well. Shaming me for coming to sort it out, it was really, really annoying. I just avoid the doctors like the plague.*
>
> *So, I got my physio referral in the end. But I also got a green prescription referral. Did I ask for that? I'm not stupid. Like, if I wanted to be thin I'm sure I could. But I don't want that. I want to love myself and make sure my kids love themselves. It's not like I don't know things about nutrition, which is good because I was like, okay let's go and check this out. Went there, and it was about nutrition. And I was like, I know this stuff. Why am I here? I was really annoyed that just because I'm big you think that I don't know what nutrition is? Or as if I don't know how to eat, or as if I don't know how to exercise, it was really bizarre. And then I was also annoyed because, wait so, I have to pay for a gym and this would give me a little discount.*

> *And none of them asked me what some of the barriers are, what you think some barriers? Because the first thing I will say was well, I've got 4 kids and I've got my job at uni, and I'm studying. And then I've got contracting work that I do, I have to survive. I don't even get 8 hours of sleep, what makes you think that I'm gonna be doing all these extra things. Like, you could give me more money? (Camilla)*

Camilla's experience highlights the intersectional aspect of these interactions reflecting not only racism, sexism, fatism, and healthism, but also classism. Ernsberger (2009) notes that socioeconomic status and fatness are interconnected in that fatness can be impoverishing due to stigma and discrimination which is then reflected in differential access to financial opportunities and employment as well as health, education, and social status. Further, Camilla's harmful experience with nutrition-based health professionals highlights what Aphramir and Gingras (2009) note in relation to the ways in which fatness and bodies are discussed within these areas:

> *When dominant theories on, and ways of speaking about food, eating, and fat do not sufficiently represent lived experiences, there exists an empathic rupture between practitioners' theories and Others' lives. Such a disparity, when viewed by the dietitian in terms of individuality and rational, autonomous client behaviour, is seen as largely the responsibility of said client. Very often, the issue at stake is fatness, the large body seen as noncompliant, disobedient, and undisciplined, which could very well apply to the bodies of knowledge that dietitians automatically disappear in order to rely on a discourse that demonizes fat. This ideology is also a likely predicate for healthism. (p. 98)*

There is an infantilisation of fat people through the (under)/(over) surveillance of our bodies that is often utilised by those within health spaces when thinking about biopolitics and the categorisation of people, particularly people who are not classified as privileged in these categories. The idea that fat wāhine Māori are required to change and conform to these categories in order to gain access to human rights and be assigned as morally good (Harrison, 2021) is prevalent throughout the fat wāhine Māori experiences within this research. 'What about health?' is often used as a means to derail conversations about inequity, oppression, and actual health and hauora. In perpetuating inaccessibility, we see many of these biopolitical, healthist discourses employed to continue harm against wāhine Māori. Meagan highlights the ways in which 'health' spaces fail to be intersectional and comprehensive for all peoples, particularly those who are minoritised:

> *I feel like this is this one-size-fits-all approach to how your body is fuelled doesn't take into account anything. But also, I feel like there's so much focus as fat people, placed on the good fatty. If you're trying to lose weight, if you're trying to be healthy, but actually also people who are unhealthy still deserve the same amount of respect and access to things. If I think about it as a chronically ill person, technically you're never gonna be healthy. What they're actually saying is in a thinner body. The focus is never health. (Meagan)*

The moralisation of health and healthism operates to obscure safe and effective diagnosis and treatment and providing care, as the research whanaunga have discussed. They speak

to the danger of fatphobic, medicalised discourses that seek to erase and problematise the fat body in order to absolve them of a duty of care (Hokowhitu, 2014). They also speak to the dehumanising and silencing of fat patients in favour of medical experts who rely on discursive heuristics at the expense of their own medical tests, data, and treatments (Andrew, 2020; Gillon & Pausé, 2021; Pausé, 2020).

Whakaaro Mōmona May 20 2018

Even if I was skinnier or weighed less, I would still, not be health-ful, I would still experience systemic disparities and I would still be un-healthy. So, why is my overall wellfulness determined by a number on a scale or a visualisation of fat. Why is there so much fat hatred, why have I internalised it so, and why is it so hard to deconstruct and decolonise. Is my worth determined in a patriarchal, misogynistic, healthist, racist society by my fat, by my fat equating to attractiveness, and worth? Are we not meant to treat people equitably even if we do not want to fuck them or find them desirable?

Is the way I feel about health and health-fullness indicative of my own biases or the way I'm treated, or both? Do I place the scrutiny on myself for being un-healthful and fat, and working and studying in health or am I recognising the implicit bias in others when they see me in those spaces, when I stand in front of students and talk about health, when I am such a visualisation of assigned 'ill-health', 'un-health'? Do my colleagues think the same? We deconstruct our racist biases often, how often do we deconstruct our fat bias? Am I a perceived visual representation, a stereotype of Māori un-needed, un-necessary in hauora spaces that already must combat institutional restrictions, discrimination, racism, accountability. Or am I just over 'sensitive' to it. Lol, the internalisation is so strong, how do I break through it.

Even if it was easy, do-able and I became un-fat, would I be selling out, would it fix the issues? Kāore au i te mōhio[73]*.*

Why is my value so weighted, why is my deservedness, my rights even, why are they so dependent on a number, on tissue, and not on my āhua[74]*, my tikanga, my values, and my overall way of being and knowing. How can you be an expert in a field, or even knowledgeable in a field when people don't take you seriously because you're an insider in that field. How can you be a wellful practitioner, an expert in a field, or even knowledgeable in a field when you don't listen to people, patients, because you're healthist and fat biased? He pātai pai ērā nē*[75]*.*

Nā Ashlea Gillon (Gillon, 2024)

73. I don't know
74. Form, shape, appearance; character, figure; beyond the physical
75. Those are good questions, right?

Whakawhitinga kōrero[76]

Research whanaunga demonstrate complex, nuanced understandings of their healthist and fatphobic experiences. They highlight the ways in which these systems of oppression affect not only their health and hauora, which is meant to be enhanced and supported by the health system, but also the ways in which their humanity, mana, sovereignty, and identities as fat wāhine Māori are disregarded (Gillon, 2020; Gillon & Pausé, 2021; Gillon et al., 2022). This paper sought to explore the complex relationships between healthism, fatness, and Māori experiences and ways of understanding health, hauora, and our bodies. It emphasises the ways in which fat wāhine Māori are continuously oppressed and denied human rights via the health system within New Zealand.[77]

Understanding the ways in which healthism and fat hatred inform 'health' practices within New Zealand is crucial to saving the lives of fat wāhine Māori. The ways in which biopower and biopolitics ensure the concurrent over- and under-surveillance as well as the reclassification of fat wāhine Māori as an individualised problem, simultaneously disadvantages them and absolves the settler-colonial state of responsibility in terms of good governance, honouring agency, and self-determination (Reid, 2011). In this way, biopolitics and healthism reinforce individualist, neoliberal discourses of "working on oneself" (Million, 2014, p. 149) in order to be assigned worth and be deemed moralistically good, as evident within research whanaunga kōrero. Further, research whanaunga illustrated various examples of how fat wāhine Māori bodies are (re)inscribed and devalued through health spaces within a deficit framing, which ultimately serves as a weaponising tool to restrict our rights to self-determination (Gillon, 2019; Million, 2014). Research whanaunga highlighted their experiences and the ways in which they are continuously pressured into pursuits of 'health', or rather, thinness (Gillon & Pausé, 2021; Hokowhitu, 2014), with this being the first barrier and focus of health spaces, rather than health issues or their needs and rights themselves. Therefore, the thinness of the body becomes a metric of healthism, which detracts from medical issues at hand or in the case of research whanaunga kōrero, would inhibit an adequate diagnosis and treatment, particularly around preventative care. These barriers to accessing health due to thinness being the healthism ideal meant that research whanaunga had to forgo their humanity, placing themselves in unsafe and harmful medical spaces. These experiences were discussed through three overarching themes: the disregard of the whare tangata and reproductive insensitivities; lose weight or lose access; and what about health(ism)/pēhea te hauora?

76. Discussion
77. New Zealand is being referred to here as the settler-colonial state within which the public health system is established; not Aotearoa.

He kupu whakakapi: Concluding comments

This paper has discussed the particular intersections of Māori bodies and fatism, which are social constructs that were introduced by imperialism and, subsequently, colonialism, taking on a series of hierarchical stigmatisation processes, which have stratified Māori in a number of ways (Tinirau et al., 2021a). Akin to the *Whakatika Research Project* that looked at racism as a health determinant on Māori, Black, Indigenous, and People of Colour, the literature reviews showed how racism was colonial and introduced, and how metrics were created to measure humanness through proximity to whiteness (Tinirau et al., 2021a, 2021b). These colonial metrics align with the research whanaunga kōrero but draw particular attention to, not only race and gender, but also fatism, illustrating that the metric for humanness within the context of healthism is to, not only have whiteness, cis-gendered maleness, but also thinness. Again, these intersections have played out in the lives of fat wāhine Māori discussed throughout this paper, highlighting essentialist thinking that has more far-reaching implications for those who are not white, not cis-gendered male, and who are not thin, in that a patient's care and access will change depending on how the medical practitioner assigns someone their race, gender, and fatness. The assignments of these intersections ultimately exacerbate negative and colonial stereotyping about a patient's intelligence and capabilities.

However, this paper illuminates Kaupapa Māori perspectives and worldviews on fatness through te reo Māori, particularly through the kupu *mōmona* which has positive and bountiful connotations with regard to health and hauora. Through the power of te reo Māori, these positive associations surrounding fatness within te ao Māori realms of well-being re-orient and re-claim spaces for our fat wāhine Māori in opening discourse on the colonial influences of healthism while teasing out the multiplicity of what health and well-being looks like for Māori.

Karakia whakamutunga

Nau mai te āio
Nau mai te mana
Nau mai te mōmonatanga
Āio ki a Papa
Āio ki a Rangi
Āio ki ngā tinana katoa, ki ngā mea katoa
Tīhei mauri ora

He kuputaka: Glossary

atua	ancestors of ongoing influence, divine
āhua	form, shape, appearance; character, figure; beyond the physical
engari	but, however
hapū	kinship group; descended from an eponymous ancestor
hau	vitality, essence; breath
hauora	wellness, vitality, in good spirits; calm, peace, tranquil
he aha tēnei mea, ko 'health'?	what is this thing called 'health'?
heoi anō	however
he pātai pai ērā, nē?	those are good questions, right?
hinengaro	mind
i tēnei wā	at this time
ia weherua-kore	non-binary
iwi	tribe, nation
Kaupapa Māori	Māori approach, Māori principles, Māori agenda, Māori ideology, theories, methodologies, and epistemologies
kāore au i te mōhio	I don't know
kia ora	command to keep well, or keep good health (utterance)
kōrero	dialogue, conversation
kōrero tuku iho	oral traditions handed down from ancestors
kupu	word
kupu mōmona	fat-describing words
mahi tonu	continue working
mamae	pain, hurt, suffering
mana	ancestral power; agency, authority; spiritual; indestructible power from the atua
matū	fat, gist, substance, richness, sense, point, spirit, quintessence, matter
Māori	Indigenous people of Aotearoa
māramatanga	understanding
mātauranga	knowledge
mātauranga Māori	Māori knowledge, wisdom, ancestral understandings, skill
moana	sea, ocean
mōmona	fat, in good condition, bountiful, plentiful, fertile; nourished
nā	written by; belonging to
nē	right?
ngako	fat, essence, gist, substance, to be ever ingrained
noho puku	to sit with and come to know through contemplation; reflection; silence; meditation

ora	wellness; safety; to live; to recover; to be healed; to survive; to revive.
Pākehā	European settlers of New Zealand
pēhea te hauora?	what about healthism?
pono	true
pūrākau	stories; Māori narratives with philosophical epistemological thoughts centring around relationships
tamariki	children
tapu	sacredness
tauiwi	foreigners
taumaha	weight, heaviness, burden
taumahatanga	heaviness, burden, weight
tākoha	gift
tāne (1)	male/s,men
Tāne (2)	atua of the forest and birds
tāngata whaikaha	people with disabilities
Tāwhirimātea	atua of the winds
te ao Māori	the Māori world
te reo Māori	the Māori language
tika	correct
tikanga	research methodologies
tinana	body, real, actual, self, person, reality
tīmatanga	introduction
tuawhiti	fat, thick, fleshy, of good quality, of substance, succulent
tunuhuruhuru o te whare tangata	disregard of the womb and reproductive sensitivities
wahine	woman
wairua	spirit
wāhine	womens', women
wānanga	discussions
whakaaro mōmona	fat thoughts
whakamā	embarrassment, shame
whakapapa kōrero	traditional Māori knowledge
whakawhanaungatanga	process of establishing relationships
whanaunga	people who engaged with the research who have ongoing relationships with the researcher
whānau	family, relations
whare tangata	womb, uterus, house of humanity
whenua	land

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Ngā āhuatanga toi: Conceptual design

Three elements make up the design of this publication. These are: the illustrations of Hineahuone, Te Pō, a pīwaiwaka, and Hinenuitepō; the front cover imagery of Te Wai Unuroa o Wairaka and continuing green colour scheme; and, the signature of Rere-ō-maki.

The illustrations of Hineahuone, Te Pō, a pīwaiwaka, and Hinenuitepō in this publication are intended to reflect the arc of the kōrero it accompanies: beginning with our current health realities and how they have been shaped, to exploring and uncovering healthism, and on to re-orienting and re-claiming spaces for our fat wāhine Māori.

- Hineahuone, the first female form, was fashioned from the red earth at Kurawaka. This conception is what lends to Hineahuone her name—Hine-ahu-one or 'earth-formed woman'.[78] Like Hineahuone, we too are moulded by our environs. Our realities are shaped and continue to be shaped by both te ao Māori, as well as te ao Pākehā and its new formations in the continuation of colonisation.
- Te Pō, the realm of the night, emerges from Te Kore, the realm of potential, and from it unfolds te ao mārama, the world of light.[79] This process or whakapapa in the creation story reflects the journey shared in this publication: beginning with a vivid understanding of the potential of Kaupapa Māori perspectives; followed by a sharing of experiences navigating healthism; and, finally, the multiplicity of what health and well-being looks like for Māori coming into view.
- Pīwaiwaka, native manu of Aotearoa, are often considered negative tohu or 'bad omens'.[80] However, pīwaiwaka are advocates and kaitiaki, speaking for those who may be unable. The participants in this publication are likened to pīwaiwaka as they share their personal stories within health spaces to advocate for those with similar experiences and create change.
- Hinetītama, the dawn maiden, was deceived by Tāne as she joined him in union and conceived a child, not knowing he was her father.[81] Changed by her traumatic experience, she transformed herself and became Hinenuitepō, atua of te pō. As this publications attempts to reclaim space for fat wāhine Māori amongst the dominant western health system, we are reminded of the courage of Hinenuitepō, who, in realising the takahi of her rangatiratanga, she reasserted her rangatiratanga and rebuilt herself.

These specific Māori characters not only reflect the kōrero in this publication, but their very use also reflects the Kaupapa Māori approach taken by the author, to use pūrākau to understand the world around us.

78. Illustration of Hineahuone on page 13.
79. Illustration of Te Pō on page 17.
80. Illustration of Pīwaiwaka on page 21.
81. Illustration of Hinenuitepō on page 29.

The front cover imagery is of Te Wai Unuroa o Wairaka, a punawai with historical significance to Ngāti Awa, and to where one of the authors (Ashlea Gillon) shares whakapapa. The pūrākau of Wairaka tells of how she grew thirsty, stamped her foot on the ground in demand of water, and from the earth there the water sprang. Te Wai Unuroa o Wairaka, through its fertility and nourishing nature as it continues to flow and flourish today, illustrates the connection between the kupu mōmona and hauora. The continuation of the green colour scheme throughout emphasises this connection and Māori perspective as the green background frames the kōrero on fatness, as well as serves as a juxtaposition to challenge the contrary Pākehā perspective.

Finally, the UV-printed signature of Rere-ō-maki at the bottom of each page is featured in all Waipuna research priorities of Te Atawhai o Te Ao. The name of this research priority comes from the spring Waipuna or Wāhipuna near Pīaea where Rere-ō-maki was laid to rest. Rere-ō-maki, a matriarch of her whānau and a wahine rangatira, signed her tohu on Te Tiriti o Waitangi at Pākaitore. Rere-ō-maki was of Ngāti Ruaka descent, to whom the other author (Dr Meri Haami) shares whakapapa connections, and continues to serve as one of the many examples of strong wāhine Māori leaders who asserted their tino rangatiratanga.


Te Atawhai o Te Ao
Independent Māori Institute for Environment & Health