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Mana motuhake, Indigenous biopolitics and health

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Abstract

The majority of Indigenous health models do not directly acknowledge that health is a contested political space. Providing a Foucauldian analysis, this article suggests a function of biopower is to naturalise discourses such as the *poor Māori health statistic* to appear based on factual evidence and thus are apolitical. Employing Foucault's triad of power—sovereign, disciplinary and biopower—to understand the genealogy of Māori health, this article proffers mana motuhake (Māori political self-governance) as an appropriate health analytic because it, first, identifies Indigenous health as political and, second, because it recognises the disempowering role that colonialism has played in relation to Māori biopolitical self-governance. Hence, we suggest Māori health will be enhanced by mana motuhake and that research underpinned by Indigenous agency and self-governance resists biopower. The article references two Ageing Well National Science Challenge–funded research projects because they innovatively fundamentalise mana motuhake and politics to Indigenous health.

Keywords

biopolitics, health, Indigenous, kaumātua, mana motuhake, Māori

Introduction

The effects of colonisation on the well-being of Indigenous cultures, communities and individuals are well-known, researched and documented and, unsurprisingly, consistent across colonial contexts (Cassim et al., 2021; Durie, 2003; Hokowhitu et al., 2010; Kauanui, 2008; Laenui, 2000; Marrone, 2007; Moreton-Robinson, 2016; Simpson, 2014; Simpson & Smith, 2014; Tallbear, 2013; Tobias et al., 2009). As a recent article bringing together practitioners and health scholars from multiple colonial contexts summarises, "Globally, health disparities between Indigenous and non-Indigenous populations are ubiquitous and pervasive, and are recognised as being unfair, avoidable, and remediable" (Jones et al., 2018, p. 512).

Similarly, the negative impact of colonisation on Indigenous lifespan is internationally endemic. Typically, Indigenous peoples die considerably earlier than their non-Indigenous compatriots, creating a great sense of loss and source of pain for cultures that view their elders as bearers of knowledge critical to survivance (Vizenor, 2008). As articulated by well-known Australian Aboriginal activist and academic, Mick Dodson: "The statistics of shortened life expectancy are our mothers and fathers, uncles, aunties and elders who live diminished lives and die before their gifts of knowledge and experience are passed on. We die silently under these statistics" (as cited in Human Rights and Equal Opportunity Commission, 2005, p. 11).

Although this article focuses on mana motuhake (autonomy; sovereignty) as a health analytic and, thus, is not centrally about ageing and Indigenous health, we reference two Ageing Well National Science Challenge–funded research projects, Kaumātua Mana Motuhake (Elder Autonomy) and Kaumātua Mana Motuhake Pōī (Elder Autonomy Research Cluster) (Hokowhitu et al., 2020; Oetzel et al., 2019) because they innovatively fundamentalise biopolitics to Indigenous health. In preparation for these research projects, we identified an epistemological fissure between dominant discourses surrounding elders in the New Zealand population in general and how Māori kaumātua are represented. Generally, the ageing baby-boomers are most often referred to in neo-liberal frames and, thus, depicted as a threat to society's economic security. In contrast, Māori elders are,

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in theory at least, culturally venerated. Kaumātua are, "carriers of culture, anchors for families, models for lifestyle, bridges to the future, guardians of heritage, and role models for younger generations" (Durie et al., 2010, p. 14). By centralising mana motuhake, these research projects sought to politicise the Māori health research space.

Similarly, this article puts into focus the idea of Indigenous health as an inherently political space. The article's theorisation is based on the French philosopher Michel Foucault's concepts of *Biopower* and *Biopolitics*. Although definitions of both concepts are wide and varied, we define biopower as the regulation of a population through disciplines, institutions and knowledge bases "whose task is to calculate, interpret, and predict the overall health of the society" (Cisney & Morar, 2015, p. 5). Rather than the focus on the individual, but rather the population as representative of the species as tracked by "birthrates, death rates, fertility rates, economic and poverty statistics, infant mortality, average longevity, and disease" (Cisney & Morar, 2015, p. 5). Most important to this article is the definition of biopolitics that, by replacing *power* with *politics* in the coinage, recognises the potential for agency within the power dynamic, that is, sovereignty or in this case, mana motuhake.

The article also employs Foucault's triad of power—sovereign, disciplinary and biopower—to understand the genealogy of Māori health, this article proffers mana motuhake (Māori political self-governance) as an appropriate health analytic because it, first, identifies Indigenous health as political and, second, because it recognises the disempowering role that colonialism has played in relation to Māori biopolitical self-governance. Hence, we suggest Māori health will be enhanced by mana motuhake and that research underpinned by Indigenous agency and self-governance resists biopower. It is important to note here that we do not view today's corporeal manifestations as divorced from colonial history; thus, we intentionally link today's health discourses to significant historical moments, such as the enactment of the *Tohunga Suppression Act 1907* and prominent 19th-century health discourses. We then go on to theorise mana motuhake as a biopolitical health strategy. It is important to also note that we deliberately use the idea of *genealogy* to demonstrate the continuity and relationality of, for example, the stripping of tohunga of their mana through the aforementioned act and the possibility of mana motuhake as a concept to think about the reclamation of Indigenous health self-governance.

Key ideas

For the purposes of this article, the insights that Foucault (2004) provides has enabled a re-theorisation of the historical and ongoing project of colonialism into three related conceptions of colonial power, which mirror his taxonomy of power; first *sovereign power*, second *disciplinary power* and finally, biopower as outlined in *Security, Territory, Population*.

Sovereign colonialism

In relation to sovereign power, Foucault originates his analysis by using the ancient *patria potestas* which, "granted the father of the Roman family the right to 'dispose' of the life of his children and his slaves; just as he had given them life, so he could take it away" (as cited in Rabinow, 1984, p. 258). Foucault suggests this power to or "right to decide life and death" (as cited in Rabinow, 1984, p. 258) was taken up by European Kings, Queens and governments in a more diminished form where the right to exercise this absolute power only occurred when there were external or internal threats to the very existence of the sovereign whereby, if threatened externally, they could sanction war and therefore expose their subjects to the possibility of death. In the case of the latter, the internal threat, the perpetrator could be sentenced to death by the sovereign. According to Foucault, the important point to remember here is that "the power of life and death was not an absolute privilege: it was conditioned by the defense of the sovereign" (as cited in Rabinow, 1984, p. 258). That is, the power of life and death was validated when either the real or perceived survival of the sovereign came into question.

In translating sovereign power to colonialism, the most important concept to focus on is the very existence of Indigenous peoples. That is, the existence of Indigenous epistemologies, Indigenous resistance and Indigenous power structures were inherently threatening to sovereign imperial power and, therefore, validated imperial powers absolute right to exercise *patria potestas*; whether that be the right to dispose of Indigenous life in relation to the outright killing of Indigenous peoples or to set up the conditions where Indigenous lives could be disposed of, for instance, through disease. Such a right demanded the dehumanisation of Indigenous peoples. Sovereign colonialism for Indigenous peoples, thus, began with the apparent lack of division between the indigene's mind, body, spirit and the external, which served to augment the European colonisers' pre-conceived imaginings that they were indeed encountering savage races, with *minds like children* (Smith, 1999). Based on these imaginations, Enlightenment philosophers were able to locate the Indigenous being in the realm of the physical and irrational, so as to deny us full humanity (Smith, 1999).

Resemblant of the underpinning concept of terra nullius, therefore, part of the process of sovereign colonialism was to imagine Indigenous peoples as less than human to strip Indigenous natural cultural claims to epistemologies, lands and resources (Moreton-Robinson, 2021). Although land and resources were probably the most important motivators for sovereign colonialism, colonialism was also epistemological in that it imagined a subhuman culture and thus set about banning Indigenous practices often validated as being in the interest of the Native themselves (Hokowhitu, 2014). Sovereign colonialism was, therefore, negative and coercive, that is, it said *no* to pre-existing realities of Indigenous peoples, and forced Indigenous peoples to relinquish their lands and resources, and used imperial legal systems to enforce that imagined reality: "We could even say that the

law works in the imaginary, since the law imagines and can only formulate all the things that could and must not be done by imagining them. It imagines the negative" (Foucault, 2004, p. 47).

Disciplinary colonialism

Indigenous scholars have typically framed colonisation in terms of vertical power, where the colonial power is endemically oppressive for those Indigenous peoples and cultures invaded. In actuality, however, what Indigenous peoples have mostly dealt with is a horizontal form of power that is productive as opposed to oppressive; producing brown citizens. The physicality of Māori, for instance, produced certain postcolonial Indigenous subjectivities; in the army, in physical labour, physical education, sport, in the laundry, on the farm, in the kitchen and at the end of a shovel (Hokowhitu, 2007). Colonisation was not mere abstract discourse; it produced colonised citizens.

Written in 1975, it is evident within *Discipline and Punish* that Foucault is formulating what he later nuances as *anatomo-politics* in relation to disciplinary power and surveillance. In the quote below, for instance, Foucault refers to *docile bodies*, which is the title of a chapter in *Discipline and Punish*, and the coinage *political anatomy*, both of which together provide the fundamentals for the conceptualisation of disciplinary power:

> What was then being formed was a policy of coercions that act upon the body, a calculated manipulation of its elements, its gestures, its behaviour. The human body was entering a machinery of power that explores it, breaks it down and rearranges it. A "political anatomy," which was also a "mechanics of power," was being born; it defined how one may have a hold over others' bodies, not only so that they may do what one wishes, but so that they may operate as one wishes, with the techniques, the speed and the efficiency that one determines. Thus, discipline produces subjected and practised bodies, "docile" bodies. (Foucault, 1995, p. 138)

Foucault's thought is important to disciplinary colonialism, the discipline of Indigenous bodies, because he provides a method that rejects the notion that materiality is somehow divorced from theory; that the body is somehow less relevant to history than philosophy. Here, the etiological importance of the word *genealogy* should not be underestimated, for it does not merely mean a textual genealogy. Foucault's nomenclature is literally referring to the material and biological descent of corporeality, where the body is "totally imprinted by history" and the healthy body, in this context, is treated as an "inscribed surface of events" (Foucault, 1984, p. 83).

Disciplinary colonialism is most relevant to health discourses because rather than the megalithic directive language associated with sovereign colonialism that first imagined the savage and then juridically subjugated them, disciplinary colonialism came later, was also subjugatory, but through the institutionalised discipline of Indigenous bodies (Hokowhitu, 2016). For instance, limited curricula in Native Schools, nuclear family structures, soap packaging (McClintock, 2002), nutritional advice, unemployment subsidies, institutionalised pre-natal and natal care, war, statistics on childhood obesity, lifestyle magazines, educational curricula, mental health, daily and weekly schedules, prisons, workplaces, sport, and baby-boomer discourses (Hokowhitu, 2014); all of these seemingly discontinuous heterogeneous *enunciations* (Young, 2001) productively disciplined the Indigenous body.

It is obvious that one of the functions of the colonial State education system was to prepare compliant Indigenous bodies for the colonial workforce. Many of today's kaumātua through the colonial education system, for example, were punished for speaking te Reo whether that was in mainstream education or in the Native Schools' system (Simon, 1986). More generally, during the time that kaumātua of today were going through State education, Māori children were defined as retarded based on Western models of developmental psychology (Bishop, 1997; Sullivan, 1993). In an influential 1966 article that was to stimulate subsequent research and inform educational policy and practice for at least 20 years afterwards (Bray & Hill, 1973; Metge, 1986; Ramsay, 1972), Lovegrove (1966) concluded that

> Maori [as spelled in original work] and European children from almost comparable home backgrounds performed similarly on tests of scholastic achievement . . . the reasons for Maori retardation are more probably attributable to the generally deprived nature of Māori home conditions, [which are not suited] to the complex intellectual processes assessed by tests of intelligence . . . compared with the surroundings in which the European child grows, typical Maori homes are less visually and verbally complex, and less consciously organised to provide a variety of experiences which will broaden and enrich the intellectual understandings of their children. (pp. 31–34)

Lovegrove (1966) blamed the *retardation* of Māori children on the rural and traditional cultural environment: "[many Māori] came from closely-knit, professedly parochial communities, the location of which has been determined by traditional factors" (p. 33).

For our Kaumātua Mana Motuhake projects, these broader societal discourses relating to Māori culture during the childhoods of today's kaumātua described Māori culture as backward, ahistorical and retarded (Hokowhitu, 2003). The central point here is that many of today's kaumātua have experienced the history related above, including what has come to be referred to as *cultural dissonance*. That is, in this case, the result of a dominant culture disciplining an Indigenous culture, leading to at least a generation of Indigenous peoples disciplined to dissociate with their culture. Indeed, there is a growing literature that not only foregrounds the effects of colonisation in relation to Indigenous health disparities, it also, in particular, assumes a causality between what is now increasingly referred to as colonial *historical trauma* and epistemological violence (Atkinson, 2013; Becenti-Pigman et al., 2008; Brown, 2009; Canada Task Force on Aboriginal Languages and Cultures, 2005; Chandler et al., 2003; Denham, 2008;

Duran, 2006; Duran & Duran, 1995; Durie, 2003; Hallett et al., 2007; Hirini et al., 2005; Marsella et al., 1985; Oster et al., 2014; Pihama et al., 2014; Pokhrel & Herzog, 2014; Raphael et al., 1998; Walters et al., 2011; Whitbeck et al., 2004; Yellow Horse Brave Heart, 2003).

Biopolitics

While criticism of *the health industry* is commonly levelled at giant pharmaceutical companies, the current dominant discourse surrounding Māori health tends to be generated by deficit-based academic research and accompanying statistics, thus, portraying poor Māori health as apolitical, ahistorical and benevolent. The research wills us into false notions of objectivity and, consequently, to forget that the genealogical manifestation of the Māori health statistic occurred because of sovereign and disciplinary power. Yet, the fact that Māori- and Pasifika-focused health researchers have more access to State-funding (Ministry of Health, 2017) than any other discipline points to the level of political investment that the neo-colonial State has in Indigenous health. Even given this funding, however, Māori and Pasifika communities remain inequitably unwell (Cram, 2014; Durie, 1998b). In trying to understand this misnomer better, Foucault reminds us that pathologising does not necessarily result from oppressive functions; rather we need to analyse the sites that are most invested in, most surveilled and most productive.

Stuart Murray (2006) elaborates that prior to modernity, power was very much invested in death, however, with modernity's industrialization, for example, and the need for productive bodies:

> [T]he balance of power is tipped in favor of life. "Life" or *bios* is now the rubric through which death must be understood. Life is no longer presumed as given but becomes discursively constituted in relation to political power—a biopolitics that is the purview of the modern sovereign state. (p. 197)

The current focus on Indigenous morbidity statistics has, perhaps, its genealogy in the facticity of colonialism, that is, its impact on Indigenous peoples in terms of death, disease and destruction. In contrast, this article asks its readers to refocus our collective attention to biopolitics; the politics of life. Specifically, the biopolitical management of Indigenous life, which becomes critical to colonial rule. Foucault (2003) says, biopolitics arrives in Europe when,

> the birth rate, the mortality rate, longevity and so on—together with a whole series of related economic and political problems . . . become biopolitics' first objects of knowledge . . . they result in the development of a medicine whose main function will now be public hygiene, with institutions to coordinate medical care, centralize information, and normalize knowledge. (pp. 243–244)

Although using medicine as the initial example, Foucault (2003) goes on to say, "biopolitics deals with the population, with the population as a political problem, as a problem that is at once scientific and political, as a biological problem and as power's problem" (p. 245).

Given Foucault outlines that he believes this form of power-knowledge arises in Europe in the latter half of the 18th century, we can assume that it was also exported to the colonies where, in Aotearoa New Zealand for example, gathering knowledge of Indigenous communities through various forms of surveillance was key to the development of policies to help "manage" Indigenous populations. For instance, in New Zealand, Native School teachers, as touchpoints within each specific community, were asked to provide information on their Indigenous communities, such as "Registrar of Births and Deaths, Post Office agent, medical adviser and dispenser of medicines" (Simon, 1998, p. 55). Teachers were instructed to frequently report the student registration:

> The master shall keep the school register correctly, and shall post his quarterly returns within fourteen days after the end of each quarter. Any infringement of this rule will be strictly dealt with. No salary will be paid to any teacher if and so long as his returns are more than one month in arrear. (The 1880 Native Schools' Code, as cited in Simon, 1998, p. 15)

Foucault's notion of biopower is useful for interpreting Indigenous health because it understands the body as a political space that materialises in part due to discourses. Biopower, thus, refers to, "a power whose task is to take charge of life" requiring "continuous regulatory and corrective mechanisms" (Foucault, 2008, p. 144). Hardt and Negri (2009) similarly define biopower as "the power over life—or, really, the power to administer and *produce* [emphasis added] life—that functions through the government of populations, managing their health, reproductive capacities and so forth" (p. 57). Importantly, Hardt and Negri recognise the *productive*, as opposed to suppressive, nature of biopower. For Foucault, such a power "has to qualify, measure, appraise and hierarchise, rather than display itself in its murderous splendor" (as cited in Rabinow, 1984, p. 20).

The genealogy created by both sovereign and disciplinary colonialism discussed above has created the conditions for what we refer to as the *Māori health statistic*, which relates both to the naturalisation of premature death and disease as inherent to Indigenous cultures, while pointing to the historical and political construction of this enunciation (Million, 2021). The materialisation of the Māori health statistic has "become the object and focus of medicalization" (Turner, 1997, p. xii). That is, the medicalisation of savage immorality and the *Māori problem*. We should, thus, analyse those areas supported by State research funding keeping in mind that although State-funded research premised on the ill-health of Indigenous communities is ostensibly underpinned by a benevolent ethos, we should nevertheless question what Indigenous subjectivities is the research producing in relation to broader discourses. That is, how such research contributes to the competing, contrasting, synthesising and dissident concepts that materialise the Indigenous body through and in resistance to colonisation (Hokowhitu, 2014).

As stated already, research that is funded and creates scientific data in academic journals based on the poor state

of Māori health reproduces the medicalisation of the Māori problem. In Aotearoa New Zealand at least, often these publications are given media airtime via a seemingly weekly barrage of uncritical reports of the disparity between Indigenous and non-Indigenous health, which among other things simply reinforce racist stereotypes of Māori as lazy and as a burden to the socioeconomic system (Hokowhitu, 2014). Thus, we reiterate here that biopower not only produces Indigenous bodies and Indigenous peoples as a recognisable category of the *Indigenous health statistic*, but also that the material production of unhealthy Indigenous bodies occurs within political and, more specifically, biopolitical frames.

Mana motuhake as a biopolitical health strategy

One of the issues with the majority of the extant health research concerning Indigenous peoples is that it is often validated by a logic of disparity, where statistics of a certain aspect of Indigenous health are measured against a non-Indigenous baseline. While the logic of disparity helps to define the problem, the issue is that this logic simultaneously defines Indigenous peoples as *the problem* to be fixed and, consequently, falls into the trap of a deficit model framing (Coulthard, 2014). Yet, we argue it is the structural discrimination within the health system itself that contributes significantly to reduced access and effectiveness of health interventions and health services (Dyall et al., 2013; Levack et al., 2016) across the lifespan for Māori (Edwards, 2010; New Zealand Medical Association, 2011; Robson & Harris, 2007). Moreover, the majority of health research on Indigenous peoples simply fails to acknowledge the presumed causative effects of colonisation. That is, the loss of Indigenous lands, cultures, languages and identities as an advent of colonisation remains largely unacknowledged in the majority of health literature focused on Indigenous peoples (Jones et al., 2018).

Indeed, the preponderance of Indigenous health models do not acknowledge that health is a contested and political space (Cram, 2014; Durie, 1985, 1998b; Health Research Council of New Zealand, 2010; Heaton, 2015; Hokowhitu, 2014, 2016; Kingi, 2002; NiaNia et al., 2019; Russell et al., 2003). Although various Māori health models, for example, may be inherently political, they all tend to describe some form of authentic Indigenous multi-layered cultural concept as a metaphor for well-being without directly asserting a biopolitical framework. That is, typically, they do not read the *Indigenous health statistic* as already located within a broader relationality of power.

In the past 30 years, in particular, a number of Māori health models have been theorised, including Te Wheke (octopus) (Pere, 1991), Te Pae Māhutonga (Southern Cross) (Durie, 1999) and Meihana (double-hulled canoe) (Pitama et al., 2007). Mason Durie's (1998a) Whare Tapa Whā (four-sided-house) model, however, is the most recognisable and reflects a holistic health model, including tinana (physical), hinengaro (mental), whānau (relationships) and wairua (spiritual). While Durie's model is popular and often cited, the reason for this is possibly because the four cornerstones conform or are easily translated into Western holistic models of health and thus simplistic translations of wairua to spirituality, for example, allow for conceptual assimilation. The point here is not to overly critique Durie's model, however, for it has been extremely important for Māori health practitioners to have an ideal to aspire to while its translatability also means it has an important utilitarian function. The point is that although the Tapa Whā model begins with Indigenous concepts, its production within the broader medical discourse soon disfigures, disassembles and reconfigures it to fit a Western medical taxonomy, which serves to highlight that powerful political discourses are operating in the Indigenous health space.

Proffering mana motuhake as a health analytic is first and foremost to recognise Māori health, Māori life, as a political space. The centrality of *politics* to Foucault's conception of biopolitics indicates the possibility that the politics of *life* is a contested space where, in this case, Indigenous bodies can and do resist. As previously stated, one of the functions of disciplinary colonialism is that it produces brown citizens. This seemingly unconscious corporeal production has been a central criticism of Foucault's analysis of disciplinary power in particular because it suggests a lack of agency. However, by also theorising biopolitics, Foucault outlines that although the regulatory and disciplinary nature of power can be subjugatory and authoritative, he also suggests that the body is a political space. Foucault (1988) reminds us that people, "are much freer than they feel" (para. 6), or, that overcoming one's own body's embedded history precedes liberation. For Indigenous peoples, the weight of colonisation can feel very heavy not only because of the ongoing colonial violences but also because of its physical genealogy; that is, the limits we put on ourselves, perhaps, as a result of internalising disciplinary colonialism (Hokowhitu, 2016).

The *Tohunga Suppression Act 1907*

The *Te Aka Māori Dictionary* (n.d.-a) defines a tohunga as "skilled person, chosen expert, priest, healer" (Definition 2, para. 1). It is worth further quoting the definition at length to convey the extent and range of the nomenclature:

> [A] person chosen by the agent of an *atua* and the tribe as a leader in a particular field because of signs indicating talent for a particular vocation. Those who functioned as priests were known as *tohunga ahurewa*. They mediated between the *atua* and the tribe, gave advice about economic activities, were experts in propitiating the *atua* with *karakia* and were experts in sacred lore, spiritual beliefs, traditions and genealogies of the tribe. *Tohunga mākutu*, or *tohunga whaiwhaiā*, specialised in the occult and casting evil spells. Those chosen to specialise in carving are *tohunga whakairo*, in tattooing are *tohunga tā moko*, in astrology are *tohunga kōkōrangi*, in composing songs are *tohunga tito waiata*, in canoe making are *tohunga tārai waka*, in rituals are *tohunga karakia*, etc. *Tohunga* were trained in a traditional *whare wānanga* or by another *tohunga*. (Definition 2, para. 1)

One of the most significant Acts in terms of sovereign colonialism in Aotearoa New Zealand was the *Tohunga Suppression Act 1907*, which banned the practices of tohunga. The preamble to the Act states:

> Whereas designing persons, commonly known as tohungas practise on the superstition and credulity of the Maori [as spelled in original work] people by pretending to possess supernatural powers in the treatment and cure of disease, the foretelling of future events, and otherwise, and thereby induce the Maoris [as spelled in original work] to neglect their proper occupations and gather into meetings where their substance is consumed and their minds are unsettled, to the injury of themselves and to the evil example of the Maori people generally. (New Zealand Government, 1907, para. 1)

The Crown realised that tohunga were able to retain pre-colonial metaphysical belief systems through practices, ritual and systems of knowledge transferral that set them beyond the imperial scope of the colonising machine and, hence, employed sovereign power to banish the crucial tie between knowledge and power.

Note, of significance to this article is that the murkiness between colonial desires to subjugate Indigenous resistance and the validation of subjugation for the *health* of the Indigenous population recalls why the epistemological suppression of Indigenous peoples through sovereign colonialism (New Zealand Government, 1907) is so critical to understanding contemporary disease. Health, from the very outset of the fledgling colonial apparatus, was employed as a political discourse to succour the suppression of Indigenous physical and metaphysical practices (Million, 2021). The enunciations of healthism that now pathologise the general population have a genealogy in discourses of class, race and colonialism underpinned by the relationship between morality and cleanliness (Hokowhitu, 2014). For instance, McClintock (2002), in her chapter *Soft-soaping Empire*, outlines the biopolitical relations between soap, cleanliness, morality and empire:

> Four fetishes recur ritualistically in soap advertising: soap itself, white clothing (especially aprons), mirrors, and monkey. A typical Pears' advertisement figures a black child and a white child together in a bathroom. The Victorian bathroom is the innermost sanctuary of domestic hygiene and by extension the private temple of public regeneration. The sacrament of soap offers a reformation allegory whereby the purification of the domestic body becomes a metaphor for the regeneration of the body politic. (p. 309)

McClintock's focus on cleanliness and empire suggests that tightly knitted to the moral validation of colonial expansion was the allegorical figure of the unclean, uncivilised and undomesticated Indigenous barbarian.

The point here is that, beyond these direct sovereign interventions by the colonial state, colonisation was partly justified upon the immorality of the savage, that is, *the White Man's Burden*, which had offshoots that are directly related to biopolitical discourses here in Aotearoa New Zealand today. The immorality of the savage body led to discourses that the savage was unclean, that the savage was unhealthy, which further naturalised the idea that if not disciplined, then the savage and its culture would die a natural genocidal death in the face of a more evolved and superior culture (Hokowhitu, 2014). None of these discourses were true of course, yet they naturalised Indigenous death and disease; a naturalisation that still pervades today through medical and health discourses. A further point here is that it was assumed that the civilised European had the technology, including medical technology, to lead the savage to have a longer, healthier life (Million, 2021). We suggest that the unbalanced concentration on Māori health research is a mere reproduction of these *saviour* discourses, that continue to proffer the White man's burden to medicate Indigenous sickness.

Tohunga are and were leaders of great spiritual mana (reverence) and, therefore, were highly threatening to the Crown's civilising *burden*. Moreover, within the context of the epistemological devastation wreaked by colonisation, the prophetic nature of tohunga meant they possessed the potential vision to lead their people from what appeared to be an exterminatory invasion. The Māori population, in general, had radically decreased from pre-colonial estimates of as high as 500,000 to a population of just 56,000 in 1857–1858, so that, by 1874, Māori had become "only fourteen per cent, a minority in their own country" (Durie, 1998b, p. 53).

Interestingly, in the relatively short period between missionary contact and the 1907 Act, the sheer weight of colonisation had forced many Māori to convert to Christianity and they, in turn, transformed Christian religious narratives into anti-colonial rebellion. Indeed, the *Tohunga Suppression Act 1907* is said to have, in part, come about solely because of Rua Kēnana (New Zealand Government, 1907). In the years immediately prior to the Act, the enforced colonial encroachment into Tūhoe (an iwi [people] of the central North Island) lands and deepening tribal structural crises brought about by displacement and, under a Western epistemology, *disease* gave rise to Rua Kēnana who, because of his prophetic political resistance, became a central figure. Kēnana, "like Moses came down from Maungapohatu, the sacred mountain of Tuhoe, and announced his divine mission . . . In 1906, [Kēnana persuaded his followers] to sell their possessions and give up material goods as Christ had done with his disciples" (Walker, 1990, p. 182), eventually leading to the consecration of Hiruharama Hou, which literally translates to "New Jerusalem", the "City of God at Maungapohatu" (p. 182).

Our rationale for recounting Kēnana here is twofold, first, to draw attention to the fact that Māori health and sickness has, since colonisation at least, been inherently political and linked to Māori mana motuhake. According to Stephens (2001), the *Tohunga Suppression Act 1907*,

> was a measure initially prompted by Māori and Pākehā concerns over the appalling state of Māori health in turn-of-the-century New Zealand. The Act, according to this view, was designed in part to counteract the consequent rise of tohunga untrained in current Western medical techniques. The other major catalyst for the Act, according to these commentators,

> was the perceived danger posed to Europeans by the Tuhoe prophet Rua Kenana . . . a direct attempt to counteract the growing influence of such charismatic and powerful spiritual leaders who were potentially subversive. (pp. 438–439)

As Māori researchers and allies, we argue that the poor Māori health statistic is not a natural phenomenon; it is very much a political one.

Second, by referencing tohunga, we draw attention to the fact that there was another epistemic health system that existed in these Indigenous lands prior to the imposition of a sovereign and disciplinary colonial system (Million, 2021); a system that evolved to continue to under-perform for Māori today. It also draws attention to the mana of tohunga, which was quite literally suppressed by the 1907 Act. Thus, as researchers invested in research methods that give agency to Indigenous peoples and, in our case, Māori kaumātua, we highlight that the centralisation of mana motuhake as a health analytic in our kaumātua-led mana motuhake projects was a strategic choice to highlight the biopolitical nature of Māori health research and to challenge the poor Māori health statistic as a natural phenomenon.

In relation to this latter point, it is important to recognise that research can resist dominant discourses as outlined by Hardt and Negri (2009):

> [Foucault's] research agenda is simple. Its first axiom is that bodies are the constitutive components of the biopolitical fabric of being. On the biopolitical terrain—this is the second axiom—where powers are continually made and unmade, bodies resist. They have to resist in order to exist. History therefore cannot be understood merely as the horizon on which biopower configures reality through domination. On the contrary, history is determined by the biopolitical antagonisms and resistances to biopower. The third axiom of his research agenda is that corporeal resistance produces subjectivity, not in an isolated or independent way but in the complex dynamic with the resistances of other bodies. (p. 31)

Mana Motuhake, as defined by the *Te Aka Māori Dictionary* (n.d.-b), refers to "separate identity, autonomy, self-government, self-determination, independence, sovereignty, authority—mana through self-determination and control over one's own destiny" (Definition 1, para. 1). Although this definition does not refer to politics, it is clear that the concept is political in nature and, indeed, Mana Motuhake was a political party led by Matiu Rata in the 1980s, using the concept to signify Māori political self-governance.

The two Kaumātua Mana Motuhake research projects previously mentioned, for example, promote the assertion of independence and autonomy by kaumātua, taking a strengths-based approach that conceptually reframes the notion of ageing away from being grounded in a deficit model as explained above. Fundamentally, kaumātua desire mana motuhake, which signals that the answers to health disparity lies within Māori culture itself. Thus, the research projects were designed to be co-led by kaumātua and kaumātua providers who were seen as the most knowledgeable in terms of advancing better life-outcomes for kaumātua, their communities and their whānau. Consequently, the research was grounded upon kaupapa kaumātua as opposed to simply kaupapa Māori, signifying the engagement with the wealth of knowledge that already exists within kaumātua communities and the determination to provide kaumātua with access to decision-making power, oversight, guidance and input in relation to research methods, procedures, data-collection processes and analysis based on a for-kaumātua-by-kaumātua philosophy.

Conclusion

Research access to Indigenous communities validated upon pathologising Indigenous peoples as unhealthy and, consequently, in demand of medical intervention has a long genealogy in colonial history. The idea that life is a biopolitical production suggests the amalgam of scientific assemblages based on research conducted on Indigenous peoples is not necessarily benevolent but rather enunciates and reinforces the idea that Māori are passive victims. The function of biopower is to naturalise discourses such as the poor Māori health statistic so that they appear to be based on factual evidence and thus are apolitical and even ahistorical, that is, unrelated to colonial history. It could be argued that research *on* the sickness and frailty of Indigenous communities is far from benevolent and, in contrast, enables surveillance of Indigenous communities and further serves to discipline the Māori body. As researchers, it is difficult not to fall into the trap of reproducing dominant health discourses because the majority of money available to Māori researchers is in the health area.

Yet, as scholars working in this space, it is our responsibility to politicise Māori health; to rally against the idea that Māori lack political agency in relation to their bodies and health. Yet, fundamentally, being healthy has nothing to do with ethnicity but rather is determined by privilege and power. Moreover, a healthy body and lifestyle have come to symbolise wealth and privilege. Being healthy signifies power as *ableness*; being able to afford the right foods; being able to afford the time to exercise; being able to afford the right education; being able to afford the time, land and resources to grow an organic garden; being able. In terms of our research, kaumātua mana motuhake highlights the strengths and mana of being a kaumātua within a Māori worldview (Edwards, 2010), while also to politicise this particular research space to help shift the public discourse surrounding ageing in recognising the right of kaumātua to exercise their mana motuhake. This article proffers mana motuhake as a biopolitical health analytic, which is less a *model* per se and more a pathway that purposefully highlights the Indigenous health terrain as politically symptomatic.

If we extrapolate the idea of Māori political self-governance into health research, then we identify that (a) sovereign and disciplinary powers have functioned to sanction, surveil and regulate the Māori body, leading to the conditions which has produced the poor Māori health statistic

and the disenfranchisement of Māori health self-governance; (b) Indigenous health as political in nature; (c) that Māori health will be enhanced by mana motuhake (Indigenous self-governance); and (d) research underpinned by Indigenous agency and self-governance resists biopower. Thus, employing mana motuhake as a biopolitical health analytic recenters Māori agency, relationality, self-governance of the Indigenous body, simultaneously un-knitting those sutures that have disciplined the Indigenous body.

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Glossary

atua	gods
hapū	grouping of people sectioned by a particular genealogy within a broader genealogical conglomeration
hinengaro	mental aspect
iwi	people
kaumātua	elder; elders
Kaumātua Mana Motuhake	elder autonomy
Kaumātua Mana Motuhake Pōī	elder autonomy research cluster
kaupapa kaumātua	elders' methods or methodology
kaupapa Māori	Māori methods or methodology
mana	esteem; respect; power
mana motuhake	Māori political self-governance; autonomy; sovereignty; Indigenous self-governance
marae	complex of buildings where people gather for ceremonial and community events
Meihana	double-hulled canoe health model
Te Pae Māhutonga	Southern Cross health model
Te Wheke	Octopus health model
tikanga	customs and protocols
tinana	physical aspect
tohunga	expert; priest
wairua	spiritual aspect
whakapapa	genealogy
whānau	family; relational aspect
Whare Tapa Whā	four-sided-house health model

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