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**A Discursive Analysis of Māori in
Sexual and Reproductive Health Policy**

A thesis presented in partial fulfilment of the requirements for
the degree of
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Jane *Alison* Green
Ngāti Awa and Ngāti Ranginui

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Kia hora te marino
Kia whakapapa pounamu te moana
Kia tere te kārohirohi
I mua i tōu huarahi

May the calm be widespread
May the ocean glisten as greenstone
May the shimmer of light
Ever dance across your pathway

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It is from my Ngāti Pukeko and Ngaitamarawaho ancestors that I inherit this interest for thinking and knowledge.

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Chapter One: Indigenous and State knowledges

‘Epistemology is concerned with the observation of how the world comes into being as a direct result of the specific perspectives held by individuals, organisations, or systems’ (Andersen, 2003, p. xiii)

Indigenous peoples and colonial settler states produce knowledge and understand their worlds in very different ways. As part of their quest to live as self-determining peoples, Indigenous peoples seek to produce new knowledge and foster and maintain older knowledges. However, not all indigenous peoples walk along the pathway towards self-determination. After generations of oppressive colonising State policies, some indigenous peoples have come to live according to knowledge that is determined by States and by the majority, non-indigenous people. Others equate living in accordance with indigenous knowledges as a step backwards into an older, slower, and less sophisticated world. Still others, following in the footsteps of their ancestors, turn toward their indigenous knowledges precisely because those knowledges have provided them with ways of speaking, thinking and interacting with the world, and so it is those knowledges that they choose to enable them to negotiate spaces for themselves and their communities for the future (Alfred, 2009).

Indigenous knowledges are not just knowledges for bygone days, even though this is one of the ways that indigenous peoples and their knowledges are depicted by the Western, non-indigenous world. The world exhibitions of the late nineteenth and early twentieth century displayed the rich and complex worlds of indigenous peoples as exotic, simplistic, and ‘othered’ totalities (Mitchell, 1992). The ‘othering’ of indigenous peoples continues today in State-determined policy for Māori sexual and reproductive health where Māori are reduced to representations that emphasise risk, need, and management by the State. The representation of Indigenous peoples as objects for the colonisers’ actions rather than subjects of their own is nothing out of the ordinary; in fact, this is a key component of the imagined world created by the coloniser. In that imagined world, the coloniser brings knowledge and progress to meet the risks and needs of what otherwise would be an unchanging and undeveloped indigenous peoples. Inasmuch as they provide colonisers with a point of comparison against which they can define themselves and assess their own progress, Indigenous

peoples are important in the imagined world (Youngblood Henderson, 2000). Against the backdrop of colonisation and the oppression of Indigenous knowledges and indigenous realities, a goal for Indigenous peoples is to bring the world into being through knowledges that are about them and for them.

The ability to construct knowledge that reflects one's own experience of the world and not someone else's experiences requires power. In the generations before colonisation, indigenous peoples had the power to self-determine all aspects of their lives, including the ability to determine what a society would recognise as legitimate knowledge. Daes (1993, cited in Battiste, 2005) defines indigenous knowledge as:

‘All knowledge pertaining to a particular people and its territory, the nature or use of which has been transmitted from generation to generation. This knowledge includes all kinds of scientific, agricultural, technical and ecological knowledge including cultigens, medicines and the rational use of flora and fauna’ (p.4).

After colonisation, the spaces that indigenous peoples had available to them to exercise power in order to foster and maintain existing knowledges and create new knowledges had all but disappeared. Whilst indigenous knowledges are being eroded and trivialized as folklore, myth and superstition, the knowledges of the coloniser have come to dominate almost every sphere of indigenous life: the political, the social, the economic, and the spiritual (Reid and Robson, 2007). Instead of indigenous nations self-determining their own knowledges and utilising these to foster and maintain wellbeing, States assert their sovereign rule through policies designed to objectify, problematise and then assimilate indigenous peoples,

‘The persistent and aggressive assimilation plan of the Canadian government and churches throughout the past century, the marginalization of Indigenous knowledge in educational institutions committed to Eurocentric knowledge, and the losses to Aboriginal languages and heritages through modernization and urbanization of Aboriginal people have all contributed to the diminished capacity of Indigenous knowledge, with the result that it is now in danger of becoming extinct (Battiste, 2005, p. 2).

Despite extraordinary pressure to ‘disappear’, indigenous peoples have resisted respective States’ efforts at annihilation by fighting back. Drawing upon their existing knowledges as well as knowledge generated in response to the various mechanisms of State oppression, Indigenous peoples are engaged in national and international relationships with each other to re-assert their self-determining powers, re-instate their knowledges, and resist State colonialisms (Russell, 2005). The process of restoring indigenous self-determination is underway but it is a complex decolonising process of losses and gains as Indigenous peoples develop new strategies and States respond to maintain Western models of sovereignty and leadership (Alfred, 2005).

In New Zealand where Māori, the indigenous peoples, are a minority of approximately sixteen percent of the total population, Māori assertions of self-determination that seek to use tribal knowledges and extend tribal self-determination into the wider political and socio-economic arenas of life are understood by the State as being divisive and undemocratic. Nevertheless, the challenge for Māori is to find ways to bring those knowledges and their self-determining assertions into everyday life so that they can be lived, examined, reflected about, and acted upon (Smith, 2010). One area in which the State and Māori are engaged in an ongoing process of challenge and negotiation over Māori knowledges is that of policymaking. Before colonisation, knowledge in the form of policy, and policymaking, was the domain of iwi and hapu, the tribal and sub-tribal political governing entities of Māori society. In his 1987 submission to the Royal Commission on Social Policy the Reverend Māori Marsden (2003) describes the Kauhanganui, the traditional leadership group, as having been prevented by governments from carrying out its traditional functions of upholding and promoting the spiritual, the intellectual and the strategic knowledges of iwi (tribes), hapu (sub tribes) and whanau (family):

‘Assimilationist policies of the past imposed by dominant Pakeha majority have eroded and undermined the mana of the recognised iwi authorities by denying Māoridom generally, and recognised Māori authorities, any real policy and decision-making powers (p. 150).

Since the 1990s, public sector reform has provided some devolved space for Māori to engage in a degree of decision-making over the delivery of social services (Durie, 2003). However the ability to make decisions about social service delivery falls a long way short of where the real nexus of power lies which is with policymaking. Policy making in New Zealand is a State-determined process and despite efforts by Māori to be involved as active and equal Treaty partners with the State, nevertheless the status quo remains.

Policy as knowledge

Making policy is described as an activity that governments undertake in order to achieve particular objectives (Shaw and Eichbaum, 2005). Who gets to make decisions about which policies will be developed and how policies address a particular policy 'problem' is the domain of governments, not of Māori, even when policies are focused on issues that disproportionately affect Māori. Policy making in New Zealand is a process with standard steps and procedures that governments follow (Hughes & Calder, 2007) and the problems that this process poses for Māori have been well described (Cheyne et al, 2005: Durie, 2005: Gray, 2006: Maaka & Fleras, 2009). What has not been addressed is the role that policy plays in the production of knowledge, in particular the State's construction of Māori as policy 'problem' and therefore, as an object for control.

There is a risk that a focus on the State and its mechanisms for policymaking inadvertently constructs Māori as reactive and the State as active (Shahjahan, 2005). This is not supported by the evidence, which demonstrates that the historical and contemporary nature of the Māori relationship with State policymaking is that it is as much proactive as it is reactive and that Māori strategies for resistance and 'fight back' demonstrate an enduring Māori agency (Durie, 2005: Walker, 2004). Policymaking is more than a reflection of power relations that already exist between the State and Māori, and between Māori and non-Māori. Rather, policymaking is a site that is productive of the power relationship between the State and Māori through the generation of discursive knowledges about Māori. Sexual and reproductive health policy for Māori draws upon particular knowledges or discourses about Māori, population, and development. Those discourses assist in structuring how Pakeha come to understand Māori, they justify the State's interest to monitor and control Māori

sexual and reproductive health and, importantly, they may structure how Māori come to understand themselves as not fully human or not fully developed (i.e. developed as in Western or modern) in the world.

This study sets out to answer the question ‘What is the nature of the construction of Māori in and through current sexual and reproductive health policy?’ The impetus for the study comes two sources. The first is an interest to explore how, through the policy making process, knowledge is created and utilised so as to foreground some issues whilst backgrounding others. State-determined sexual and reproductive health policy for Māori is a form of knowledge or a discourse about Māori, their sexual and reproductive health status, and the strategies and programmes for their sexual and reproductive health improvement. How that knowledge has come about, who is involved in its construction, how policy problem identification proceeds and what information is used to justify policy problems and solutions are issues that are far from straightforward. In the Māori sexual and reproductive health policy sector in New Zealand, these have received little attention. For the most part, Māori working in the sector are involved in improving front line sexual and reproductive health services and workforce development (Te Puawai Tapu, 2003). The policymaking model preferred by the State restricts opportunities for substantive Māori engagement into sexual and reproductive health policy, thereby limiting Māori control over policy as a body of knowledge about Māori. That model marginalises Māori in the construction of sexual and reproductive health policy. Marginalisation increases when it is revealed that current sexual and reproductive health policy for New Zealand exists as part of an international sexual and reproductive health policy discourse.

In New Zealand, the policy discourse or knowledge about Māori in sexual and reproductive health is composed of discursive statements about risk, preventing sexually transmitted infections, reducing unwanted and unintended pregnancies, and so on. These statements have specific historicities that belie their appearance that they are simple and self-evident claims: rather, they warrant a closer examination. Which is not to say that current rates of sexually transmitted infections among Māori do not warrant attention, that infection rates are acceptable in a comparatively wealthy country like New Zealand, or that Māori ought not to be concerned about unsupported, financially compromised, young Māori men and women becoming

parents. These are indeed issues of grave import and Māori communities are understandably concerned. What warrants attention is how it is that sexual health policy discourse can portray Māori people in such a consistently negative way, with no public outcry or consequence. If discourses exist that permit the negative portrayal of Māori, then these may have the effect of entrenching such representations. Negative discourses about Māori may be so commonplace and such a part of everyday life for Māori and Pakeha in New Zealand that they pass unnoticed. If this is the situation, then strategies are required that will assist Māori to identify discursive statements and the negative discourses that support these, as well as addressing problems that are of concern to Māori, instead of problems as these are constructed by others.

The second impetus for the study comes from an interest to understand how it is that the statement ‘Māori teenage pregnancy’ has such a negative connotation in current sexual and reproductive health policy for Māori. This interest was sparked by an informal discussion over a cup of tea with young Māori parents and Māori social service workers who had been interviewed for the New Zealand ‘arm’ of the 5-year ICIHRP Health Research Council-funded research project called ‘Mauri Tu Mauri Ora’. Some of the young people asked why New Zealanders think Māori teenage pregnancy is such a ‘problem’ and such a stigmatised topic, why the media sensationalise it, and why it’s a topic that is hard to talk about in a matter-of-fact way. For the researcher, those questions sparked more questions about policy as knowledge, and the ideologies and values that influence the choice of research that underpins policymaking. Current sexual and reproductive health policy in New Zealand makes an association between Māori teenage pregnancy and poor socio-economic outcomes for mother and child (Ministry of Health, 2003). However, a cursory overview of literature and informal discussions with Māori working in the social service sector suggests that the reasons for poor outcomes may not be solely a consequence of the age of Māori teenage parents, which is what current policy suggests.

Research process

The question ‘What is the nature of the construction of Māori in and through current sexual and reproductive health policy?’ is, at the level of epistemology, an enquiry

about the theory of how something can be known. Crotty (1998) describes epistemology as,

‘involving knowledge...and [it] embodies a certain understanding of what is entailed in knowing, that is, *how we know what we know*’ (p. 8).

The epistemological approach that this study utilises is constructionist.

Constructionism is an approach that posits that human beings construct meaning and meaning does not exist separate from the human mind. The constructionist approach fits well with this study because policy, which is a type of knowledge, is, by definition, the result of human activity. Human beings construct sexual and reproductive health policy; it does not exist in the world independent of humans. If people construct policy, then different people might construct policy in different ways, and produce different meanings. The constructionist approach, therefore, draws attention to important aspects of how policy is made: that is, policy is the result of human activities, policy is influenced by who makes it, and who makes policy will be influenced by who has power. The distribution of power and how it affects who makes policy or knowledge about the sexual and reproductive health of Māori is explored in more detail in Chapter Two. Objectivism and subjectivism, both epistemological approaches, clashed with the Foucaultian theoretical approach that I have chosen to use for this study. Objectivism was incompatible because Foucault opposed the notion that objects, for example policy, have an intrinsic meaning that is already present but waiting to be discovered. Instead, Foucault proposes that the meaning or knowledge that is policy is discoverable if one knows the historical conditions that constitute policy. Subjectivism is also incompatible because Foucault’s theoretical approach is anti-structuralist; that is, Foucault proposed that an object reveals its meaning in its immediacy and that meaning should not be sought ‘beneath the surface’ as in an interpretation of myths or dreams and suchlike.

The decision as to which theoretical approach best supported this study was not an easy one to make. Kaupapa Māori research approaches have provided Māori with a way of analysing the world based on principles drawn from historical and contemporary Māori worldviews (Pihama, 2000). I have chosen, instead, to use a Foucaultian discourse analysis as the theoretical perspective for this study. There were

two reasons for my choice. The first was that I wanted to find out whether that approach could contribute new information and provide me with new ways of thinking about sexual and reproductive health policy for Māori. Thinking about Māori sexual and reproductive health policy in new ways might assist with finding new ways for addressing health issues and policy problems. The second reason is that I felt confident that I could apply a Foucaultian theoretical approach in a way that maintained a regard for Kaupapa Māori principles that operate from the premise that:

- The validity and legitimacy of Māori is taken for granted;
- The survival and revival of Māori language and culture is imperative;
- And, the struggle for autonomy over our cultural wellbeing and over our lives is vital for Māori survival (Smith, 1990, p. 100)

For example, tino rangatiratanga, or the struggle for autonomy, has been an enduring vision for Māori, and a consistent feature of the proactive and reactive interactions between Māori and the State (Durie, 2005). Having regard for the principle of ‘tino rangatiratanga’ when undertaking a Foucaultian discourse analysis of State-determined sexual and reproductive health policy for Māori is, I think, a practical goal. ‘Taonga tuku iho’ or the validity of being Māori is a principle that validates and legitimates what it is to be Māori, according to Māori worldviews. In colonial contexts, this principle is important, as it is normative to Māori values and traditions, and it is an assumption that underpins my study and something that I choose to make explicit. I have been careful to maintain a critical position with both principles, as both are vulnerable to reinterpretation by governments and other powerful forces.

Other Foucaultian theoretical approaches would also have been useful for this study. The genealogical analysis as described in ‘Nietzsche-Genealogy and history’ (Foucault, 1991) is one example. Other obvious choices would have been to use ‘The history of sexuality’ (Foucault, 1978) or ‘Foucault effect: studies in governmentality’ (Foucault, 1991) as my study focuses on sexual and reproductive health and government policy. For reasons to do with space and focus, I chose to narrow down the analytic approaches and focus solely on Foucault’s discourse analysis. After all, this study does not set out to draw upon all of the themes or employ all of the analytic approaches devised by Foucault in relation to, for example, psychiatry, human

sciences, medical sciences, the penal system, and sexuality (Townley, 1993). Nor is there an intention to compile a biography of Foucault's life, or reproduce what others have written. Although I have narrowed the field of what could be written about Foucault and the analytic strategies he developed, nevertheless the task is still considerable.

The choice of methodology or rationale for the design of the research was determined by the requirements of undertaking a Foucaultian discourse analysis, as was the choice of methods. The Foucaultian discourse analysis requires the researcher to compile what Foucault described as 'the archive' of the historical conditions that have given rise to a particular discourse. The purpose of the archive is to reveal how a particular discourse comes into being, and what the rules are which govern what is said and not said about an issue, whatever that issue might be. Accordingly, this approach required of me that I compile an archive of events and literature. I chose review literature produced over the period 1922 to 2003 for the purposes of describing every event and activity that had an impact upon the production of current sexual and reproductive health policy for Māori. Having regard to the principles of tino rangatiratanga and taonga tuku iho, therefore, I deliberately sought out events and literature produced for Māori audiences such as the magazine 'Te Ao Hou' as well as material that recorded the activities of key Māori spokespeople over the period of the study. In this way, I was able to ensure that Māori 'voice'; that is, Māori initiatives and responses to issues and activities over the eighty-year period were included into the study and considered as key archival material.

My hope is that other Māori researchers and Māori involved in the sexual and reproductive health sector will find the Foucaultian approach to health policy to be a useful tool for critically deconstructing sexual and reproductive health policy for Māori. Overall, the study makes a case for a critical engagement with sexual and reproductive health policy for Māori, to take into account the productive role of policy making in structuring knowledge, relationships, and the distribution of power between Māori and the State.

A brief note on the terminology used in the study. The phrase 'sexual and reproductive health for Māori' is used to specify sexual and reproductive health policy

that policy makers expect will affect Māori. This is distinct from policy language that uses the ethnically unspecified phrase ‘sexual and reproductive health’ which, in policy documents, almost always means the sexual and reproductive health of the general population, including Māori. The word ‘policy’ is used in a general way to refer to high level policy statements made by governments, as well as to the operationalisation of high level policy which occurs in the form of strategies and programmes. The phrase ‘State-determined policies’ refer to all policies that are made by New Zealand governments, including health policy for Māori. Ministry of Health sexual and reproductive health policies for Māori are State-determined policies. State-determined policies are at a political level, distinct from Māori self-determined policies as the latter are made by iwi (tribes), hapu (sub tribes), and Māori organisations. However, the two policymaking entities are not entirely disparate as both are governed by common legislation, standards, and processes. The term ‘policymaking’ is used to refer to the whole policymaking process; that is, the planning, development, implementation, the evaluation and review process and public consultation processes which may occur at various stages of the policymaking process. Last, the term ‘Māori’ is used to refer to people of Māori descent, and the term ‘Pakeha’ is used to refer to everyone else in New Zealand who is not of Māori descent. The exception to the use of the term ‘Pakeha’ is made when referring to people of specifically British origin who immigrated to New Zealand in the 1900s under the Empire Settlement scheme. In this study, those people are referred to as immigrants of British origin.

Chapter Two focuses on health policymaking as a knowledge-making process in New Zealand, and the relationship between knowledge and power. Policy as a series of normative statements is discussed, as is the role, not always apparent, that ideologies and values play in policymaking. Policymaking at the national and global levels is presented, and the rise of supranational or global policy coherence is explored, particularly as this relates to sexual and reproductive health. Global policy coherence presents a challenge for Māori and indigenous peoples seeking to orient State-determined policymaking so that it reflects their own priorities. An overview is presented of the impact that neoliberalism and structural adjustment policies have had on New Zealand and the health sector, including opportunities for Māori to deliver devolved services. A number of reports have highlighted the shortcomings of State-

determined health policies for Māori, and Māori responses to those problems are described. Gains made by Māori in the education sector, particularly with regard to Kaupapa Māori, are compared against the position of Māori, and Māori knowledge, in the health sector.

Chapter Three provides an overview of the key Foucaultian approaches used to analyse the nature of the construction of Māori in current sexual and reproductive health policy. The chapter begins with an overview of Foucault's life that provides, at some level, an account of the form of critical analysis that he developed and the affect that other theorists, particularly the structuralists, had upon his analysis. The three texts that I used to draw upon Foucault's theoretical approach are outlined, along with an explanation of Foucault's discourse analysis. Themes that concerned Foucault and which I have used in my study are also presented: knowledge and power, the historical conditions that determine discourse, self-evidencies, surveillance, normalisation, and problematisation.

In Chapter Four, I apply Foucault's theoretical approaches to an analysis of sexual and reproductive health policy for Māori. The discursive statements in current policy are outlined, and using a process of historicity, the conditions that have allowed the discursive statements to operate in current sexual and reproductive health policy for Māori are presented. Last, the phenomenon of Māori teenage pregnancy, a discursive statement that is part of the larger discursive policy formation, is examined

In Chapter Five I return to the key question that my study addresses which is 'What is the nature of the construction of Māori in and through current sexual and reproductive health policy? The Foucaultian theoretical approach reveals the existence of discourses about population, economic development, State-determined policies for Māori, and more recently, global rights-based approaches to sexual and reproductive health. The effect that those discourses have in terms of their discursive construction of Māori as consistently negative, and as 'other', and 'risk' and as a problematised 'object' for State control, are discussed. The strengths that the Foucaultian approach has brought to the study of policy for Māori are discussed, and a more nuanced Foucaultian approach to the problematisation of Māori teenagers who are parents is presented.

Chapter Two: Health Policy

*Knowledge...wields power by directing people's attention:
it carves out and highlights a certain reality, casting into oblivion other ways
of relating to the world around us (Sachs, 1992, p.5)*

State-determined sexual and reproductive health policy for Māori operates as a knowledge or a discourse about Māori, their sexual and reproductive health status, and strategies and programmes for improving their sexual and reproductive health. Historical and contemporary Māori self-determined knowledges about sexual and reproductive health also exist (Aspin and Hutchings, 2007) but these are not part of, nor do they connect with, State-determined knowledge about Māori. How State-determined knowledge about Māori sexual and reproductive health is constructed, who is involved in its construction, and what evidence is utilised to support knowledge, are issues that are far from straightforward, but in the sexual and reproductive health policy environment in New Zealand these have received little attention. Policymaking, a technique for the production of power over and knowledge about Māori, appears to operate, for the most part, as if it were an entirely rational, objective, and locally-situated project. However a brief review of one international rights-based instrument for addressing sexual and reproductive health indicates a closer relationship with New Zealand's own policies for sexual and reproductive health for Māori than is immediately apparent.

This chapter describes the national and international policy context against which State-determined sexual and reproductive health policy for Māori will be analysed, using a Foucaultian approach, in Chapter Four. The context that surrounds how Māori sexual and reproductive health policy operates is important because it is a part of what regulates what can be said and thought about sexual and reproductive health policy for Māori. I have chosen to provide the context as a separate chapter, rather than try to locate the contextual material in amongst or in relation to the theoretical analysis. In particular, I have chosen to highlight the differences between State-determined and Māori self-determined policy making. The reason for this is to show how power is distributed between the State and Māori and the difficulties that this creates for Māori in policymaking processes. Although I have presented State-determined and Māori

self-determined policymaking as disparate knowledges and activities, this is a simplification and there is a high degree of overlap. Taiaiake Alfred has drawn attention to problems that exist in some indigenous communities where the assumption is that because leadership and governance is by the band, as opposed to the government, that the leadership and governance structures and practices of the band councils are free of the hegemony of the West (2009). I have also highlighted the policy relationships that exist between national and supranational policy. The reason for this is to indicate the importance of examining sexual and reproductive health policy for Māori to a depth beyond what appears to be self-evident Māori sexual and reproductive health policy. The coherence that exists between national and supranational policy is a consequence of a globalising world but it has implications for how Māori respond to State policy making.

Policy

In the context of government, policy is defined as a statement of action, or intended action made by government and recognised as official (Hughes and Calder, 2007). In this study the word 'policy' is used to refer to legislation, policies, strategies and programmes. Policy also exists as overarching ideological principles and values which are derived from a government's political manifesto and which reflect the norms, values and beliefs of dominant groups in society (Drake, 2001). At the liberal / neoliberal end of the ideological continuum are political parties which hold that States have few obligations and little business in people's everyday lives. At the democratic welfarism and socialist end of the continuum, parties are more likely to contend that States have a central duty to regulate wellbeing and redistribute resources (Drake, 2001). Using various policy processes, governments work to make policies that will build societies which match their ideologies, values and principles:

'Policy making, then, is a deeply political activity, requiring difficult and contentious choices over the scope, cost and design of policies. For that reason [policy making] is frequently characterised by heated debates over the values that inform policy choices; whether or not scarce resources are being distributed efficiently; the effectiveness of policy interventions; and, the appropriate role of the state in the economy and individuals' lives (Shaw and Eichbaum, 2005, pp. 2-3).

Policy making is also deeply normative; that is, policies are made up of statements about how societies should be. Policies to do with sexual and reproductive health are sometimes contentious because differences exist within societies about what it means for everyone to have good sexual and reproductive health. Norms and values determine what policy makers and the general public understand as a policy ‘problem’, and a policy solution. The normative dimension of policy means that policy problems and their solutions are for the most part those which the general public understands as ‘problem’. Writing about the problematisation of Asian women’s sexuality in New Zealand, for instance, Kumar-Simon (2009) reminds the reader that problematisation is rarely the consequence of self-evident facts and is, instead, heavily influenced by the morals, values and cultural beliefs of policy makers and the general public.

Ideologies and values

Ideologies and values play an important part in policy making but their contribution to policy making is not always easy to discern (Drake, 2001). The policy cycle, first proposed by Lasswell in the 1950s (Shaw and Eichbaum, 2005), is made up of a series of stages, activities and actors, and in the health sector in New Zealand the cycle has been customised by the Ministry of Health into a process called the Health Policy Wheel. The Wheel focuses on the mechanics of making policy: what is missing is an account of the role that ideologies, values and principles play in health policy making. This is an important omission because how policy problems are defined, including the choice of evidence that underpins a policy, is influenced by ideologies and values which, in turn, shape policy solutions. In an example involving public health policies for addressing persistent health inequalities in England and Australia, the Blair Government took an ideological approach characteristic of democratic welfarism and addressed personal risk factors *as well as* social determinants. By comparison the Howard Government, faced with persistent inequalities between indigenous and non-indigenous Australians, chose a liberal focus and addressed only personal risk factors (Nutbeam and Boxall, 2008). The Australian case study illustrates how dominant negative ideologies and beliefs about the socio-economic position of Australian Aboriginal peoples influence how policy problems are understood by policy analysts and the general public. In this example, inequalities

between Aboriginal and White Australians are understood as a policy problem that arises from the actions and inactions of individual Aboriginal Australians. Solving the problem, therefore, must involve making Aboriginal Australians individually responsible for remedying the inequalities. The Howard government shifted responsibility for remedying inequalities between White and Aboriginal Australians away from government and society, and onto Aboriginal individuals. Typically, how a policy problem is defined influences what policy solution is reached (Hughes and Calder, 2007). If the policy problem is understood as resulting from a difficulty at the level of an individual, then the policy solution is likely to be proposed in terms of the individual. Teenage pregnancy is another example of a policy problem that some governments understand as arising solely from the actions or inactions of individuals, thereby leading to individually-focused policy solutions. The case study about Aboriginal and White Australian inequalities is a good example of how ideologies and values influence the way that governments define policy problems and arrive at policy solutions. Locating ideologies and values in the process of defining policy problems and solutions challenges the notion that policy making is an objective and values-free process.

Country-level policy

Recent Māori and indigenous development literature makes a distinction between State-determined policy and Indigenous self-determined policy. This is a useful distinction for this study as it draws attention to power; that is, how power is distributed between the State and Māori. Indigenous and Māori self-determined policies are defined by Loomis as policies that tribes determine themselves (1999). Research involving tribes in the United States and Canada that self-determine their own strategic and day-to-day policies has produced findings that show that there are significant and sustained socio-economic benefits to be gained from tribal self-determined policy making. State-determined policies for Māori and indigenous development, by comparison, are policies that are developed, managed and controlled by State governments. In developed countries, mechanisms exist for Māori and indigenous peoples to be involved in State-determined policy making, but the basis upon which governments invite their participation may be underpinned by principles of participatory democracy (Hughes and Calder, 2007) and inclusive citizenship (Lister, 2007) rather than recognition of indigenous rights or support for indigenous

self-determination (Humpage, 2010). Unlike the positive outcomes generated by Indigenous and Māori self-determined policies, Loomis writes that State-determined policies can give the appearance, politically, of benefiting those affected by disparities, but longer term they fail because the policies don't challenge the underlying structures that produce disparities (2000). Māori self-determined policies are those policies that, for example, are made by iwi (tribes) and over which iwi have total control (Development Ngati Awa, 2009). Durie proposes that in the New Zealand context the State should continue to play a major role in the development of Māori policy, but that Māori may wish to address national and global policy issues with other indigenous peoples or with international government and non-government organisations where opportunities may exist for greater Māori self-determined control (Durie, 2000).

Global policy

In a globalising world, policy making exists at the level of countries *and* at the supra-national level where multiple countries are involved in the construction of global policies. One of the goals of supra-national policy making is policy coherence which is achieved by member countries of, for example, the European Union, through agreements and treaties for agreed outcomes (Jachtenfuchs, 1996). An example of a supranational health policy-focused agreement is the European Partnership on Global Health which was established in 2005. The Partnership is a group of organisations working toward a comprehensive approach to global health, and in 2008 they joined the World Health Organisation (WHO) and the European Commission to form the European Council on Global Health. The aim of the Council was to exercise a stronger leadership in global health. The Council proposed this would be achieved by using a platform that promoted European health values, good governance, coherence in policy making, and a synergy between regional Councils in the future:

‘The meeting welcomed the possibility that such a European Council on Global Health could become part of a larger alliance of similar councils from other regions of the world’ (Kickbusch and Matlin, 2008, p. 1733)

Policy coherence at the international level is promoted by global non-government organisations such WHO, the International Monetary Fund (IMF) and the

Organisation for Economic Cooperation and Development (OECD). The OECD promotes policy coherence across a range of issues such as achieving co-ordinated and coherent governance, finance and health policies within countries and across regional networks. Supranational health policy coherence is thought to be an effective tool in the management of risk and prevention of communicable diseases (Banatvala et al, 2009). In June 2008 the OECD and member countries adopted a Declaration on Policy Coherence for Development (PCD):

‘No-one knows exactly how much ground can be lost due to incoherent policy, though we do know that for policymaking, coherence within and across borders pays. Our organisation stands for economic co-operation and development around the world, and helping governments forge coherent development policies is a central part of our job’ (OECD, 2008/2009, p. 39)

Individual countries also pursue global policy coherence. In 2008 the United Kingdom (UK) launched its own global health strategy in which it agreed to work with the WHO to improve the health of its own internal population, and pursue global health through the Millennium Development Goals (MDGs).

International declarations, treaties and agreements have an influence on the way that signatory countries go about cohering their own internal policies, as well as external policies. After over twenty-five years in the making, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) was signed in 2007. Even before it was signed the Declaration had had an effect upon other United Nations documents such as the 1992 Biodiversity Convention, the 1992 Rio Declaration, and the 1994 the Programme of Action from the International Conference on Population and Development (ICPD). The Programme of Action, for example, linked indigenous rights to the achievement of good sexual and reproductive health for indigenous peoples. The UNDRIP is also expected to have an effect upon international customary law. This was recently confirmed by the Supreme Court of Belize which supported Mayan communities in their opposition to timber extraction on the basis that they have customary land rights (Barelli, 2009).

Restructuring the health sector

The influence of ideologies and values upon New Zealand health policy can be seen in the struggle between proponents of modern liberalism who accept the need for governments to have an active role in delivering health services, and those who support neo-liberalism (Cheyne et al., 2005). Characterised by its emphasis on the supremacy of individual rights, neo-liberalism supports a reduced role for governments in health services, increased privatisation, and the use of market mechanisms to regulate access and distribution (Shaw and Eichbaum, 2005). In 1990 the National government, following in the footsteps of the structural adjustment programme that was begun by the Labour government in 1984, undertook a review of the health sector. In 1993, underpinned by a neo-liberal ideology about the benefits of moving health into the marketplace, the administrative, funding and policy making structures of health were separated from health service provision and health purchasers (i.e. health contractors) contracted health providers (i.e. health organisations) to deliver services to populations. Initially government and non-government health providers were expected to return profits but three years later, and under a New Zealand First and National coalition government, the profit-making requirement was withdrawn. However the newly reformed structures of the health sector remained. Competitive tendering, full and part user-charges for primary and specialist health care and partnerships between public and private hospitals and health services became ‘business as usual’ in the health sector. The architects of these changes shared much in common with ‘new right’ economists who supported reducing the ‘public sector’ and expanding the use of the market to ensure that where there was a public sector, it functioned in a way that corresponded to market principles (Parsons, 1995).

Ideologically driven by sector interest groups outside of Māoridom and influenced by international capital (Kelsey, 1995), the changes were presented to iwi (tribes) and Māori communities in the language of devolution and a Treaty-based relationship with the government. And while it appeared to some that Māori had greater control, any gains were a result of free market policies rather than a change to government Treaty policy or support for Māori self-determination (Durie, 2000). Neoliberal advocates of the restructuring, some of whom were Māori, promoted the changes as new opportunities for iwi and Māori health organisations to actively participate in the health sector through the delivery of health services to Māori. Delivering health

services fell a long way short of developing health policy with governments; a role that remained firmly with the State:

‘The prospect of greater Māori control over health services was taken as evidence of a greater willingness by government to address Māori health. This was understandable given Māori desire for empowerment and autonomy, but in the context of other public policy changes impacting on Māori as a population, this was perhaps too generous a view. There was hope that control over some health services and improvement of access would address the key problems impacting on Māori health. However evidence showing a link between improved accesses is absent, especially improved access at the low level which exists even after the reforms and after the establishment of many more Māori health providers’ (Kiro, 2000, p.162).

Even as the restructuring of the economy was underway, the casualties of restructuring were growing. Economists and politicians framed the casualties in terms of an inevitability of modern economic theory, and when poverty, unemployment and family disintegration rates among Māori were twice those of Pakeha, the explanations were almost always ‘deficit-based’: blame for poor socio-economic outcomes was attributed to Māori and their cultural background (Smith et. al., 1998). In 1990, Labour’s Minister of Social Welfare was warned that the proposed benefit cuts would hit Māori disproportionately hard given almost a quarter of Māori families were beneficiaries compared with nine percent of Pakeha. The Minister dismissed this advice, saying it was inevitable that some would be better and some would be worse off, in any reform (Kelsey, 1995). Poverty, alienation and stratification along class, ethnic and gender lines increased as a result of the restructured New Zealand economy. Māori unemployment rates rose from 13% in 1988 to a high of 29% in 1992, three times higher than the Pakeha rate. Compared to Pakeha, Māori were more likely to live in low income households, and more likely to receive lower incomes in almost all occupations. Further, the rate of receipt for the Domestic Purposes Benefit was 314% higher for Māori than for Pakeha. In education over the same period the disparity widened between the percentage of Māori and non-Māori school leavers moving directly into tertiary education (Te Puni Kokiri, 2000). The National Advisory Committee on Health and Disability advised the Government that health inequalities

were increasing between Māori and Pakeha and that these were the result of socio-economic factors in New Zealand (National Health Committee, 1998).

Māori response to restructuring

Māori approached the restructuring of the health sector with caution, despite the ‘hard sell’ by governments. In April 1992, three national Māori authorities, the New Zealand Māori Council, the Māori Women’s Welfare League and the National Māori Congress, formed a taskforce ‘Te Waka Hauora O Aotearoa’ and presented the government with a proposal to ensure what they believed to be effective Māori participation in the development and implementation of new health policies. The three Māori authorities argued that Māori were more than stakeholders or interest groups; rather, Māori were a Treaty partner with the Crown in the health reform policy process. The Taskforce proposal concluded that while it may be the intent of the health reforms to address Māori health issues, nevertheless there remained a definite need for a national policy mechanism that was Māori-driven and controlled. The proposal also noted that earlier changes to the health system had not resulted in improvements to the health status of Māori (Durie, 2005).

In September 1992, six months after the formation of Te Waka Hauora O Aotearoa, the government released ‘Whaia Te Ora Mo Te Iwi’, a policy statement outlining the governments’ strategic direction for Māori health (Department of Health, 1992). Designed to ensure that Māori engaged with the health reforms, the statement referred to the principles of the Treaty of Waitangi, and in particular, promised Māori increased representation in decision-making, and improved health outcomes. In December 1992 the proposed health reforms became legislation in the form of the Health and Disabilities Service Act and the newly established Ministry of Health contracted Te Waka Hauora O Aotearoa to provide national policy advice on Māori health. However the contract was short-lived and in the face of opposition from Māori, the Ministry of Health terminated the contract and instead sought policy advice on Māori health from Te Kete Hauora, the Ministry’s own Māori Health Unit. In 1998 the National Health Committee advised the Ministry of Health:

‘there are persisting health inequalities as a result of socio-economic factors in New Zealand and some evidence that these may be worsening’ (1998, p.3).

Although the National Health Committee advocated for actions to remedy the socio-economic inequalities between Māori and Pakeha, the Committee was careful not to alienate itself from neo-liberalists and, instead, chose more of a liberalist position:

‘Good health underlies a person’s freedom to pursue their own goals and capability to succeed in life. From a libertarian perspective, reducing socio-economic inequalities in health will improve individuals’ choices in life’ (p.13).

The Committee was also careful to present remedial actions to reduce inequalities in terms of benefits to wider society, not just benefits for Māori. In 1999 the incoming Labour government made Māori development a central focus of its Māori policy platform. The new ‘Closing the Gaps’ policy aimed to reduce the disparities between Māori and Pakeha across all areas of government, including the health sector. In 2002, summing up a decade of health reforms and the emergence of fragmented and inadequate Māori health policy, the National Health Committee stated:

‘The [health] sector is characterised by a loss of specificity and vision regarding the Treaty of Waitangi and its position within health policy. The major Māori health policies of the 1990s were Māori provider development and Māori workforce development. These policies have not been grounded in a Treaty-based framework or strategy...In contrast to successive governments’ approach to the Treaty, many Māori people have remained firm in their belief that the Treaty of Waitangi has primacy, forms the basis of the relationship between Māori and the Crown, and should guide the activities of government and its agencies with respect to all Māori issues, including health’ (2002, p. 16).

References to the Treaty of Waitangi in the health reform legislation and policies were cursory, with little attempt to explicate the principles of the Treaty into the development, implementation and evaluation of health policy. Māori leaders advocated for a Treaty-based partnership with the Crown in order to undertake the reform and develop new Māori health policies. Small gains were made: the

Government was required to consult with Māori, Māori participation in health service provision increased, as did Māori workforce development, Māori provider development, and mainstream services enhancement (National Health Committee, 2000). However these gains fell a long way short of reflecting a Treaty-based partnership in the health policy process, or a consistent Treaty-based framework from which to develop health policy. Commenting on the small gains in Māori health, Durie attributes this to governments' concerns about cultural values and disparities, rather than from any sense of Treaty-based obligations or rights. In 2001, citing Māori health researchers Dr Papaarangi Reid and Bridget Robson, the Public Health Intelligence document 'Monitoring Ethnic Inequalities in Health' explained poor Māori health statistics in terms of colonisation, the solution of which would require framing issues and interventions from a Treaty rights perspective (Ministry of Health, 2001).

Māori resistance to State-determined policy

Resistance has been the consistent response from Māori to State-determined policy making. The State's model does not provide for Māori as an equal Treaty partner, and Māori are positioned as objects rather than architects of policy that affects them. State-determined policy making has been a site for Māori resistance since the Treaty of Waitangi was signed by Māori and representatives of the British Crown in 1840. Successive New Zealand governments have refused to recognise the Treaty as a framework for governing relationships and power between Māori and the State. As a result Māori have been unable to exercise their rights over their livelihoods and their dominions as guaranteed by the Treaty (O'Sullivan, 2007). The enduring vision that Māori have for self-determined rather than State-determined policy making has led Māori to try out a range of strategies for influencing or resisting State policies.

The first strategy involves influencing standard public policy consultation processes to orientate State policies so that these more closely reflect iwi and Māori agendas. In June 2000 the Ministry of Health ran a two-month public consultation process as part of developing the New Zealand Health Strategy. The Ministry of Health received nearly five hundred written submissions and public meetings were held across the country. Although there is no public record of the number of Māori who engaged in the consultation process, what is known is that thirteen hui were held on marae and

those meetings were well attended. A number of submissions supported acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi. Some Māori wrote that they would prefer the Strategy to use the term Te Tiriti o Waitangi, indicating their preference for the Māori rather than the English language version of the Treaty. Others wrote that they would prefer the special relationship to exist between hapu or iwi and the Crown, not the more generic ‘Māori’ and the Crown relationship. A key theme from Māori organisations was the importance of ensuring that gains such as the increase in the number of Māori health providers were not ‘lost’ through the formation of new District Health Boards (Ministry of Health, n.d.). Despite Māori input into the consultation process for the Strategy the advice from Māori was not adopted into the new Health Strategy. Two years later when the National Health Committee reported to the government on the state of Māori health policy the report noted that governments had taken a weak approach to recognising and implementing the Treaty of Waitangi in health policy (National Health Committee, 2002). Instead of the Treaty partnership role, the role that is available to Māori to engage in government policy making is as one of any number of sector interest groups involved in a particular policy area. As a group, Māori comprise approximately 16% of the New Zealand population and unlike powerful sector interest groups like Independent Practitioner Associations (IPAs) and the New Zealand Medical Council (NZMC), the standard public consultation-style of engagement into policy making has not provided Māori with sufficient leverage to ensure that government policies reflect Māori goals. Despite claims by Hughes and Calder (2007) that mechanisms exist for all New Zealanders to influence government health policy, Māori have found those mechanisms ineffective and so they have resorted to other strategies including resistance.

A second strategy for influencing policy and ensuring a better fit between State and Māori policy agendas was trialled in 2006 by Te Puni Kokiri (Ministry of Māori development) and iwi. The pilot project involved Te Puni Kokiri and six tribal authorities jointly contributing to the design and implementation of policies that would achieve iwi and government long term objectives. Called the ‘co-production project’, the impetus for iwi to join the trial was the opportunity to work with government, as a joint partner, to plan and develop policy using a Treaty-based relationship (Kowhai Consulting Ltd, 2008). The co-production pilot was supported

by Te Runanga o Ngati Awa because it reflected the joint partnership relationship that the iwi sought with governments and because the standard policy consultation processes had failed to produce policies that met the goals of iwi (Development Ngati Awa, 2009). The co-production pilot was a Labour-led government project which was discontinued when a National-led coalition won the government elections in 2008.

A third strategy that Māori have used when faced with State-determined policy that does not fit with Māori objectives, has been to create spaces within which to develop Māori self-determined initiatives. Kohanga Reo and Kura Kaupapa Māori are both examples of Māori self-determined initiatives that, in their early phases, operated outside of State-determined education policy for Māori (Smith, 2003). However, Smith (1996) argues that over time State and global forces have challenged and encroached upon these initiatives:

‘...gains made a decade ago in one context can become losses through changes, which also occurred a decade ago, at the macro level but which have taken ten years to ‘trickle down’. In this sense the spaces are constantly shifting, the struggles are simultaneously being played out at the imperial/global, regional and local levels. The struggle, then, is not about making or reclaiming a single or even unidimensional ‘space’, but making and reclaiming space/s, that is multiple spaces. Spaces are a necessary condition for the reformulation of codes and the reclaiming of rangatiratanga (p. 330-331).

The State, using its own strategies, has absorbed and regulated both initiatives into the education policy. The new challenge, Smith (1996) writes, is for Māori to find ways to create and maintain Māori self-determined initiatives within State-controlled or devolved institutions, in the knowledge that these are highly unstable places, and the State is always making adjustments so as to maintain control.

In the health sector the spaces and the opportunities for Māori to institute self-determined health initiatives outside of State-determined health policy may be limited by the regulatory nature of the sector. Traditional Māori healing which has existed outside of State-approved treatment services for over one hundred years, now looks

set to join the core health services. Unlike the education sector where Māori fought to stay outside, some traditional Māori healing services are seeking recognition and regulation to move inside the State health services. Jones (2000) proposes that over the period 1980 to 2000 there was a resurgence of interest among Māori in traditional healing, and in the 1990s the Ministry of Health funded an evaluation of traditional healing services in anticipation of producing policy and guidelines for contracting for these services. Possibly the impetus to be a regulated part of the core services was that Māori health providers were providing traditional healing as a part of their services but were not funded for those services. Jones notes that despite some concern about how traditional healing might take its place alongside Western medicine, there has been strong support from Māori for formal contracting arrangements to enable traditional healing services to become an integral part of primary health care. An exploration of why it is that Māori have not sought to set up Māori self-determined health initiatives outside of State policy is beyond the scope of this study. What can be asserted is that differences exist between the ways that Māori respond to State determined policy in the education sector, and how Māori have responded in the health sector. Shut out of a health policy making partnership with governments and unable to garner public support to orientate health policies so that these reflect Māori aspirations, the challenge for Māori in the health sector is to find ways to leverage more Māori control into health policy making with governments. If the spaces do not exist outside of the health sector, then the challenge is to find spaces within the national or the global health sector, where these activities can be achieved.

This is a difficult path to travel. However what emerged from the spaces that Māori created through the process of politically self-determining the Kohanga Reo and Kura Kaupapa Māori initiatives was a body of Māori critical knowledge. That knowledge or discourse which is called Kaupapa Māori and which exists as a diverse historical and contemporary body of theory and practice, has provided a framework for thinking and speaking about the Māori - State relationship in the education sector. Kaupapa Māori has assisted Māori to pursue a strong Māori self-determined political vision for education as well as producing transformative strategies to achieve Māori goals in the highly unstable (i.e. changeable) State-regulated education sector. In the health sector, as in the education sector:

‘Spaces have to be made inside institutions, which exist inside a market place, [and] whose rules and regulations are mediated by the State (Smith, L.T., 1996, p. 341).

Reporting to the Health Research Council in 2010 about the last fifteen years of Kaupapa Māori in health services and research, participants told the researcher that Māori self-determined power and control in health was critical to achieving Māori goals. The development of Kaupapa Māori, an ongoing process, had had a transformative effect upon how Māori go about their work in the health sector. However participants raised concerns about the future of Kaupapa Māori, particularly the importance of maintaining the political and critical dimensions of Kaupapa Māori, and advancing Kaupapa Māori in ‘mainstream’ health services although no detail was given about those dimensions (Pihama, 2010).

Advancing Kaupapa Māori as a platform for transformation and ways of speaking and thinking about Māori interactions with the State in the health sector is an important goal. In the education sector, Māori were able to build a body of knowledge about the sector such that they developed successful transformative strategies through a critical Kaupapa Māori engagement with the sector. However, one of the findings of Pihama’s report was that some Māori researchers, academics and health providers appear to be engaging in uncritical ways with the health sector. One Māori researcher compared the two sectors and proposed that the health sector was very unlike the education sector; possibly more challenging:

‘It seems to me there’s another fundamental difference between health and education. I think we were able to actually get kind of more, it was a bit easier for us in education. I think health is a bit more clouded by medical science and controls. Medicine and the body is much more heavily regulated, its much more dangerous, considered dangerous, so it’s a real hard area to get clear Kaupapa Māori working well’ (Pihama, 2010, p. 44).

Smith contends that spaces that once existed in the systems, structures and relationships with governments, institutions, and possibly international fora, are continually changing as indigenous peoples intervene, countries respond, and

globalising ideologies are advanced (Smith, 1997). Kaupapa Māori strategies that assisted Māori to work towards a Māori self-determined vision in the education sector may require adjustment in order to be as effective in the health sector.

The final section of this chapter describes sexual and reproductive health policy for Māori. The relationship between Māori and the Crown, and the influence that global policy coherence and rights-based approaches to sexual and reproductive health has on health policy for Māori, are highlighted. Problems with the policy making process, notably the failure to review and evaluate health policy for Māori, are presented because these failures represent obstacles to the possibility that State-determined sexual and reproductive health policy could be of benefit to Māori. Increasingly, indigenous self-determined policy making is argued by Māori and other indigenous peoples as a customary right (Maaka and Fleras, 2000), a value rooted in indigenous philosophy (Alfred, 2006), and as an international right (Magallanes, 1999).

Sexual and reproductive health policy in New Zealand

The Strategy

The New Zealand Sexual and Reproductive Health Strategy: Phase One (the Strategy) was produced by the Ministry of Health in 2001. The Strategy sets out the overarching direction, guiding principles and priorities for achieving good sexual and reproductive health for all New Zealanders. The goals for the Strategy are described as improving health, reducing inequalities, improving the quality of care, and alignment with the objectives of the New Zealand Health Strategy. The specific focus for the Strategy is reducing sexually transmitted infections and reducing high levels of unintended or unwanted pregnancies, and attention is drawn to the high rates of both among Māori populations.

The strategic approach for New Zealand sexual and reproductive health is described as cohering with other New Zealand health and wellbeing strategies as well as to models and responsibilities that New Zealand has agreed to internationally. Those that specifically relate to sexual and reproductive health are:

1. Charter for the Elimination of Discrimination Against Women (CEDAW);

2. Conference on Population and Development – Programme of Action +5 (ICPD +5);
3. United Nations HIV/AIDS Declaration;
4. Beijing +5 – Programme of Action, and;
5. United Nations Convention on the Rights of Children (UNCROC).

The Strategy also notes that the Government is committed to fulfilling the principles of the Treaty of Waitangi through the special relationship between Māori and the Crown:

‘Central to the Treaty relationship and implementation of Treaty principles is a common understanding that Māori will have an important role in developing and implementing strategies for Māori...Māori should be able to define and provide for their own priorities for participation and be encouraged to develop the capacity for delivery of services for their communities’ (Ministry of Health, 2001, p. 5)

Tempering the commitment to the special relationship between Māori and the Crown is the statement that the relationship needs to be calibrated against the duty that governments have to govern on behalf of the total New Zealand population.

The Resource Book

The guide to implementing the Strategy was produced by the Ministry of Health in 2003. The ‘Sexual and reproductive health: A resource book for New Zealand health care organisations’ (the Resource Book) is implementation-focused and was developed to assist national and local health funders and health service organisations to implement the goals of the Strategy. The Resource Book provides what are described as practical steps for achieving good sexual health in the general population, as well as better access and user-friendly services for young people, Māori and Pacific peoples. The Resource Book also sets out the research which underpins the guidelines for service design and strategies for action (Ministry of Health, 2003). Sections Four and Five of the Resource Book contain population-specific strategies for addressing Māori and Pacific sexual and reproductive health.

Covering ten pages and referencing four sets of statistics taken from national datasets and one research study, Section Four – Strategies for Māori, describes goals for improving Māori sexual and reproductive, and ways to progress the goals.

The Strategy and Resource Book are important higher level statements about what government policy is for sexual and reproductive health, and how policy goals will be achieved. There are a number of problems with both documents, some of which have been raised already and relate to a failure to implement the Treaty of Waitangi in health policy and the marginalisation of Māori in the policy making process. In addition to those problems, both documents fail to engage with strengths-based and culturally located approaches to sexual and reproductive health sourced in Māori as opposed to Western understandings of sexuality (Aspin and Hutchings, 2007). Both documents fail to account for the impact that colonial religious institutions have had on contemporary Māori sexual and reproductive health, or the deleterious effect that New Zealand's structural adjustment policies from the 1980s onwards had upon Māori sexual and reproductive health.

Furthermore, a serious policy-related problem with both the Strategy and the Resource Book is that there has been no monitoring or evaluation of the uptake of either policy documents and, as a consequence, no way of assessing the impact these particular policies have had upon Māori sexual and reproductive health. The Ministry of Health's Health Policy Wheel proposes that policy monitoring, review and evaluation are important components of the policy making process:

‘A review or an evaluation [of policy] is an assessment of the policy after its implementation. Usually this assessment is done against the policy's objectives; you examine the effects of the policy with the intended outcomes, including external influences... It is important to review and evaluate policy because it adds to a broader evidence and knowledge base for future policy development (Ministry of Health, no date).

Reviewing and evaluating policies which are expected to improve health outcomes is an important policy process that has a bearing upon the health and wellbeing of all New Zealanders. However the failure of governments to undertake the review and

evaluation components of the policy process as they relate to improving Māori health outcomes is particularly serious given the commitment from governments to reducing health disparities. In 2000 the National Health Committee described the failure of the Ministry of Health to monitor and evaluate its own policy as locking Māori into a cycle of policy reiteration:

‘There has been little effective monitoring of government agencies, either of their own work on implementing Māori health policy, or of the efforts of other non-government organisations in doing so...Familiar policy approaches are supported and repeated, not because they have been evaluated as effective, but because they are familiar, they have been used in the past (National Health Committee, 2000, p. 17).

In 2002, at around the time the Strategy and Resource Book were developed and implemented, the National Health Committee reported a range of factors likely to have hindered Māori health gain over the previous decade. Factors cited included a limited implementation of the Treaty of Waitangi in health policy, and no clear framework from which to develop, implement, monitor and evaluate Māori health policies. The concerns of the National Health Committee echoed one of the findings of the WAI692 Claim which was that failing to comply with the principles of the Treaty of Waitangi had seriously affected Māori health (Waitangi Tribunal, 2001). The general reluctance of governments to evaluate their own policies and programmes has been described by Ringold (2005) as stemming from a government perspective that the evaluation of programmes that affect Māori are complex and expensive. Ringold also proposes that the intense scrutiny that programmes for Māori attract from political parties and the media make their evaluations far less appealing to governments. By comparison Māori communities have a high level of interest in ensuring that policies and programmes for Māori health are monitored and evaluated. Ferguson writes that Māori expect the Ministry of Health to demonstrate leadership in the health sector and this includes modelling effective Māori health policy making (National Health Committee, 2002).

Global sexual and reproductive health policy

The New Zealand Sexual and Reproductive Health Strategy is aligned to five international policy instruments to which New Zealand is a signatory. The instruments, in the form of declarations, action plans and charters advocate rights-based approaches for improving the sexual and reproductive health of men, women and children in the countries that are signatories. Instruments such as the International Conference for Population and Development (ICPD) – Programme of Action operate as international policy statements which, once signed, become part of each country's compliance programme. The Conference and Programme of Action defined sexual and reproductive health as a basic human right, and highlighted the critical nature of the relationship between population health, the environment, and sustainable development. The definitions for sexual and reproductive health used in the New Zealand Strategy (Ministry of Health, 1996) and the National Strategy for the United Kingdom (Department of Health, 2001) are both lifted directly out of the ICPD in 1994 indicating the strength of policy coherence among signatory countries. The New Zealand government reports on progress toward achieving the ICPD Programme of Action through its own departments which include the Ministry of Women's Affairs (2004) and the Ministry of Youth Development (2004). Reports detail New Zealand's processes for monitoring and achieving particular instrument targets.

Rights-based approaches that underpin policy instruments such as the ICPD Programme of Action are normative to values and beliefs that are part of the Western world and which advance Western interests (Jackson, cited in Solomon, 1998). Differences arise between Western and indigenous understandings and approaches to defining and achieving human rights (Mead, 1998) and may at times lead to conflict over the values or rights that indigenous peoples aspire to, as well as failing to speak to indigenous realities (Arons, 2009). Rights-based policy instruments foster a high degree of policy coherence among signatory countries. Operating at national and international levels, rights-based approaches have the effect of creating internationally accepted norms and standards associated with sexual and reproductive health. New Zealand is an active member of the international rights-based sexual and reproductive health policy community. In New Zealand and in the Pacific, the Parliamentarians Group on Population and Development (NZPGPD) progresses New Zealand's commitments to meeting the ICPD Programme of Action. The New Zealand Family Planning Association (NZAF), a non-governmental organisation with a small

international division called Family Planning International (FPI), has had a big influence on New Zealand's involvement with the ICPD – Programme of Action, and works closely with the NZPGPD. New Zealand government and non-government representatives from are frequently cited as having influenced the direction that the ICPD took with respect to individualizing sexual and reproductive health rights and advocating for the empowerment of women as a key strategy for enhancing family and wider community socio-economic development (Pool, 1999).

Conclusion

Policy making in New Zealand is a process that is controlled and managed by governments and marginalises Māori. This was evident during the restructuring of the health sector in the 1990s which was driven by powerful ideologies and international interest groups. It is also evident in the form of international agreements and treaties which are advanced through national and supranational policy coherence to achieve a range of economic and social goals, some of which are rights-based and involve issues such as sexual and reproductive health.

In New Zealand successive governments have refused to utilise the Treaty of Waitangi as a mechanism for structuring the power relationship between Māori and the State, despite acknowledgement in policies that a special relationship exists. A range of strategies have been used by Māori to influence and resist State-determined policy making. One of the more successful strategies occurred in the education sector where, for a time, Māori stepped outside of State-determined education policy and set up their own Māori self-determined education initiatives. A consequence of stepping outside of State education was the expansion of an already existing Māori body of critical knowledge called Kaupapa Māori which has provided a platform for transformation and ways of thinking and speaking about Māori interactions with the State. By comparison, in the health sector Māori have sought to find ways to influence and work within State-determined health policy and to use that to set up and operate Māori health initiatives. Kaupapa Māori operates in the health sector but there are differences and some concern that the critical and transformative aspects of Kaupapa Māori, as it evolved in Māori education, may be lacking in the health sector.

As globalising neoliberal policies deepen across the world it is difficult to see how Māori self-determined policy making can be advanced in the national context. Durie (2000) proposes that the State should continue to play a key role in policy making for Māori but that relationships with indigenous peoples and global organisations may provide Māori with the ability to exert more influence into State policy making. Smith (1995) proposes the challenge for Māori in the new millennium is to find spaces inside the mainstream that will support greater Māori self-determined control over, for example, policy making. Operating in spaces that are inside of national and supranational health policy environments will require ways of thinking and bodies of knowledge that are both critical and transformative. However, critical bodies of knowledge such as Kaupapa Māori which were transformative in the education sector are not, themselves, exempt from the pressure to change and destabilise. In addition to the challenge of how to ensure that State-determined health policies match Māori policy goals is another challenge which is to understand the specific nature of how Māori are constructed in current health policy. The point of understanding that construction is to provide a stronger platform from which to operate inside national and supranational health policy environments. The Foucaultian theoretical approach that follows is a mechanism for examining the nature of that construction.

Chapter Three: A Foucaultian theoretical perspective

'It is the subsoil of our modern consciousness... that I have wanted to investigate. If there were not something like a fault line in this soil, archaeology would not have been possible or necessary...this is a critical analysis of our own condition'
(Foucault, 1972, p. 263)

What is this fault line that Foucault proposes as existing within our modern consciousness, and why do we need a critical analysis of our own condition? In State-determined sexual and reproductive health policy for Māori there is a fault line. Upon the smooth surface of what it is that is acceptable to write and speak and think about the sexual and reproductive health of Māori communities the fault line manifests itself as a silence about how it is that Māori are represented in sexual and reproductive health policy as 'object', as 'risk', as 'problem', and in need of State control. Discourses that problematise Māori sexual and reproductive health may be at odds with how some Māori communities represent themselves (Clark, 2002: Ministry of Health, 1997), yet these discourses continue to flourish. Like the representation of the non-West in Edward Said's critique of Orientalism, the consistent representation of indigenous peoples as always in the negative, deficit, as lesser, and as the 'other', is a representation that is imagined by the coloniser (Mitchell, 1992). This notwithstanding, it is a key part of the colonisers' story that attempts to justify why colonisation happened, why the British Crown asserted sovereign control, why Pakeha are the majority population, and why State-determined policy making is in the best interests of Māori.

The representation of Māori as 'problem' is more than an imagining. Instead, it has a materiality in the form of how knowledge and power are produced and how these are implemented in the health policy sector. Smith describes problematising indigenous peoples as a Western obsession (1999). The representation of Māori as 'problem' justifies the growth of the institutions and instruments involved in the surveillance, the management, and the control of Māori sexual and reproductive health. Negative policy representations of Māori, as in the discursive statement 'Māori teenage parent' operate by helping Pakeha New Zealanders to define and regulate themselves and their sexual and reproductive health as 'not Māori', not a 'risk' and not a 'problem'.

As tempting as it is to read policies and their statistical reports and research evidences as if they were objective statements about the actual state of sexual and reproductive health among Māori, what I propose in this study is that these too are representations. Policies exist as a type of knowledge that States produce. That knowledge is about how Pakeha should be, even though who is being described are Māori. State-determined policies for Māori bring into existence particular meanings about Pakeha, about Māori, and about what passes for good or normal sexual and reproductive health. Those meanings are conditioned by discourses which, although they are not always easy to discern, can be identified through a process of historicity or a compilation of the archive of what has been said, written, and recorded about Māori sexual and reproductive health and associated ideas and events. The governments' sexual and reproductive health policy environment is not an objective, an isolated, or an ahistorical policy space: rather, it operates as the intersection point for various discourses, all the time maintaining the fault line or the silence over the negative representation of Māori in health policy. A Foucaultian theoretical analysis is a useful tool for critically analysing how it is that policy environments construct negative discourses about the sexual and reproductive health of Māori.

The introductory section of this chapter sets out the theoretical backbone of my study; that is, it describes Foucault, the author, in order to provide context for the theoretical strands of Foucault's analyses that follow. Next is an outline of Foucault's discourse analysis, followed by an overview of three Foucaultian concepts: surveillance, normalisation. and problematisation. The Foucaultian theoretical analysis in this chapter is the platform from which my analysis in chapter four of current sexual and reproductive health policy for Māori proceeds.

Who was Foucault?

Foucault would caution against being deterministic and essentialist in the compilation of contextual information about any author, including himself. But he would also agree that unless there is something compiled of the conditions of existence of the author, of his or her 'exteriority', then we are in danger of overly focusing on the author, instead of examining the historicity that gives rise to authors, their publications, and their particular ways of thinking (Shumway, 1989).

Writing about Foucault is to ask the question ‘who was Foucault?’ and to answer it by identifying the historical moments which have constituted his approaches to knowledge and power and represented him as the writer that he is known as today (Rocha, 2009). Except that Foucault would have cautioned the researcher not to conflate authors with the texts they produce: Foucault’s retort would have been that to be an author and to be Foucault are both discursive statements, and the texts that authors produce are also discursive, yet these statements don’t necessarily emerge from the same discourses. This is an example of the Foucaultian approach to examining the world. The world exists through a particular discourse or system of meaning, and at the same time that discourse produces the world. A Foucaultian approach to understanding the world is not to ask what an object is, or even why an object exists: rather, the Foucaultian approach is to ask how is it that an object exists in a particular place, at a particular time. And importantly, why this particular object and no other?

What were the historical conditions that constituted Foucault as one of the most influential thinkers of the late twentieth century (Andersen, 2003)? Michel Foucault was born in Poitiers, France, in 1926 and died in 1984 of AIDS aged only 57 years. During Foucault’s life he studied psychopathology, history and philosophy, taught French language, philosophy, as well as his own theoretical approaches to understanding the development of the history of ideas; specifically ideas about madness, sickness, crime, punishment and sexuality (McHoul & Grace, 1993). Foucault is described as a writer who was ‘an original and provocative thinker, celebrated and criticised, but also paraphrased and misrepresented (Smart, 1985, p. 19). A prolific writer, Foucault’s ‘oeuvre’, as he described the opus of an author’s works, included twelve books published in his lifetime, as well as numerous articles and interviews. Two publications by Foucault appeared twenty years after his death, and a journal is published bi-annually that carries his name, indicating the volume of contemporary research and publications associated with Foucault. Foucault gave numerous lectures across Europe and the United States, as well as interviews, and a brief chronology of Foucault’s life identifies him as a teacher, an author, an activist, and an intellectual who was gay and who became a symbol of French thinking; in short, a cultural icon (Shumway, 1992: O’Farrell, 2005).

However, Foucault would probably not be interested in what others thought about him; what would interest him would be examining the circumstances that gave rise to public interest in his thinking. Possibly he would attribute his popularity to the failure of other theorists, for example the French structuralists, to provide the public with adequate answers to questions of the day. The intellectual environment in France during the 1950s and 1960s had a profound effect on what has come to be known as the Foucaultian approach; Foucault challenged what he perceived as the weaknesses of existentialism, phenomenology, Marxism and structuralism. In the case of existentialism, Foucault proffered there was no accounting for the influence of the social on the individual or the effect that notions such as value and freedom have on how people experience the world (Smart, 1985). Phenomenology, a form of interpretation that understands objects as they are (Crotty, 1998), was also rejected by Foucault: this was because it did not take account of what Foucault called the ‘already-present interpretation’. Foucault proposed that everything is interpretation, and that in the case of phenomenology and the quest for the original object, there is no primary object to interpret (Faubion, 1998).

Foucault’s sexuality was not an unlikely reason for his insight into the marginalisation of particular groups of people: people with a mental illness, people who commit crimes, people who expressed their sexuality as other than heterosexual. His sexuality may also have contributed to his opposition to notions such as universal truth, normativity, self-evident claims, and the drive to understand how the most powerful discourses are those that we are least aware of. Foucault lived and wrote in a society where homosexuality was illegal and a conviction could have led to incarceration in prison or in a psychiatric institution (Rowan and Shore, 2009). He described the marginalisation and the fear of punishment he felt as a gay man:

‘In my personal life, it happened that after the awakening of my sexuality, I felt excluded, not really rejected, but belonging to the shadows of society. All the same it is a very distressing problem when you discover it for yourself. Very quickly it was transformed into a kind of psychiatric threat: if you are not like everybody else, then you are abnormal, you are sick (O’Farrell, 2005, p. 20)

Foucault is also known as a philosopher because of the philosophical nature of the questions he asked about how knowledge is produced and how power is exercised in relation to knowledge. Referring to these kinds of questions as exploring our ‘ontology of the present’, Foucault was concerned to understand how it is that we know what we know, and how it is that we are who we are today: in short, questions about being human, and the interactions between consciousness, origin and the subject (Foucault, 1989).

Structuralism was possibly where Foucault developed his strongest counter-position through his insistence that statements in a discourse exist in their immediacy and should be understood that way, not as signs whose true meaning is yet to be revealed (Andersen, 2003). Foucault’s work is sometimes described as structuralist or post-structuralist as he developed his particular form of discourse analysis in an environment of well-known structuralists that included Claude Levi-Strauss and Louis Althusser (Andersen, 2003). But it is more likely that Foucault developed his form of analysis as a response to what he opposed about structuralism; in particular its ahistorical approaches. Structuralists such as Levi-Strauss proposed that a difference exists between meaning that is manifest, and the real meaning which is latent. Manifest meaning is what is present at the surface of an event or a narrative, but the latent meaning must be revealed by exploring relationships within the underlying structure. Foucault refuted the structuralist method of analysis, instead insisting that it is the meaning which is on the surface and immediately present that is of importance, and it is that meaning which derives from discourses constructed as a response to their historical conditions.

Foucault’s form of analysis was also likely to have been a response to classical Marxist thinking, which posited that power exists as a product of the relations of production between those who own the means of production, and the working classes whose labour produces commodities for profit and exploitation. Three developments took place in the 1960s that highlighted deficiencies in the Marxist model. The first was the shift away from primary industry and towards science and technology. The shift suggested that the realm of ideas and ideologies would have a far greater influence over the future of the world than would the means of production. The second was the emergence of struggles associated with gender, race, nationhood, and

the environment. Those struggles, although they were not class-based, nevertheless, had a profound effect upon how societies were structured as well as upon their internal power relationships. Third, the Marxist States such as Hungary and Czechoslovakia had failed to provide for a re-distribution of power and wealth thereby seriously calling into question the theoretical foundations of Marxism and its application to creating a more equitable world (McHoul & Grace, 1998).

Foucault came at power from a different angle to the Marxists. He was concerned about how power was distributed and its effect upon the world, but he understood it as embedded into a whole range of relationships. Foucault's approach to power was that it exists in relationships within discursive fields. The 'Birth of the Clinic' was a body of evidence that Foucault built which supported his position that medicine, and importantly the power of medicine in the form of medical science, exists as a discourse. Foucault was able to demonstrate that what is understood as the discourse of medicine in contemporary times is very different from how medicine was understood two centuries earlier. Importantly, he was able to show that there was nothing innate or natural about medicine and its power; rather medicine had arrived at its current position of power because of a series of State-level proclamations in France and in Europe from the seventeenth century onwards. Those proclamations progressively relocated medicine away from the patient's bedside, and gave it a materiality in the form of powerful institutions in society such as churches, governments, the justice system and the medical profession:

‘...in the nineteenth century, medicine...became the major authority in society that delimited, designated, named and established madness as an object; but it was not alone in this: the law and penal law in particular...the religious authority...literary and art criticism (1989, p. 26)

In this way the power of medicine became dispersed across multiple sites: exercised in hospitals, public institutions, beneficent societies, by the police, by professional associations, and universities, bureaucracies, governments, and territories (Foucault, 1989). The 'gaze', a technique of power exercised through the discursive relationship that operated between patients, institutions, and the medical profession, enabled doctors to make statements about patients, or objects. Through the act of seeing,

supported by the knowledge and the exclusionary language of the medical profession, psychiatrists described, named, and made manifest psychiatric conditions, which society came to understand as madness. Meantime, the patient and his or her body, objects in the diagnostic process, were rendered silent. If patients spoke at all, the discourse of medicine constructed their relationship within the diagnostic process as one of ‘talking object’, thus maintaining the power relationships between psychiatrist and patient as one of subject and object. Objects, albeit ‘talking objects’; cannot escape their own objectification in the discourse. This is because it is the role of the subject to bring the object into existence. It is not possible, in the discursive relationship, for the object to bring itself into being.

Possibly controversial in colonial contexts, Foucault proposed that because power is relational, it can be exercised among oppressed groups in society, as well as by the dominant groups who hold power (Downing, 2008). Foucault was not the only scholar who proposed that oppressed groups exercised power, but his reasons for reaching this conclusion were different. The European anti-colonial scholars such as Aime Cesaire, Franz Fanon and Paulo Freire drew attention to how dominant colonial modes of oppression were incorporated by the oppressed and used amongst themselves to replicate colonial hierarchies of power. Freire understood this is a preliminary stage that the oppressed go through which, after a process of praxis, would enable them to reach their authentic existence:

‘their perception of themselves as oppressed is impaired by their submersion in the reality of oppression. . . although they desire authentic existence, they [also] fear it (Freire, 1996, pp. 27-30)

Foucault, although he was involved in the 1960s in French public campaigns supporting the liberation of Algiers from French control, appears to have been less inclined toward understanding power as a technique for liberation. Instead he remained focused upon understanding how power is produced through the existence of historical conditions and then embedded into relationships and into the material structures and institutions of societies. Edward Said used Foucault’s notion of discourse as set out in ‘The archaeology of knowledge’ and ‘Discipline and punish: The birth of the prison’ to illuminate how the discourse of Orientalism, a creation of

the West, became a systematic way by which the West maintained a domination and an authority over the Orient:

‘My contention is that without examining Orientalism as a discourse one cannot possibly understand the enormously systematic discipline by which European culture was able to manage – and even produce – the Orient politically, sociologically, militarily, ideologically, scientifically, and imaginatively...so authoritative a position did Orientalism have that I believe no one writing, thinking or acting on the Orient could do so without taking account of the limitations on thought and action imposed by Orientalism’ (Said, 1979, p. 3).

The power of the discourse on Orientalism was, as Said exposed it, that it existed as an entire system of meaning and representation, constructed upon other discourses about European superiority and Western hegemony. Said found evidence of a long history of Orientalism, reaching back to the period of the Enlightenment. Since then, Orientalism had been reproduced and embedded materially in almost every political, social, economic, and cultural domain of the West and the Orient. So powerful was Orientalism that Said wrote that one of the effects was that Arab students came to understand their own world through the damaging discourse of Orientalism. Using their American academic training to elevate themselves above their own people and satisfy American market needs, the role prescribed for the Arab intelligentsia was:

‘a modernising one, which means that it gives legitimacy and authority to ideas about modernisation, progress, and culture that it receives from the United States for the most part...the modern Orient, in short, participates in its own Orientalizing’ (Said, 1979, p. 325).

Foucaultian discourse analysis

There are a number of strands of research that pursue a discourse analysis approach: studies of conversational speeches, studies of discourse as storied grammar, studies of social practices and the actions that constitute them, and what is sometimes termed the Continental discourse analysis of Michel Foucault (Potter et al., 1993). The discourse analysis this study uses is that of Foucault, taken from three publications produced by

Foucault over the period 1973 to 1975. However, Foucault rejected the notion that his writings amounted to a theory of discourse. In fact, his own ideas about discourse, and how a discourse comes into existence at a particular point in time, evolved and changed from one publication to the next. This makes the business of explicating a process for discourse analysis a tricky and uncertain venture and other authors have made this point (Rowan and Shore, 2009). Their response has been to use his writings about discourse analysis as a framework, even as a metaphor, for developing a deeper understanding of the practices and techniques associated with power, its relationship to knowledge, and self-evident claims for the truth. Even Foucault wrote of his own deliberations and approaches that he was uncertain at times, as to where his investigations would take him:

‘...hence the cautious, stumbling manner of this text: at every turn, it stands back, measures up what is before it, gropes towards its limits, stumbles against what it does not mean, and digs pits to mark out its own path’ (1989, p. 18)

Foucault uses a complex style of writing; for example, he uses negative descriptions to illustrate what it is that he is describing. Shumway (1989) proposes that Foucault’s particular style of writing is a strategy for disorienting the reader, a process that asks the reader to step away from what he or she already knows in order to ask a series of strategic questions about how it is that something has come to be known. The question about how one comes to know something and whether what we know can be critiqued from within an already established system are concerns that are central to Foucault (Andersen, 2003). These are also concerns for Māori and other indigenous peoples who, at times, seek to foster and maintain systems of knowledge that are critically different from those of the coloniser. The challenge that this presents indigenous peoples is whether it is possible to create new indigenous and transformatory knowledge from within an existing, oppressive and colonised system. If it is possible, then it is also important to know whether there are preconditions. For example, can tino rangatiratanga operate inside the nation State, and if so, how might Māori think about this in ways that are mindful of but also unencumbered by colonial ways of thinking. If Shumway is correct and Foucault’s style of writing has the effect of disorienting the reader sufficient to create self-awareness about the problems of thinking critically from within an already established system of discourse, then his

complex and convoluted writing style might be understood as a useful strategy for encouraging new and critical Māori and indigenous knowledges.

The toolbox

Foucault described his writings about discourse as a ‘tool box’ for others to use, but being able to apply Foucault’s particular way of approaching knowledge and power is no easy matter:

‘I would like my books to be a kind of a tool box which others can rummage through to find a tool which they can use however they wish in their own area...I don’t write for an audience, I write for users, not readers’ (Foucault, cited in O’Farrell, 2005, p. 50)

In ‘The Archaeology of Knowledge’ Foucault provides something of a stair-cased process for understanding what discourse analysis is, although he stops short of providing a users’ guide. What can be confusing is that Foucault does not always use his own toolkit when he writes about discourse analysis. An example of this is the interchangeable way in which he uses particular words or phrases: for example, ‘historicity’ and ‘compiling the archive’ and ‘compiling a chronology of the discourse’. His work is also unsystematic. Instead of describing, step-by-step, the process of discourse analysis, Foucault takes the reader on a series of journeys back and forth along the pathway of discourse analysis. Possibly this is because he didn’t want to develop a theory that could be replicated indiscriminately, but the result is that it is almost impossible to document his approach as something that is linear, and which can be followed by others with ease. However, if Foucault can be changeable about the words, phrases and processes he uses and if, as he writes, ‘[users] are welcome to find a tool to use however they wish’ (O’Farrell, 2005, p. 50), then researchers should not be overly concerned to replicate Foucault’s own analytic pathway. I have taken the author at his word. What follows is an overview of the discourse analysis process as I understand it and as I am prepared to use it.

Discourse analysis

Discourse analysis is an analytic strategy for addressing questions of the order of 'how'; for understanding how it is that a particular discourse, a body of knowledge or a system of meaning has come into existence at a particular time and place:

'We must be ready to receive every moment of discourse in its sudden irruption; in that punctuality in which it appears, and in that temporal dispersion that enables it to be repeated, known, forgotten, transformed, utterly erased, and hidden far from all view, in the dust of books. Discourse must not be referred to the distant presence of the origin, but treated as and when it occurs' (Foucault, 1989, p. 28)

In this instance, then, Foucault is clearly differentiating his form of discourse analysis from that of the structuralists who, he contends, would be concerned with the quest to discover the origin of the discourse (i.e. the already-said), or the interpretation of the discourse (i.e. the not said). Foucault disputes both positions, and in order to avoid the likelihood that some sort of interpretation will occur he insists on an analytic approach that focuses on the historical conditions from which the discourse emerges. The central question that a Foucaultian discourse analysis seeks to answer is,

'What is this specific existence (i.e. discourse) that emerges from what is said (or written, or displayed), and nowhere else?' (Foucault, 1989, p. 31).

A discourse can be said to be a 'way of speaking', bound up by particular rules, rules which regulate what can be enunciated, by whom, and when. In order to understand the discourse and the rules that govern it, Foucault maintains that discourse analysis can only take place once the discourse has happened. This is because examining a discourse requires the analyst to construct the 'archive' of all the historical conditions, all the rules spoken or written or displayed, which have shaped the discourse. It is not possible, therefore, to extrapolate the rules of one discourse and apply them to a discourse that one expects to emerge in the future.

In the 'Archaeology of knowledge' Foucault describes a discourse analysis as establishing the chronological or historical limits of, for example, the discourse of

medicine. Foucault applies this approach in 'Birth of the clinic', demonstrating how it was that historical conditions shaped the emergence of particular forms of medical discourse. Calling this the process for historicity, Foucault argues that knowledge or discourse does not come into existence as a consequence of a naturally evolving, continuous process of the development of ideas, contrary to what historians would have us believe. Instead, using the process of historicity, Foucault conducts a meticulous examination of all that was written about medicine, medical institutions, medical associations, legislation, and statutes over the seventeenth to the nineteenth century. By documenting every instance Foucault compiles what he calls 'the archive', thus enabling him to demonstrate that the early discourse of medicine was generated at the patient's bedside and was entirely dependent upon what was *said* between the patient and the doctor. However a rupture occurred in the nineteenth century with the advent of medical dissections and autopsies and, as a result, a new and more powerful medical discourse emerged which almost entirely excluded the patient and what he or she said. Instead of a discourse derived from what the patient and doctor said to each other, the new discourse was based entirely upon what the doctor *saw*. What the doctor saw inside the body was mediated by what was recorded in medical textbooks and taught in medical schools. This exteriority of illness, that is, the ability of doctors to make the body speak and render its mysteries knowable, is at the heart of the new medical discourse and the power of the medical profession. In other words, the body cannot proclaim its own illness; it is the role of the doctor to speak on its behalf (Foucault, 1973). The historicity of medical discourse is an account of how it is that the patient and his or her body are silenced by a change of discourse which transformed them from the position of being subjects who proclaimed their own circumstances, to objects over which the medical profession took control.

Discursive statements

For a discourse to be examined in the context of its historical conditions, first the analyst has to be able to discern the existence of the discourse. Discourses are complex entities, traces even, which are not always easy to discern. Foucault describes discourses as comprised of a series of statements, the smallest atom of discourse. The statement is something that is written, or spoken or visual and which, through its enunciation, produces phenomena and materiality (i.e. effect). Thus a

statement must create an object, a discursive object, which it brings to life. In 'Discipline and Punish: The birth of the prison' the delinquent emerges as a statement in the discourse of nineteenth century penalty: the delinquent is a discursive object whose existence is created discursively by the existence of subjects and institutions: the police, the law courts, the reformatories, and the general public who wished to reform and control the delinquent. The materiality of the statement 'delinquent' can be observed in the raft of legislations, and policies, institutions and programmes aimed at controlling the delinquent so that he or she better fits into the accepted norms of society.

This example of the statement as productive, as producing phenomenon, confirms Foucault's form of discourse analysis as constructivist; that is, phenomena do not carry an inherent meaning. Rather, phenomena derive meaning from the historical conditions of which they are a part. The statement 'delinquent' derives its meaning from the historical context associated with its emergence. Theoretically, the term delinquent could be said to be a free entity until it is 'captured' by the rules of a particular discourse, at which time it takes on a contextually-driven meaning. What is clear from this example is that if meaning is historically derived, then knowledge, at least some of what is called knowledge, is socially constructed. However, the meaning that a statement carries, derived from its historical context, can change as that context changes. Early medical discourse regarded the 'body' as the space within which disease resided, but this meaning changed with the development of the clinic, medical teaching schools, autopsies and so forth, all of which had the effect of developing a new clinical discourse and transforming the statement 'body' into a new phenomenon; that of 'pathological anatomy'.

Discursive formations

Discourses like medicine, Foucault argued, exist across a number of domains simultaneously: hospitals, public health authorities, the police, the legal system, politicians, and the powerful medical profession. The most powerful discourses, Foucault argued, were powerful because components of the discourses, present in the form of various discursive statements, were dispersed across multiple domains. Foucault argued in 'Discipline and punish: Birth of the prison' (Foucault (1977) that the techniques for establishing discipline in modern societies weren't solely confined

to prison. Instead, most aspects of the disciplinary technique that operate through the discursive statement 'self-discipline', function on a day-to-day basis in the ordinary institutions of a nation: institutions such as schools, government bureaucracies, factories and offices, religious communities, the army, and the police. However, the power of these dispersed discourses is not just that they exist across multiple domains. The discourse of self-discipline is powerful because, Foucault proposes, it carries within itself traces of an older and harsher discourse; the discourse of corporal punishment. Before prisons were established, the discourse of corporal punishment was the main societal disciplinary technique. Foucault provides graphic detail in the introductory section of 'Discipline and punish: Birth of the prison' (1977) of how public torture operated as the system of corporal punishment and public control in the seventeenth century. However, by the eighteenth century the old discourse of corporal punishment was transformed into the new discourse of 'punishment by self-discipline'. The transformation took place as part of a process of gradual penal reform. Instead of punishment functioning as a display of the monarch's power to rule over the people, punishment developed into a technique for the control and reform of individuals, ostensibly for the good of the individual, and for society.

Discursive formations, comprised of statements, are linked together by rules which govern the associations or links between statements. The formation is made possible because rules exist which govern the relations by creating associations or links between discursive statements. In the discourse of medicine, for example, Foucault notes that the body as 'pathological anatomy' was one of a number of discursive statements about the body: other linked statements included the body as 'teaching domain', the body as the site of 'pathological phenomena' and finally, the body as 'corpse to be opened up as a means for acquiring knowledge'. These discursive statements are linked by the rules of formation which are, Foucault emphasises, *more* than an examination of words, their origins or their semantic uses. The rules of formation cannot be found by simply discovering the original date and context for the words 'pathology' or 'anatomy', even though the context that produced both words is a part of the historicity of the discourse of medicine. Revealing the rules of formation is, Foucault proposes, to ask a series of questions. The first question is 'Who has the right to enunciate discursive statements, who has the status, who derives benefit, and who receives assurances that what he or she enunciates is 'true'? The doctor emerges,

through various systems of accreditation and in relation to others such as the judiciary, different professional bodies, and the religious orders, as having the right to utter discursive statements, and create discursive objects. The second question Foucault poses is ‘What institutional sites are these assertions of ‘truth’ made from. The answer is that a whole host of institutions exist which support doctors to enunciate particular statements, and those statements, in turn, produce particular meanings which add authority to the status that doctors already have. The third and last question that Foucault asks is ‘What position does the discursive subject occupy in relation to the discursive objects in the formation: in relation to patients, the public health of society, the trainee doctors, the laboratory technicians, the teachers, the researchers, the statisticians and the demographers? The answer to this question is that a hierarchical relationship exists between discursive subjects i.e. those who have clinical knowledge of some sort, and those people and things that are the discursive objects. So, to answer the question, what are the rules of formation that link discursive statements in the discourse of medicine in the nineteenth century, the answer is that it is clinical discourse that links the elements into the same formation. Clinical staff, clinical institutions and clinical hierarchies are all part of the same clinical discourse that existed in the nineteenth century:

‘It can be said that this relation between different elements (some of which are new, while others were already in existence) is effected by clinical discourse: it is this, as a practice that establishes between them all a system of relations...’ (Foucault, 1989, p. 59).

Historicity and the archive

Having identified the statement, the next level on the staircase of discourse analysis is identifying how it is that a discourse comes into existence. This is achieved by undertaking a process called historicity, or constructing the archive. Foucault uses the concept of the archive to describe the material that the analyst amasses in order to understand a discourse; however, the process of compiling the archive Foucault calls ‘historicity’. The archive is the collection of all statements made in a discourse, and recorded in their historical dispersion or, as Foucault describes it:

‘the law of what can be said, the system that governs the appearance of statements as unique events...[and] it is that which differentiates discourses in their multiple existence and specifies them in their own duration’ (Foucault, 1972, pp. 145-6)

The goal of constructing the archive is to document everything that has been said (and not been said) in a society about a particular issue or event. The archive, once constructed, provides a historical record that serves to account for the discourse, as it exists in the present, and in its dispersion. Discourse analysis can only take place after a discourse has emerged; therefore, it is entirely possible to say that the archive, once compiled, is the finite record of all statements in the discourse, or, as Foucault describes it ‘the general system of the formation and transformation of statements’ (p. 146). Foucault presents a useful example of an archive in pages 64-85 of ‘Birth of the clinic’ and in the Notes section on pages 309 – 325 of ‘Discipline and punish: The birth of the prison’. The discourse analyst, Foucault advises, must:

‘...read everything, study everything. In other words one must have at one’s disposal the general archive of a period at a given moment’ (Foucault, 1989, p. 30).

By reading everything and studying everything, we assume that Foucault meant for the analyst to work in ever-expanding circles, drawing in everything that was associated with a particular topic or event. Constructing the archive of medical discourse in the nineteenth century, for example, would likely involve a study of all published and unpublished books on disease, diaries, diagnostic manuals, the records of professional associations and the legislation governing hospitals, but it could also involve studying the physical designs of hospitals, the development of medical equipment, furniture, paintings and so forth. Writing about the breadth of the archive that was constructed in order to examine the discourse of Orientalism, Said commented that:

‘...each work on the Orient affiliates itself with other works, with audiences, with institutions, with the Orient itself. The ensemble of relationships between works, audiences, and some particular aspects of the Orient therefore

constitutes an analyzable formation – for example, that of philological studies, of anthologies of extracts from Oriental literature, of travel books, of Oriental fantasies – whose presence in time, in discourse, in institutions (schools, libraries, foreign services) gives it strength and authority’ (1979, p. 20)

Notwithstanding the size of the archive that Said constructed, nevertheless Said wrote that his archive on Orientalism was incomplete. He explained this as being a consequence of the vast amount of material about Orientalism dispersed across Western society. Instead, what Said described were parts of the archive at particular moments, with a suggestion that the existence of a far greater volume of material would require others to carry on where he left off.

Transformations and generalisations

In ‘The archaeology of knowledge’ Foucault’s focus can be seen to shift from an examination of discursive formations and discourses that transform over time, to an examination of the interactions between different discourses, their points of diffraction and, importantly, what Foucault calls their link points of systematization. Discourses transform because the historical conditions that provide for their existence also change. The link points enable discursive objects in different discourses to appear in a powerful relation to each other, forming what Foucault calls a discursive constellation. The modification of the original discursive object, its shift out of the sub-level discourse and its appropriation into a higher level discursive constellation takes the form of what Foucault calls a generalisation,

‘...a certain significant generality moved between the least irregularity and the greatest crime; it was no longer the offence...it was the departure from the norm...it was this that haunted the school, the court, the asylum or the prison. It generalised in the sphere of meaning the function that the carceral generalised in the sphere of tactics...the carceral network linked, through innumerable relations, the two long, multiple series of the punitive and the abnormal’. (Foucault, 1977, p. 300).

Andersen describes how the concept of ‘prisonisation’ functions as a new discursive object which, while it carries the former meanings of discipline and of punishment, is

now used in a generalised sense in the context of other discourses such as schools, the workplace, the payment of taxes and so on (2003).

One of the most powerful examples of a discursive constellation is that of 'development'. In the 1950s President Truman spoke about the importance of transforming the underdeveloped areas of the world as part of the United States' imperial project. Development meant coercing underdeveloped, poor countries of the world to increase their efforts to emulate the capitalist, industrialised countries of the West. By the 1970s the discursive statement 'development' no longer referred to Third World countries: instead, development had become a more generalised statement that existed in a multitude of discourses as disparate as Western real estate, urban planning, and Third World poverty eradication. The term 'development' has become part of the constellation of 'development' that operates across multiple domains and within multiple discourses. The power of the word 'development' resides in its ability to speak authoritatively to Western, normative ideas and values about the world and how it should be. But it is only ever effective because it conceals the threat that without 'development' humankind would revert, would be backward, ignorant, poor, and uncivilised; such is the power of the Western notion of development in the twenty-first century (Escobar, 1995).

Knowledge and power

Discourses are systems of meaning or forms of knowledge. Unlike the kind of knowledge associated with disciplines like medicine and psychiatry, discourses go beyond disciplinary boundaries, and precede disciplines. While bodies of knowledge exist independent of Western sciences and disciplines, there is, Foucault contends, no knowledge that is outside of discourse:

'There are bodies of knowledge that are independent of the sciences...but there is no knowledge without a particular discursive practice; and any discursive practice may be defined by the knowledge that it forms' (Foucault, 1989, p.210).

Knowledge comes together with power through discursive acts. The subject produces discursive statements through the enunciative process that regulated what could or could not be said at a particular time. As a result, the discursive object is created.

The ability of the subject to enunciate statements that produce particular meanings is the nexus of the discursive relationship between knowledge and power. However, for the subject to enunciate and for the statement to produce the required meaning or knowledge, the historical conditions or the rules of formation must already exist. To take an example associated with 'Discipline and punish: The birth of the prison' (Foucault, 1991), humanists were unable to end the macabre public spectacle of corporal discipline until a particular set of conditions and relationships came to co-exist in seventeenth century France that changed the discourse of punishment to one of imprisonment, self-discipline and reform.

Knowledge or discourse cannot exist separate from the socio-economic conditions that surround it. Power is in an eternal relationship with knowledge because, Foucault contends, the discursive subject exercises power through the enunciation of the discursive object, thus creating knowledge. Power in this context refers to a whole range of possibilities. In the medical context of the seventeenth century, the power relationship between the doctor and the patient allowed both to generate statements about illness. That situation changed as the discourse of clinical medicine developed and rules governing who could enunciate discursive statements changed. By the eighteenth century, it was the doctor who, legitimised by the rules of enunciation, could make statements and produce meaning about the discursive object, the patient. Knowledge or meaning generated by the doctor overtook the meaning that the patient could give to illness in his or her own body.

In colonial contexts, the rule that defines who can be constituted as the subject and produce discursive statements and objects is shaped by discourses about colonialism and racism. For example, when the New Zealand government defended the police raid on Tuhoë homes in October 2007 and used the Terrorism Suppression Act to justify their actions, two very different discourses were invoked, and the New Zealand public were, in effect, asked to choose between the two. The New Zealand police drew upon a discourse about national security and the need for New Zealand to stay abreast of

the ‘war against terror’ that the United States and other developed countries were involved with. The people of Tuhoe, supported by other Māori interest groups (Waikato Times, November 12, 2007), tribes, Pakeha supporters, and international activists, invoked a traditional tribal discourse about tino rangatiratanga and also drew upon contemporary indigenous rights-based discourses (New Zealand Herald, Tuesday 13, 2007). Although the New Zealand public was unaccustomed to thinking about tribal self-determination and autonomy, they were also unaccustomed to images of the police raiding school buses and childcare centres, and to the need for national and international security and surveillance.

Surveillance

Foucault was interested in the technique of surveillance and the role that the ‘gaze’ or seeing would have had on the production of discursive statements, their objects, and the justification for object control. Foucault understood surveillance and ‘the gaze’ as techniques for monitoring and correcting abnormal ways of thinking and behaving. School buildings, hospitals, and prisons were physically designed to permit greater social control by rendering visible those who were inside, to those outside who were in control and invisible. It is easy to think that details such as the small observation window in the psychiatric hospital room, or the circular prison with its courtyard and watchtower, are insignificant and unconnected to the discourses of madness and crime in the seventeenth century. However Foucault argues that the observation windows and the prison’s physical architecture functioned as a kind of telescope by which the patients and the inmates were objectified, and their individual behaviour was scrutinised, recorded, timed, dated, and corrective discipline in the guise of training and routine was provided. Ultimately, the goal of corrective discipline was normalcy. In the education and medical systems, standardised education and a standardised national medical qualification were both techniques for power by which normalisation could be achieved.

As a discursive practice, ‘the gaze’ was productive of the power to name the symptoms, to diagnose and to bring about a materiality to the surfaces and interiors of the body:

‘For clinical experience to become possible as a form of knowledge...the patient had to be enveloped in a collective, homogeneous space. It was also necessary to open up language to a whole new domain: that of the perpetual and objectively based correlation of the visible and the expressible. An absolutely new use of scientific discourse was then defined...showing by saying what one sees’ (Foucault, 1973, p. 196).

In the clinical context ‘the gaze’ took place in the form of the clinical observations that were the domain of medical doctors, backed up by institutions, codes of practice, policy, and legislation. The medical ‘gaze’ gave doctors the right to make clinical decisions, carry out interventions, and calculate risks (Foucault, 1973). Today, the medical gaze continues to operate as a technique for power. The 1988 Report of the Cervical Cancer Inquiry, for example, contains many references to doctors justifying their decisions not to treat patients, and withholding information from patients because they were the objects of the doctors’ clinical care. Doctors literally chose to observe the range of clinical outcomes that unfolded, some of which resulted in what the Committee of Inquiry reported as very preventable patient deaths. Under cross-examination about the possibility that patients in the 1966 research trial had known and untreated invasive cancer that doctors chose to observe and not treat, Professor Green, the medical specialist leading the 1966 trial said:

‘It was always a calculated risk that invasive cancer could be overlooked, although it was hoped that colposcopy, clinical examination and repeat directed biopsies would minimise if not actually avoid this’ (Committee of Inquiry, 1988, Chapter 4, p. 82).

‘The gaze’ was also a technique in the discourse of punishment. In the context of the prison and punishment, the notion of ‘the gaze’ was generalised into the concept of ‘surveillance’. Instead of the brutal displays of torture and branding as punishment of the body in the eighteenth century, punishment became ‘surveillance’; what Foucault called punishment by control of the soul. ‘Surveillance’ was a particularly effective form of punishment because it contained within it the traces of physical punishment of the body. Instead of physical punishment of the body, its success was dependant upon prisoners following tightly scheduled and closely monitored regimes that

required self-discipline and self-control, monitored by the surveillance of the prison guards. The 1843 architectural plan by Bentham of the penitentiary panopticon gave a materiality to discourses of surveillance and self-discipline (Foucault, 1977, Plate 3). The panopticon, although it was never actually built, was planned on the principle that a supervisor in a central tower could constantly 'see' each captive locked into their individual cells, and could simultaneously 'say' whether regimes were adhered to and self-discipline was being maintained. The panopticon potentially enabled one supervisor to maintain control over a large number of people, whilst remaining invisible. The physical design also limited prisoners from communicating with each other in ways that could lead to a challenge for power.

Foucault also used the term 'panopticism', to refer to societies where self-discipline, surveillance, power, and social control operated simultaneously. Foucault notes that although societal surveillance and the growth of the disciplinary society were borne out of the need to control contagious diseases as opposed to the need to punish crimes against people or against society, nevertheless the two were not incompatible. In Western societies, the projects for fostering a self-disciplining society, maintaining societal surveillance and implementing systems for punishment come together in the sphere of public health. Public health surveillance is a technique for power closely linked to contemporary public health discourses about managing HIV/AIDS, but it is also a response to what the United States and other countries now perceive to be a threat to national and international security from the HIV/AIDS pandemic. Surveillance systems include a range of strategies for monitoring the health status and movements of infected and at-risk populations within countries and across borders (Valdiserri, 2003).

The technique of panopticism, like that of punishment, has been generalised beyond the prison setting and is now a central operating technique in factories, offices, schools, and psychiatric institutions, to name just a few. The 'gaze' gives factory overseers, office managers, teachers and medical staff the power to name, to make something manifest, and then to control it. In the workplace, for example, procedures exist that make workers visible, and known. Systems exist to record the start and finish of the working day, to register the presence or absence of employees, to inspect

the quality and quantity of work produced, and compare workers one against the other (Townley, 1993).

The world exhibitions of late nineteenth and early twentieth century can also be understood as a form of panopticism; as techniques for politically and socially ordering the world, based on who is looking, and what is to be seen:

‘The world exhibitions of the second half of the century offered the [European] visitor an educational encounter, with natives and their artefacts, arranged to provide the direct experience of the colonized object-world. In planning the layout of the 1889 Paris Exhibition, it was decided that the visitor ‘before entering the temple of modern life’ should pass through an exhibit of all human history...[and] the display would demonstrate the history of human labour by means of ‘objects and things themselves’ (Mitchell, in Dirks (ed), 1992, p. 294).

The colonial ‘gaze’ constructed indigenous peoples and their worlds as imagined worlds of the past: as museum objects, reduced and visible only inasmuch as they were a part of a dichotomy: uncivilized/civilized, East/West, the past/the future, chaotic/organised, native/modern, and other/European. Through these dichotomies, the exhibitions sought to order the indigenous world, but they also ordered the European world by presenting indigenous peoples as the antithesis of everything that was natural, normal and acceptable to Europeans.

Normalisation

Discourses that produce people or objects as deviating from what society defines as normal become targets for techniques of power in the form of surveillance, punishment, and reform. What Foucault found unacceptable was the way in which societies accepted, with very little scrutiny, discourses about normalcy. Arguing the case that norms related to sex and gender are presented not as norms but as givens which are outside of power, Taylor describes normalisation as:

‘repeated behaviours [that] become embedded to the point where they are perceived not as a particular set of prevailing norms, but instead simply as

‘normal’, inevitable, and therefore immune to critical analysis. Normalising norms thus hinder not only critical analysis itself but also, to the extent that they become naturalised, the recognition that such engagement is needed or possible at all’ (Taylor, 2009, p. 47).

Foucault was, as has already been mentioned, deeply suspicious of what he called grand abstractions, totalities, and self-evidencies. He understood these as ways of knowing, talking and claims about people and events that assume a high level of truth without investigation; discursive statements that are never examined or authenticated because they are thought of as normal, natural and beyond question. Foucault writes that:

‘Medicine...in the ordering of social existence, assumes a normative posture which authorises it not only to distribute advice as to a healthy life, but also to dictate the standards for physical and moral relations of the individual and of the society in which he lives (Foucault, 1977, p. 34).

Foucault contends that medicine was originally focused on health and people’s ability to address their own ill health. This changed in the nineteenth century as medicine formed its theories and practices based on standardizations; that is, what was considered to be normal physiological and psychological conditions, normal interventions, and normal responses. The change was subtle, but important. People no longer thought about how economic, social, and political arrangements contributed to contagious disease or even if and how the spatial arrangements, the surveillance, and population registers contributed to disease control. Instead they focused on simple dichotomies, distinguishing what was normal from that which was abnormal: the healthy from the diseased, the clean from the infected, and those populations that were flourishing, as opposed to those ‘at risk’ and those that posed a risk to others.

Like medicine, Foucault also described prison systems as normative. In order for the concept of self-discipline to work, prisoners had to first know what the standards were that societies would accept as normal ways of thinking and behaving. Prisoners were engaged, then, in their own reform, monitored by systems of surveillance. A rationale for the architectural plans for the Panopticon was that the level of surveillance the

institution could provide would enable jailers to identify abnormal thinking and behaviour amongst the prison population and then utilise that information as a first step to reform. Abnormal states such as laziness and stubbornness, for example, could be distinguished from imbecility and, once classified, a programme to reform lazy and stubborn prisoners could be instituted.

Normalisation has the dual effect of individualising by measuring gaps and differences, and at the same time, it homogenises by creating the incentive for group membership.

‘It is easy to understand how the power of the norm functions within a system of formal equality, since within a homogeneity that is the rule, the norm introduces, as a useful imperative and as a result of measurement, all the shading of individual difference’ (Foucault, 1997, p. 184).

In colonial contexts the production of normalcy exists as a discursive constellation, linking discourses about education, training, social values and behaviour, the military, religion, the employment sector and many other domains of society. This constellation operates to subjugate indigenous peoples by promoting homogenising discourses about a single nationhood and democracy, and it regulates thinking and behaviour amongst or within Māori and indigenous populations. By association, this same discourse has the effect of drawing attention to differences: the risks, the gaps, the disparities, the needs and the problems. One of the most powerful ways that normalcy operates is that it provides a rationale for the problematisation of difference. (8,993)

Problematisation

Problematisation, in the sense that Foucault used the term, refers to the process by which a set of thoughts, or actions, or ways of being, becomes the object of attention by others. As such, ‘problematisation’ directs attention to ‘how’ something has come to be revealed as an object of thought at a particular time in history. For example, as a process, problematisation asks how it is that a discursive statement such as ‘teenage pregnancy’ has come to be the object of thought and action. After all there have always been parents who bore their children in their teenage years. Furthermore,

research has demonstrated that for some teenagers, parenting in one's youth can be a positive experience and a rational choice, so why is it that teenage pregnancy has come to the attention of communities, researchers, and policy-makers at this particular point in time (Arai, 2009; Collins, 2009)? Problematisation is more than simply accounting for the transformation of a set of thoughts or actions into an object of human thought. For something to be problematised, there must be a difficulty that requires a response that is greater than simply revealing or describing the difficulty. The issue that is problematised must become an object of thought in a way that removes it from how it has previously been thought about and presents it as an issue requiring a solution. Further, problematisation requires the solution to the problem, whatever that problem is (i.e. teenage pregnancy), to be contained in the language in which the problem is formulated. Problematisation proceeds from the position that a discourse or discourses already exist that allow the subject to problematise the object in a way that requires action. The British parliament in the case of the problematisation of the Orient, designated Egypt, and countries of the East as objects for action on the basis that the British believed they had a responsibility as the superior race, over particular countries. Having problematised the Orient, Britain used its knowledge of the Orient as a form of power to justify British occupation.

‘To have such knowledge of such a thing is to dominate it, to have authority over it. And authority means for ‘us’ to deny autonomy to ‘it’ – the Oriental country – since we know it and it exists, in a sense, as we know it (Said, 1979, p. 32).

Finally, problematisation involves the discursive subject utilising knowledge in some form, in order to justify action or power over the object.

Conclusion

In summary, Foucault was concerned to understand how particular discourses or bodies of knowledge come into existence at a particular time and place, and no other. His form of discourse analysis was anti-structuralist; that is, discourses were to be understood as they emerged, not as signs of something hidden. Foucault contended that power was closely associated with knowledge, and embedded in discursive relationships, particularly the relationship between the discursive subject and its

object. Analysing how a discourse came into existence required the analyst to use a process of historicity or compile an archive of the historical conditions that gave rise to the discourse. Foucault proposed that discourse analysis could only take place in relation to events or actions that have already passed. Analysing a discourse required identifying the existence of a discourse. Discourses can be identified through the presence of statements which, as a consequence of their emergence, produce discursive subjects and objects. Statements are linked together in discourses by the rules of formation. Those rules govern what can be said (or what produces meaning) at a particular period in time. Rules are identifiable by asking questions about subjects, objects, hierarchies, and materialities:

‘discourse analysis consists of an analysis of statements, in which statements exist as an event, constantly enunciating subject positions, discursive objects, conceptual relations and strategies. The world comes into being, so to speak, through the statement as event’ (Andersen, 2003, p. 13).

Chapter Four: The fault line in Māori sexual and reproductive health policy

'...it is not possible for us to describe our own archive, since it is from within these rules that we speak, since it is that which gives to what we can say – and to itself, the object of our discourse – its modes of appearance, its forms of existence and coexistence, its system of accumulation, historicity, and disappearance' (Foucault, 1989, pp. 146-7)

Introduction

Understanding current sexual and reproductive health policy is an exercise that involves suspending so much of what Māori know about what it is to be Māori: the strengths of Māori collectivism, the richness of Māori language and culture, the depth of Māori knowledge about the principles of life and the universe, everything Māori in its sophistication, its fullness, and its infinity. Instead, to be Māori and to be represented in sexual and reproductive health policy is to be truncated, unintelligible, lacking substance, an object that is of interest only insofar as it defines everyone else as 'not itself' and therefore not 'at risk', not 'over-represented', and not 'unwanted or unintended'. In short, Māori become 'knowable' to the health sector through sexual and reproductive health policy: knowable as 'rangatahi at risk' or as 'teenage parents' or as a 'fertility rate' or as 'three times more likely to be sexually active'. After two hundred or so years of observing, categorising, and rendering Māori through various discourses, so much of the groundwork required to construct Māori as 'problem' has already been done. It wasn't a difficult task to present Māori as 'problem' in sexual and reproductive health policy: the rules which regulated what could be said or written and what meanings would be accrued had already been laid out. After all, wasn't this just another colonial exercise not too dissimilar from the representation of Māori as exotic, or as minority, or as disparity in artwork, in literature, and in health services, policy and research?

In as much as health policy is an account of the problems that beset societies (Cheyne et al., 2005; Baldock et al., 2007; Dean, 2006), so too is it a process for representing people, their ways of life, and their environments (Fleras and Maaka, 2009).

Policymaking is a discursive technique for producing knowledge, for surveillance and categorisation, the aims of which are training, modification, and normalisation. Health

policies, programmes, and services give a materiality to particular representations of Māori in health policy, representations which are supported by the existence of discourses about population, about development, and about universal rights. In current sexual and reproductive health policy a body of discursive statements exist about Māori, yet these statements, what they represent, and the meanings they produce are not immediately apparent. Statements such as ‘rangatahi Māori continue to experience significantly higher rates of STIs’ and ‘Māori teenage pregnancy’ are more than an arrangement of words in a linguistic sequence: they are densely populated fields of meaning which produce particular representations of Māori, and importantly, of non-Māori. Mbembe writes that Africa functions as a metaphor, through which the West represents and defines itself, for itself. It is useful, therefore, to think about health policy as a site of colonisation, not just in terms of the material outcomes of policy, but the very processes by which health policy constructs meaning and representation about indigenous peoples, ultimately for the benefit of others. Mbembe writes that there is hardly ever any discourse about Africa for itself (Mbembe, 2001). In sexual and reproductive health policy in New Zealand there is hardly ever any discourse about Māori sexual and reproductive health that is for itself.

In this chapter, I apply Foucault’s theoretical approaches as described in the chapter three, to current sexual and reproductive health policy. My goal is to explicate the nature of the construction of Māori in and through current sexual and reproductive health policy. This chapter begins with a discussion about current sexual and reproductive health policy for Māori as a discourse that is underpinned by a distinctive colonial rendering of other discourses about population, economic development, State policies for Māori development (Havemann, 1999), and global rights-based approaches to sexual and reproductive health. The accumulation of these discourses and their intersections in contemporary health policy provides, I contend, for the construction of Māori as always in the negative, as other, and as ‘problem’. The construction of young Māori parents as ‘problem’ is analysed as a specific discursive text that embodies the same discourses, and serves to problematise Māori youth who are parents, therefore producing them as available to the State for surveillance and training as techniques for normalisation.

Knowing¹ the sexual and reproductive health of Māori

Health policy for good Māori health requires Māori leadership, Māori knowledge, and Māori control (National Health Committee, 2002). It requires the involvement of a range of people with different skills (i.e. analysts, community and tribal leaders, knowledge experts, researchers and others), working together over time to make policy that works for Māori; policy that addresses Māori imperatives; that improve the sexual and reproductive health of Māori; that reduces disparities, and utilises sound research that is supported by Māori. By comparison, State-determined policymaking is a relationship between subject and object. In State-determined sexual and reproductive health policymaking, Māori communities are objects of the States' knowledge and power. As objects, Foucault would likely propose that objectification allows the State to define and represent Māori in sexual and reproductive health policy.

In the health sector, policymaking proceeds in accordance with the Health Policy Wheel (Ministry of Health, no date) that promotes public participation. Māori are involved in policymaking as a sub-group of the public. Public participation was a feature of the policymaking process employed by the Ministry of Health to guide the development of current sexual and reproductive health policy, including policy for Māori. A small number of Māori were involved in the Sector Reference Group, established by the Ministry of Health to provide advice, submissions, and feedback to the Ministry's own Project Team. This model is a long way short of the Treaty of Waitangi partnership model that the National Health Committee in 2002 proposed would improve Māori health policy and Māori health outcomes.

In the absence of Māori policy leadership, knowledge, and control, the sexual and reproductive health policy that was produced by the Ministry of Health is overwhelmingly negative in its construction of Māori as 'other' and 'at risk', and as 'problem'. Supporting the production of such negative policies about Māori in sexual and reproductive health are particular discourses that influence State policymakers and policy stakeholders. Those discourses promote the belief that Māori can be 'known' by the State, and by the medical profession as well as, if not better than,

¹ From 'Knowing the Oriental', the title of Chapter 1, *Orientalism*, by Said, E., (1979). New York: Vintage Books.

Māori can know themselves. In fact, the reference sections of both current policy documents indicate that Māori have no knowledge or anything of value to contribute toward the development of sexual and reproductive health policy for themselves. Current sexual and reproductive health policy for Māori has no point of intersection with traditional knowledges about Māori sexual and reproductive health. Instead, current policies are underpinned by statistics drawn from incomplete national datasets, and what Smith calls ‘outsider’ research or ‘research through imperial eyes’ (Smith, 1999, p. 42). The knowledge required to develop policy for Pakeha New Zealanders is, therefore, the same knowledge used to develop sexual and reproductive health policy for Māori. Yet, the Ministry of Health have produced no justification to support this position.

The discourse about Māori in sexual and reproductive health policy is that they are ‘knowable’ by the discursive statements such as ‘rangatahi at risk’, ‘Māori teenage parents’, ‘fertility rate’, and ‘three times more likely to be sexually active’. What are the historical circumstances that have produced this negative discourse, who enunciates the discursive statements about Māori, and what are the rules that allow such representations of Māori in policy documents? The consistently negative representations of Māori in sexual and reproductive health policy exist, I contend, as the fault line, indicating the presence of intersecting discourses that have influenced current policy. The fault line runs through sexual and reproductive health policy for Māori, but it is possible that the fault line also runs through sections of Māori communities. A consequence of health funding, some Māori health organisations, for example, may find themselves joined with the State to problematise Māori teenage pregnancy. While it is not in the scope of this study to investigate whether the fault line is present in Māori communities, nevertheless it is useful to ponder for the future. There are many reasons why Māori communities and iwi might not dispute the consistently negative representation of themselves in health policy. The negative representation of Māori in all health policy has, I contend, become so ‘normal’ and such a natural state of affairs. Possibly the power of medical discourse with its exclusionary clinical language and its materiality also creates an obstacle to the possibility of thinking critically about how Māori have been represented in sexual and reproductive health policy? Also, not to be underestimated, is the power of the

medical profession and the influence of biomedical discourses about sexuality and reproductive health on Māori responses (Maloney and Kirkman, 2005).

Foucault was concerned to understand how it is that current ways of thinking come to exist in their particular form, and at a particular time. Importantly, he would have been concerned to demonstrate that there is nothing innate or natural about sexual and reproductive health policy, its knowledges, and its power. I have undertaken a process of historicity to compile the archive of conditions that have generated the discourse about Māori in current sexual and reproductive health policy. I will demonstrate that there is nothing innate or natural about current policy for Māori; that it has arrived in its present form because of a series of what Foucault describes as State proclamations, or enunciations. The archive that I have compiled is an account of the power that the State has to ‘know’ Māori, to produce ‘knowledge’ about Māori and to wield power over Māori by using State-determined knowledges in order to create particular representations of Māori in sexual and reproductive health policy.

Policy discourse about Māori

The discourse about Māori that emerges from current sexual and reproductive health policies is discernable by the discursive statements which, taken together, produce a certain knowledge or representation about Māori. Foucault would have proposed that the institutions, the employment practices, the standardisations, and all the other materialities of current health policies are also productive of the construction of Māori. Drawn from current policy documents, some of the discursive statements are listed below, as follows:

- ‘Māori and other communities have issues specific to them’ (Ministry of Health, 2001, p. iii);
- ‘Rates of both diseases (chlamydia and gonorrhoea) are disproportionately high in young people, Māori and Pacific peoples’ (Ministry of Health, 2001, p. 1);
- ‘young women who become pregnant were more likely to be Māori...’ (Ministry of Health, 2001, p. 1);

- ‘The groups most likely to be in at risk situations are youth, Māori, and Pacific peoples’ (Ministry of Health, 2001, p. 2);
- Māori students were nearly three times as likely as European students to be sexually active’ (Ministry of Health, 2001, p. 13);
- ‘Overall the birth rates for Māori are slightly higher than those for the total population’ (Ministry of Health, 2001, p.13);
- ‘New Zealand researchers have concluded that teenage pregnancy is more common among – Māori ...’(Ministry of Health, 2001, p. 16);
- ‘Among young New Zealanders, and rangatahi Māori particularly, unplanned pregnancies, abortion and sexually transmitted infections are becoming more common – with potential long-term consequences for their health and their fertility’ (Ministry of Health, 2003, p. v)

Constructed by the State, and supported by knowledges chosen by the State, these discursive statements and the discourse they produce about Māori in sexual and reproductive health policy is entirely negative. As discursive statements, they are productive of other discursive statements. The statement above, concerning unplanned pregnancies among rangatahi Māori (Ministry of Health, 2003, p. v) generates other discursive statements about ‘unwanted pregnancies’ (Ministry of Health, 2003, p. 29) and ‘Māori teenage pregnancy’ (Ministry of Health, 2003, p. 29).

Most every section of the Strategy and the Resource Book contains discursive statements that serve to construct Māori as ‘other’. The statements draw attention to differences between Māori and everyone else, as in a statistical difference (i.e. percentages), and quantities (i.e. three times higher), and emphasised by the use of adverbs (i.e. disproportionately higher, significantly higher, and particularly high). The difference that is being emphasised is always between Māori and everyone else and with what Boucher (2009) calls, their attendant absence of ethnicity. Those with no ethnic identifier are always and already racially coded as white.

Difference between Māori and everyone else is not just limited to numerical difference. There is another difference that exists in policy and that is difference as it refers to 'comprehension'. Current policy starts from the premise that things Māori are difficult to understand, even incomprehensible. The task is, therefore, for the State to intervene and correct things so that Māori can be comprehended, as in the statement 'Develop a good understanding of Māori sexual and reproductive health issues' (Ministry of Health, 2003, p. 30) and 'use existing data to draw a clear picture of Māori sexual and reproductive health status' (Ministry of Health, 2003, p. 31). In spite of the words, the idea that forms in the mind of the reader is that there is something unusual, perhaps irregular, and certainly something ambiguous or obscure about Māori sexual and reproductive health issues. Health organisations are urged to 'Find out what Māori want and need to know more about' (Ministry of Health, 2003, p. 33). This statement assumes that what Māori want to know about sexual and reproductive health matters is not the same as what they need to know. What Māori need to know is a matter not well understood by Māori, but well understood by Pakeha. To summarise, gaining a good understanding and clarity about Māori sexual and reproductive health requires special attention, and Pakeha.

Difference is also about overcoming ignorance; ignorance in Māori communities. Ignorance, according to the policy document, exists in the form of discriminatory behaviour as in 'Work with Māori community leaders to tackle stigma and discrimination often directed at people because of their sexual orientation or HIV status (Ministry of Health, 2003, p. 32). Continuing the same theme in the Māori Strategies section of the policy document is another discursive statement 'There is a considerable amount of ignorance around HIV and AIDS and this can lead to fear and rejection' (Ministry of health, 2003, p. 32). Presumably there is very little discrimination and ignorance about sexual orientation and HIV/AIDS in the wider New Zealand population; such things only exist in Māori communities. There is no attempt to contextualise contemporary Māori responses to sexual orientation or to HIV/AIDS in terms of the damage caused by Christianity and two hundred years of colonisation.

How did a discourse that is so consistently negative about Māori knowledges and Māori communities come to exist? Foucault describes questions of this order as an

exploration into the ontology of the present (Foucault, 1989), or an examination of the historical conditions that produce the discourse. Current sexual and reproductive health policy for Māori is, I will argue, the result of an accumulation of discursive statements and events that I have chosen to trace from 1922 onwards. Themes of population control and its association with New Zealand's economic development are evident from the period 1922 onwards to 1994, after which time the emphasis shifts from population control to rights-based approaches to sexual and reproductive health, although the impetus for population control continues, albeit as a transformed discourse and set of policy imperatives. New Zealand, although it is a signatory to various rights-based international instruments, has taken a muted approach to explicating sexual and reproductive rights into its current policies.

Influential throughout the period from 1922 onwards are what Havemann (1999) calls State-determined policies for Māori and indigenous development. In New Zealand, policies pre-1920 were characterised by coercion, segregation, and assimilation. From 1920 to 1960, assimilation was the dominant policy approach associated with Māori development. From 1970 to 1980, the policies were focused on achieving integration, followed by biculturalism. From 1990 through until 2000 and the two sexual and reproductive health policies that are the focus of my study, the emphasis has been devolution (Te Puni Kokiri, 2005), and self-management. I argue that the degree to which Māori are visible to the State from 1922 onwards is, in a large part, a consequence of State policy for that particular period.

Archive of sexual and reproductive health policy for Māori

'A better distribution of the Empire'

During the early years of the twentieth century, the chief concern of Britain was to maintain its colonial power and influence over the British Empire. Maintaining power was the subject of intense parliamentary debate and newspaper reports in Britain, and in New Zealand. In 1922, the English Parliament passed the Empire Settlement Act. The purpose of the Act was to stimulate emigration by discounting costs for British and Irish families: single males, single females, and children, to relocate to the Dominions. Promoted to the British public as a solution to the problem of unemployment, the Act was expected to achieve full employment in Britain as a result

of extracting minerals and other resources from the lands of the Empire, thereby increasing Britain's industry and trade.

According to a New Zealand newspaper report in 1922, the British people and the people of the Dominions understood the development of the Dominions as also expanding and developing the power of the Empire. However, the success of that development was contingent upon the emigration of British men, women, and children to the Dominions (Evening Post, 1922). Promotion of the 1922 Empire Settlement Act in Britain and in New Zealand was accompanied by a distinctly colonial discourse about New Zealand as a vast and empty land, and in need of the right people i.e. white people. People of British ancestry would bring civilisation to the Dominions and economic gain for the Empire. Imaginary notions about New Zealand as an empty space and an area well suited for settlement by the white race turned upon the colonial idea that economic development was contained in the core, Britain, to be progressively rolled out to the periphery, the Dominions, through the process of emigration (Evening Post, 30 June, 1925: Evening Post, 2 November, 1936). The belief that a relationship existed between economic development and population control was well established in New Zealand in 1922, although there was no evidence to justify the belief.

In a message to his fellow citizens in Great Britain and the Dominions, Mr J. H. Thomas, MP, issued a speech from the Overseas Settlement Department of the Colonial Office, London. What follows is an extract from a much longer speech:

'Building Up Empire – The Meaning of Development'

'...I am writing this message in the hope of convincing anyone who may need to be convinced that the best way in which the Dominions and we can face up to the future and meet whatever difficulties it may bring is by development of the Empire. This can only be done by settling more people in those parts of the Empire...where more population is urgently needed...we know that the Empire contains vast areas well suited for permanent settlement by the white race. We know that it contains unlimited natural resources...we know that its resources are largely untapped, and its vast areas mostly thinly populated. We want manpower to develop the Empire's resources...this Empire is a trust of

which we are the keepers, for the British race. Can we not develop it, as it deserves? Let there be no mistake. What I mean by development is a fair chance for the child, a real outlook, and opportunity for the parent; in short, an Empire of happy and contented people' ((Evening Post, 30 June 1925).

The speech is of interest because it presupposes a particular audience in Britain and the Dominions, and that audience was people of the British race. The audience was not the indigenous peoples of the Dominions. Nor is there any attempt to apologise for or justify the absence of any reference to indigenous peoples. The speech gives no indication that the Minister was uncomfortable referring to the lands of the Dominions as 'empty', or that it was troublesome for the Minister to speak with such knowledge and authority about the future of Dominion lands that had been governed by indigenous peoples for hundreds, even thousands of years. As objects of British authority, the power to make indigenous people and Māori people in New Zealand, visible or invisible, lay with white governments. The New Zealand governments' policy for Māori at the time of the 1922 Empire Settlement Act was assimilation, (Havemann, 1999). MP Thomas was simply saying what he saw, and along with other ministers of the crown in Britain and in New Zealand, he did not see indigenous and Māori peoples.

'Māoris are [not] a source of danger to the European community' – 1922

Venereal Disease Inquiry

Over the period 1922 to 1945, the State entered the lives of New Zealanders around matters of an intimate nature: venereal disease, abortion, and contraception. The report of the Venereal Diseases Inquiry of 1922 contained two references to Māori that are of interest to this study. The first reference is to a Māori village in the Far North who were employed at a whaling station where they became infected with a venereal disease and brought the disease back to their village on the mainland. The report noted that venereal disease had been common among Māori in the early colonial period when it caused sterility and miscarriages, but was now no longer common. The second reference is to a statement made by Dr Te Rangi Hiroa, Director of the Division of Māori Hygiene, to the Committee of Inquiry. Dr Hiroa said:

‘In my experience of eighteen years’ constant work amongst the Māoris, venereal disease has been comparatively rare...I see very little of it at present, but now and again [I] hear reports from medical officers that it has cropped up in the settlements near them...In all cases I am convinced that the origin is from a white source, and the problem amongst the Māoris is not nearly so serious as amongst Europeans. It seems to me unjust that the idea should be circulated that the Māoris are a source of danger to the European community – the reverse is much more likely. It is impossible for me to supply accurate data as to the incidence of the disease amongst the Māori at present, but I am confident that reports have a natural tendency to be exaggerated’
(Committee of the Board of Health, 1922).

The references to Māori and venereal disease are of interest because they suggest that the European communities viewed Māori as vectors for transmitting the disease into European communities. In his statement Dr Hiroa appears to have been trying to disprove the view that Māori were the source of European infection, therefore Māori were a risk to European communities. At the time, there was no data collected of Māori infected with venereal disease. However, Dr Hiroa was unequivocal that there was no evidence to support the belief that Māori were a vector for transmission into European communities.

A decade before the Venereal Disease Inquiry in New Zealand, the Royal Commission on Venereal Disease and the Birth Rate Commission were held in Britain (Evening Post, 28 February 1922: Evening Post, 8 August 1922). Evidence from both Commissions was presented at the New Zealand Inquiry. Prevention and treatment strategies used in other countries of the Empire to control and manage sexually transmitted infections were examined, and New Zealand’s strategies were compared. As early as 1922, an international medical, public health, and policy exchange existed. That exchange, over time, developed into global policy coherence around the prevention and control of sexually transmitted infections. Policies may give the appearance of being nation-specific projects, however the nature of the colonial system is that it involves what Boucher (2009) describes as a complex transnational flow of bodies, ideas and capital, which manifests itself in the production of globalised but locally specific political, economic, and social institutions and policies.

‘A burden to the State and a serious deterioration of the race’

In 1924, the New Zealand government held the ‘Inquiry into Mental Defectives and Sexual Offenders’. The Inquiry was set up following concern that despite the Empire Settlement Act and the desire to populate New Zealand from the best of British stock, nevertheless there had been an increase in the number of people in New Zealand deemed to be feeble-minded, lunatic, degenerate, and deviant. The terms of the Inquiry noted that these people and the children they would produce were likely to create a social and financial burden upon the State, as well as damage the health and purity of the white race of New Zealanders. The Inquiry found that unchecked, the multiplication of feeble-minded and degenerate New Zealanders was indeed a threat to the idea of founding an extension of the British race in New Zealand. To avert this threat the Inquiry recommended setting up a Eugenics Board to manage the care and control of feeble-minded and degenerate people, using techniques such as institutional correction and sterilisation, as well as increased surveillance of prospective immigrants (Wanhalla, 2001).

‘Other countries are now alive to the importance of greater care being taken to guard against the admission of those who are likely to lower the mental and physical standards of the race, and in the opinion of the Committee, stricter precautions should be taken in New Zealand’ (Report of Committee of Inquiry, 1925, pp. 22-27)

The Report of the Inquiry is an important component of the historicity of current sexual and reproductive health policy for Māori because it confirms the existence of a discourse about the State having a responsibility for establishing and maintaining a particular kind of citizenship for New Zealand. Whereas the 1922 Empire Settlement Act envisaged New Zealand having greater control over the racial quality of immigrants coming into New Zealand, the report of the 1924 Inquiry recommended a new focus for population control; maintaining the racial qualities of the already-resident New Zealand population. In summing up the work of the Committee of Inquiry, the report notes that,

‘It has been rightly decided that this should be not only a ‘white man’s country’ but as completely British as possible. We ought to make every effort to keep the stock sturdy and strong, as well as racially pure’ (Report of Committee of Inquiry, 1925, pp. 22-27).

A number of points can be made about the 1924 Inquiry. The first is that New Zealanders of British stock were highly visible to the State. The report of the Committee of Inquiry is focused exclusively on maintaining the race vigour of people of British stock. This is not to say that no mental degenerates and sexual offenders were Māori. Rather, what I think it says is that the ‘gaze’ that emanated from the Commission of Inquiry did not ‘see’ Māori people, and so it was simply not possible for them to include Māori degenerates and offenders into the Inquiry. Māori were invisible to the State’s Committee of Inquiry in 1924, as they had been for the Venereal Diseases Inquiry two years earlier. The State’s policies for assimilation provide an explanation for Māori invisibility. However, Sachs (1992) describes the phenomena of visibility and invisibility as a function of knowledge and power. The State, exerting its power, creates a particular kind of knowledge that foregrounds one kind of reality, all the while backgrounding another. The kind of reality that the State had created in the minds of New Zealanders, and certainly in the minds of the members of the Committee of Inquiry, was that New Zealand was British and a white man’s country. The members of the Committee could not ‘see’ Māori because the rules of discourse about population, economic development and citizenship, did not permit Māori to be seen.

The second point is that in twentieth century colonial settler states, the rules of discourse about race suggest that terms like ‘race’ and ‘white’ and ‘native’, all of which were used in the report of the Inquiry, were self-evident signifiers for a desired category of citizens; those of British origin (Woollacott, 2009). The Committee of Inquiry was chaired by the Honourable Sir Maui Pomare, Minister of Health, who was a prominent Māori politician and leader. His leadership of the Committee appears to have made no impact upon the invisibility of Māori, or the deliberations of the Committee!

The third point is that the report of the Inquiry constructs binary oppositions around particular terms: visible and white is opposed to invisible and Māori. Foucault wrote that discursive statements were productive of other statements, creating a rich field of representation and meaning. These highly racialized binary oppositions were similarly productive of other binary oppositions such as ‘citizenship’ and ‘non-citizenship’, and ‘normal’ and ‘abnormal’. In the case of citizenship, the Inquiry focused its attention upon white New Zealanders of British origin, thereby confirming their citizenship and their normalcy. By inference, non-citizenship, and invisibility was the fate of Māori. However, in the context of the Inquiry, the binary opposition ‘normal’ and ‘abnormal’ is one that relates solely to white New Zealanders and operates to distinguish ‘normal’ white New Zealanders from ‘abnormal’ or feeble-minded and degenerate white New Zealanders. However this study argues later in the chapter that as the discursive contexts changed in New Zealand, so too did the meanings attached to ‘normal’ and ‘abnormal’, and in the twenty-first century, the meaning attached to ‘normal’ and ‘abnormal’ became moored to race. In the 1920s discursive statements like ‘race’ and ‘white man’s country’ operated effectively to produce meaning about New Zealanders of British origin, but they also produced meaning about Māori; those who did not even need to be named because the discourse had already truncated them, produced, and reduced them to invisible, non-white, non-citizen, and object for State control.

Global sexual and reproductive health instruments

New Zealand has a long association with international economic and social instruments and conventions. Instruments and treaties related to human rights, the rights of women and children, and sexual and reproductive health have influenced the development of the New Zealand government’s current sexual and reproductive health policy (Ministry of Health, 2001). In developing countries it is recognised that population policies are donor-driven because they are donor-funded (Richey, 2009) but the driver that operated in developed countries to orient population policies so that these emphasised sexual and reproductive health was as a result of the women’s rights and gay and lesbian rights movements, and the AIDS pandemic (Tiefer, 2002). At a global level, rights-based approaches to sexual and reproductive health have emerged gradually with progress hindered by the influence of fundamentalist Christian interests in the United States, and the Vatican (Petchesky, 2000). The 1995 Beijing Platform of Action, to which New Zealand is a signatory, took a small step towards

sexual rights, but after much debate what was produced was conservative (Tiefer, 2002). International non-government organisations like the International Planned Parenthood Federation (IPPF) produced a charter of sexual and reproductive health rights, and the World Association of Sexology has a statement about sexual and reproductive health rights. Although New Zealand is a signatory to the important instruments for sexual and reproductive health, those instruments fall short of enshrining sexual and reproductive health rights. The New Zealand Strategy document (Ministry of Health, 2001) takes a needs based rather than a rights-based approach to sexual and reproductive health. This is likely a response to the intense debates among countries about the strengths or challenges of progressing rights-based approaches to sexual and reproductive health.

In 1948, New Zealand was a signatory to the Universal Declaration on Human Rights. Article 16 of the Declaration refers to the right of adults to marry and found a family. Two decades later, in 1967 New Zealand signed the United Nations Population Declaration that gave official government endorsement to fertility regulation in New Zealand.

‘The [Declaration] supported the basic right of parents to plan and space their families. It was not until 1971, however that the Department of Health gave official permission for medical personnel to promote and discuss family planning’ (Sceats, 1988, cited in Pool et al., 1999, p. 142).

The Declaration described the importance of the links between population growth and human rights and freedoms although it did not elaborate on the nature of those links. Importantly, it emphasized the role that population planning could play in economic and social development within countries, and in modernisation across the world. No detail was provided about the notion that a relationship existed between population, development and modernisation, or whether evidence existed to support the notion. Newspaper reports and parliamentary speeches about the 1922 Empire Settlement Act described a relationship between population control and economic development. When the United Nations Population Declaration reiterated those claims in 1948, they were simply re-stating something that, at least for the New Zealand public of British descent, they were already familiar.

‘Restrained population growth’

In 1974, as part of the New Zealand government response to the World Population Conference, the public was invited to make submissions about the relationships between population change, and economic and social development. The report on the public responses was important because it revealed a change to the discourse underpinning the 1922 Empire Settlement Act which was that a growing population equalled enhanced economic development. Instead, the report of the Environmental Council recommended zero population was the only way to achieve economic growth:

‘the present rate of population growth in relation to resources and our way of life is too high, and restrained population growth alone will not solve the problems we have, but without it no problems can be solved’ (Environmental Council, 1975, p. 11).

The majority of submissions contained concerns that population growth placed strain on resources, and arguments were made on economic and environmental grounds that economic development and a higher per capita income were no longer dependent upon an increased population. The report also recommended that the government reduce the incidence of unwanted pregnancies, and provide free and accessible family planning services.

In 1979 the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) was adopted by the United Nations General Assembly and it was ratified by New Zealand in 1985. To date the CEDAW is the only human rights treaty that affirms the rights of women, including their reproductive rights and their rights to family planning (Ministry of Women’s Affairs, 2010). The Convention marked a break in the discourse about population and development in that it shifted the focus from the discursive statement ‘population control’ to a more gendered language that was focused on reproductive health.

The historical conditions that brought about the break in the discourse from the focus on population control to one of reproductive health and health rights is not easy to

establish. Knudsen (2006) attributes the break to mounting public concern over the focus of population control policies driven solely by demographic targets and fertility rates. Women's health advocate groups claimed that demographic targets and fertility rates were the focus of governments and others at the expense of women's health. Further, family planning programmes in developing countries were promoting contraceptive methods such as Depo Provera, IUDs and sterilization, even when those methods were under fire in developed nations (Knudsen, 2006). However, the Center for Reproductive Rights (Centre) attributed the change from population control to reproductive health to the impact of the U. S. Supreme Court's decision in *Roe v. Wade* in 1973 and the growth of women's rights movements across the world.

Right-based approaches to health

In 1994, the International Conference on Population and Development (ICPD) took place in Cairo. The Conference built upon the rights-focus of CEDAW, this time specifying sexual and reproductive health as a rights-based issue and in doing so it officially ended the focus on population control, and on reducing the world's population. Family Planning International, the international 'arm' of the Family Planning Association of New Zealand, was established in 1994 to focus on the Programme of Action that came out of the Cairo conference. The Family Planning Association of New Zealand credits New Zealand delegates with taking a lead in the negotiations for the Cairo 20-year Programme of Action (Family Planning International, 2008):

‘Internationally, prior to the Cairo Conference, population issues had been defined as growth. At Cairo they were manifestly re-defined as reproductive health and the empowerment of women...’ (Pool, 2001, p. 96)

New Zealand in the 1980s was experiencing an assertion by Māori conservative and activist organisations of Māori rights to greater self-determination in government, education, health, and broadcasting as well as Treaty claims (Walker, 2004). As a consequence the policy for Māori development was changed from integration to biculturalism (Havemann, 1999). The biculturalism policy had the effect of increasing the visibility of Māori in a range of government policy documents. By 1990, a number of Māori education and health organisations were established, including Te Puawai

Tapu, the first Māori organisation focused on sexual and reproductive health. Using a bicultural model, Te Puawai Tapu operated, for a time, as an autonomous but partnered organisation with the Family Planning Association of New Zealand (Smyth, 2000).

In the 1980s, the Ministry of Health had established a national taskforce to produce recommendations on policy for positive adolescent sexuality. However, the taskforce:

‘fell short of recognising the unique sexual wellbeing and reproductive health challenges of rangatahi’ (Ministry of Health, 1997, p. 12).

Following the new biculturalism policy of government, in 1997 the Ministry of Health undertook a public consultation into rangatahi sexual and reproductive health in order to identify issues that had an impact on their health. The findings of the consultation would, the Ministry of Health proposed, support improved policy advice. In 2000, the New Zealand Labour-led government adopted a policy for Māori self-management. Over the 1990s and into the early part of the next decade, government and non-government organisations produced policy, and policy related documents and research about sexual and reproductive health in New Zealand, and Māori were visible, albeit discursively represented, in a number of those documents. Their visibility, which was highly negative, was discursively produced: not for the benefit of Māori, but for the benefit of everyone else.

The discourses about population control, economic development, and globalised, individualised, and modernising norms about what constitutes good sexual and reproductive health, are linked together by associations, possibly held together by an economic market discourse that seeks to homogenise but also individualise communities and cultures. Foucault proposes that the rules of formation that bring discourses into association with each other can be discerned by a series of questions. Notwithstanding Foucault’s explanation, I was not able to clearly identify the rules of association that bring the discourses together, as Foucault suggests. What was discernible were the rules that each discourse produced that regulated what could be enunciated and what contributed to the negative construction of Māori in sexual and reproductive health policy. The discursive statements about disproportionately high

rates of disease among Māori peoples, young pregnant women more likely to be Māori, and Māori more likely to be a group at risk, derive meanings because of what Foucault describes as the already-said; the discourses that are already present. These and other discursive statements contained in current policy documents that represent Māori in the negative, exist as a type of benchmark; what Mbembe describes as a metaphor, around which Pakeha New Zealanders define themselves and their own sexual and reproductive health. Disease, teenage pregnancy, and risk, for example, are racially coded to being Māori and not normal. Pakeha New Zealanders can be encouraged to self-monitor and survey themselves and their own populations from the position that being disease-free, delaying pregnancy, and reducing one's risk is part of what it means to be 'not Māori' and normal. To be Māori in sexual and reproductive health policy in 2000 is to be 'problem', and in need of State surveillance and control.

Problematization in health policy

Problematization, in a Foucaultian sense, refers to the process by which a set of thoughts, or actions, or ways of being, becomes the object of attention by others. As such, 'problematization' directs attention to 'how' something has come into existence or how something has come to be revealed as an object of thought at a particular time in history. Edward Said wrote that the Orient was problematic: European writers, painters, bureaucrats, the military, architects, and others constructed the Orient as 'problem' for two reasons. First, the construction of the Orient as 'problem' justified Western domination and re-structuring of the Orient so that it represented their imaginings. Second, the Orient and its problems were constructed in such a way so as to represent the antithesis of everything which the Western world wished for itself. In other words, the Orient functioned as the 'Other' against which the West could define itself: a comparison against which European women, for example, could define and control their selves. Said wrote that Flaubert described Egyptian women as sexual machines; that they possessed a mindless coarseness, and that their sexuality was such that they made no distinction between one man and another. Discourses of representation such as these required no supportive evidence since their function was not to provide a credible rendering of Egyptian society, let alone the sexual practices of Egyptian women (1979).

Writing about disability as an object of problematisation at the end of the eighteenth century Verstraete (2009) asks the question, ‘As there have always been disabled people, what was it that constituted disability as an object for problematisation at that particular time in history and no other?’ What Verstraete discovered by examining the historicity of disability was that, as we would expect, disability did not appear out of nowhere, nor was it a new representation of an already-existing object. Instead, what gave disability an importance and made it visible was the emergence of particular schools of thought about individual freedom and mobility. This came to regulate how disability would be thought of and talked about:

‘The prevalent norms of freedom, activity and mobility proclaimed by contemporary politicians, pedagogues and philosophers on the one hand, and the association of deafness with solitude on the other, made the lives of these [disabled] people visible and intelligible’ (Verstraete, 2009, p. 288).

Problematisation of Māori teenage pregnancy

As a process, problematisation asks how it is that a discursive statement such as ‘teenage pregnancy’ has come to be the object of the State’s actions. Research demonstrates that for some teenagers, parenting young can be a positive experience and a rational choice (Arai, 2009; Collins, 2009)? However, problematisation is more than simply accounting for the transformation of a set of thoughts or actions into an object of human thought. For something to be problematised, there must also be a difficulty that requires a response greater than simply revealing or describing the difficulty. For teenage pregnancy to be problematised it must become an object of thought in a way that removes it from how it has previously been thought about and presents it as an issue requiring a solution. Further, the solution to the problem (i.e. teenage pregnancy) must be contained in the language in which the problem is formulated. In Britain, the introduction of the Teenage Pregnancy Strategy (TPS) had the effect of problematising teenage pregnancy by portraying it as a major public health problem, equating poor mother and child outcomes with the age of the mother, and advocating for delaying pregnancy beyond the teens (Arai, 2009). In New Zealand, teenage pregnancy amongst Māori is problematised, and one of the public health solutions to Māori teenage pregnancy, derived from the way the problem of teenage pregnancy is constructed, is to advocate for delaying pregnancy (Ministry of

Health, 2001). The rationale is that delaying pregnancy beyond the teen years improves the socio-economic outcomes for parents and children despite the fact that there is no clear evidence to support this allegation (Geronimus, 2004).

A key feature of the process of problematisation is the way in which something once considered invisible, is transformed into an object for someone else to see, to think about, and to know. In the New Zealand policy context, ‘Māori teenage pregnancy’ has become problematised. According to current policy, Māori teenage pregnancy, once an un-noticed phenomenon, is now an object of national concern. Foucault would have been concerned to find out whose gaze it was that problematised young Māori women who are pregnant, and the historicity of the ‘problem’?

Clark (2002) notes the pro-natal position adopted by some Māori in relation to Māori teenage pregnancy, and the position of Te Puni Kokiri, the Ministry of Māori Development, which supported an approach that minimised the negative outcomes associated with teenage pregnancy. Kumar (2009) focuses on the emergence of the sexual and reproductive health of Asian communities in New Zealand as a public health ‘problem’, and proposes the problem might not be to do with the sexual and reproductive health of Asian women:

‘The analysis argues that alternative readings that construct Asian women as rational in sexual decision-making are possible; however to do so would disable the Asian abortion problem. Caught between multiple interpretations, it is the frame – and its consistent values- that deserve interrogation’ (Simon-Kumar, 2009, p. 3).

Breheeny and Stevens (2010) analyse the problematisation of New Zealand teenage mothers in medical and nursing journals, revealing how the eugenics discourse has affected how some teenage mothers are constructed in the literature.

Problematising Māori teenage pregnancy

The problematisation of Māori in sexual and reproductive health policy reveals itself through discursive statements such as ‘young women who become pregnant were more likely to be Māori’ (Ministry of Health, 2001, p. 1), ‘Māori unwanted /

unintended pregnancy’ (Ministry of Health, 2001, p. 12) and ‘teenage pregnancy is more common among Māori’ (Ministry of Health, 2001, p. 16). These statements are productive of particular meanings and representations of Māori because they draw from discourses that determine how they will be understood.

Unmarried pregnant young women are degenerates

The notion that teenage pregnancies might be problematic for governments in New Zealand has its own historicity. A previously un-noticed phenomenon, white, young, and unmarried women having babies was the subject of newspaper reports during the early years of the twentieth century when New Zealand was concerned about maintaining the vigour of its population of people of British ancestry. To be white, young, unmarried, and pregnant was to be considered a degenerate, feeble-minded, possibly a sexually deviant woman (Wanhalla, 2001). Feeble-minded and degenerate young women and their illegitimate children were also thought to be a burden to the country, a threat to the population derived from good British stock, and a risk to the future wealth and wellbeing of New Zealand. Newspapers reported on the benefits of reformatory homes for feeble minded and degenerate young women, particularly those who had illegitimate children.

Degenerate young women can be reformed

In 1908, a Commission of Inquiry was conducted into the affairs and management of Te Oranga Home for Girls, Christchurch. The Home, through various classifications and grades of reformatory treatment, aimed to ‘prevent a life of shame’ and ‘fit a girl for a bright and pure life’ (Star, April, 1908). In 1910, a report into the operations of St Mary’s Home in Auckland noted that those people who were concerned for the wellbeing of New Zealanders should advocate for reformatories like Te Oranga. Reformatories, it was posited, could prevent young, feeble-minded, and unmarried women producing offspring who would ultimately become an economic burden and reduce the country to pauperism (Evening Post, 27 October 1910). Reformatories, like Foucault’s panopticon, operated as techniques for power and normalisation, regulating, monitoring, and training young women so that they more closely matched the models for women that were acceptable to wider society.

Maintain British race vigour

The eugenics movement, another technique for power and normalisation in New Zealand, took up the theme of maintaining British race vigour, and preventing an increase in the number of young feeble-minded and degenerate mothers and their children. In his 1934 address to the General Conference of the Royal New Zealand Society for the Health of Women and Children in New Zealand, Lord Bledisloe pondered the problems of how to control the reproduction of the unfit,

‘I realise that there are critics of this [Plunket] movement on the grounds that it perpetuates the lives of some who are congenital human wrecks, whose post-natal survival is not in the public interest. The difficult problem whether, and how, it is possible, or desirable, to check the propagation of the unfit is becoming a major problem in all the civilised countries of the world.’ (Buick, 1935, p.271).

Public debate over birth control, contraception, and abortion took place from 1935 onwards in New Zealand. The issue of population, in particular how to increase the fertility of some sections of the public while decreasing the fertility of others was a part of that debate. The ideas that a declining population threatened the economic development of New Zealand and that it engendered white ‘race suicide’ were recurring themes during this period (Smyth, 2000).

By the 1970s, the fertility rate of the Pakeha population was falling, after a post-war fertility high. From 1962 to 1971, the fertility rate for Pakeha fell by 25 percent, compared to the Māori fertility rate that fell by only 16 percent. The introduction of the contraceptive pill accounted for the some of the downward effect, but the trend was already underway at the beginning of the twentieth century (Department of Statistics, 1986).

In 1971, the New Zealand Medical Journal carried an article about pregnancy among unmarried women. The article noted that a disproportionate number of unmarried girls having babies were Māori or mixed ethnicity; however, the focus of the article was preventing ex-nuptial conception and the importance of sexuality education and the availability of contraception (Simpson, 1971).

Unmarried (Pakeha) pregnant teenagers

In 1972, a survey of 150 pregnant women at Wellington Public Hospital found that just under half of those pregnancies were unplanned, and most of them occurred among unmarried teenage women. The response from the Family Planning Association to this new information was to campaign harder for both married and unmarried women to be able to access contraception and abortion services (Smyth, 2000). Two points are made about the survey as it was reported. The first is that pregnant teenagers were recorded as either married or unmarried. No reference was made to the ethnicity of the pregnant teenage women. This suggests that Māori were either left out of the survey population, or did not utilise hospitals when they were pregnant, or they were part of the survey but their ethnicity was invisible, possibly as a consequence of government policy for Māori which, at that time, was integration. The second point is that the survey was conducted at a time when the Pakeha fertility rate, including the birth rate for teenage parents having children, was declining at a much faster rate than that of Māori (Pool, 2003: Department of Statistics, 1986).

Pakeha anxiety over Māori fertility can be traced back to 1922. At that time, the Māori population was approximately 6 percent of the Pakeha population. Māori communities were recovering from the effects of disease and population decline from 1850 to 1900s, and the 1918 influenza epidemic. In 1922, a government inquiry into the Māori birth rate found that the Māori rate was higher than that of Europeans. The inquiry noted that although the Māori population was increasing, so was intermarriage, which meant that the numbers of full-blooded Māori were decreasing (Wanhalla, 2001). In 1974, the Environmental Council reported that New Zealand would need to revise its population policy to one of zero growth in order to maintain its socio-economic development status and lifestyles.

In the 1970s, the phenomenon of teenage pregnancy was visible because it was productive of meaning associated with marital status (Midland Regional Health Authority, 1997), with access to contraception, and possibly with anxiety about the declining fertility among Pakeha New Zealanders (Smyth, 2000: Pool, 1991). Although teenage pregnancy was visible, the ethnicity of those teenagers was invisible. Discourses about the right kind of population, the association between population and economic development, and possibility that organisations like Plunket

could train good mothers, may have provided a kind of legitimacy for married Pakeha teenage mothers. Two decades later, the discursive rules governing teenage pregnancy had changed. Whilst teenage pregnancy is was still productive of meaning associated with access to contraception (Ministry of Health, 2003), the marital status of the young mother was no longer significant. What is significant in current policy is the ethnicity of the teenage mother; that is, whether she is Māori or Pacific Islands (Ministry of Health, 2003).

Māori teenage pregnancies – State control

As an object for problematisation by governments, the medical profession, statisticians, and non-government organisations, the State's policy solutions for Māori teenage pregnancy have been to promote contraception and a full range of options to prevent and delay pregnancy. However, there is no evidence that these are viable solutions for Māori communities, or that the health resources exist to support implementing these policy solutions. Further, the responses from some Māori communities to a negative view of Māori teenage pregnancy has been that other options such as increased social and economic support may be preferred (Tunks, 1996).

Consistent with the construction of Māori teenage parents as problem, and as object of the State's problem, is the assumption that the State knows what is best for Māori communities. Problematisation, which proceeds from the position that there is a variance between the subject and the object, is a technique for power and control, through the production of a certain type of knowledge about the dangers of Māori teenage parenting. The Ministry of Health sexual and reproductive health policy documents propose, based on outsider research (Smith, 1999), that many young Māori parents will be unable to support or care for their child (Ministry of Health, 2003, p. 2). This particular knowledge is just one part of a field of knowledge that is much broader and offers a wider range of representations of teenage parents than the consistently negative representation of Māori teenage parents contained in current policy documents.

Conclusion

Policymaking is a discursive technique that produces Māori as object of State policy. In the absence of Māori policy leadership, knowledge, and control, the construction of Māori in current sexual and reproductive health policy is overwhelmingly negative. The silence that has accompanied such a negative representation of Māori exists as a fault line in sexual and reproductive health policy, indicative of discourses that allow such a representation to flourish. Knowable to the health sector as ‘other, as risk, and as ‘problem’, Foucault would have been concerned to understand how it was that this particular way of thinking about Māori had come into existence. Using the process of historicity, an archive of the historical conditions that produced particular discourses, was constructed. Those discourses regulate the meanings and representations about Māori in current policy, for the benefit of Pakeha. Discourses about population, economic development, citizenship, and State policies for Māori development (i.e. assimilation, integration, biculturalism, devolution, and self-management) played a role in supporting the negative construction of Māori. Dichotomies centred around visibility and invisibility, and normal and abnormal, operate to foreground some representations, while backgrounding others. An area of sexual and reproductive health where representation is at the fore of how an issue is addressed is the problematisation of Māori teenage pregnancy. A once un-noticed phenomenon, Māori teenage pregnancy is a discursive entity that is part of a much broader discursive field that constructs Māori negatively in sexual and reproductive health policy.

Chapter Five: Conclusion

In this study I set out to answer the question ‘What is the nature of the construction of Māori in and through current sexual and reproductive health policy? In order to do that, first I had to set out the field of inquiry. The starting point was to discuss the role that State policymaking plays in the production of knowledge about Māori, and for Māori. An examination of State-determined policymaking and Māori self-determined policymaking was discussed. Keeping in mind that these two modes of policymaking operate in the same political sphere and are therefore not completely disparate, nevertheless some useful points of difference can be made. The first is that the State engages Māori into policymaking as members of the public rather than as partners in a Treaty of Waitangi policymaking model. The second is that Māori have responded to the inappropriate and inadequate role given them by the State. A range of responses have been utilised to try and orient State policies so that these more closely match Māori policy priorities. In the education sector Māori withdrew and set up their own education initiatives which, for a period of time, remained outside of the education sector. During that period Māori expanded their traditional Kaupapa Māori knowledge base, adding to this by theorising their contemporary engagement experiences with the State. In the health sector Māori took a different approach, working to achieve Māori priorities within the health sector and engaging in health contracting and service delivery. The third point is that a recent report of Kaupapa Māori in the Māori health sector identified that the critical and theorising aspects of Kaupapa Māori that were present in the education sector, appeared to have been blunted or dissipated among some Māori health services, researchers and communities involved in health.

The next stage of the inquiry was to set out the theoretical perspectives that I would be using to carry out the inquiry. I chose a Foucaultian approach, in part because I was interested in the way that the State, in its policies, chose to use some knowledges but not others. The choices that the State made in the sexual and reproductive health policy field have had the effect of foregrounding some issues and backgrounding others. What was foregrounded was a consistently negative representation of Māori, a representation that I think Māori would not have chosen had they the opportunity to construct health policy about themselves and for themselves.

The Foucaultian theoretical approach that I drew upon was set out in three of Foucault's publications published over the period 1973 to 1975. Using Foucault's process of historicity, an archive was compiled of enunciations made over the period 1922 to 2000 by the State that, I contended, provided the rules surrounding the construction of Māori in health policy. What emerged was a sequence of legislation, inquiries and reports which described the activities of the State with regards to population control, economic development, State policies for Māori development, and global rights-based approaches to sexual and reproductive health. The interactions of all of those discourses with each other served to create a discursive context within which the State's negative construction of Māori in health policy could be both produced and sustained. Population discourses with their dichotomies of 'visible and invisible', 'white and other', 'normal and abnormal', were closely linked the discourses about economic growth and prosperity, and those links had existed well before 1922 which was the starting point for this study's archive. State-determined policies for Māori development, as discussed in chapter two, had contributed discourses that had their roots in policies for assimilation, integration, and then, biculturalism, devolution, and self management. These discourses had determined the extent to which Māori were 'visible' over the period of the archive, although their representation, when they were visible, was truncated and othered and problematised.

Discursive representations are a consequence of the subject – object positions of discourse. The State, the subject in the current policymaking model, brings the object into existence through the act of enunciation. Māori are engaged in the health sector as contractors and service deliverers, as analysts and researchers, and as communities concerned to improve the health of Māori people. In a policymaking model where Māori are not the subjects, an important activity is to maintain a critical engagement with the State. Key to this is a critique of aspects of the sector that appear with such regularity that they are in danger of becoming normalised and a part of everyday life. The consistently negative representation of Māori in all of the sexual and reproductive health policy is a phenomenon that requires critique, as does the problematisation of Māori who are teenage parents. The silence that accompanies these damaging constructions of Māori in health policy is, I contend, a fault line that warrants closer inspection.

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