

# Introduction. Culture, change and well-being: health transitions in the Pacific

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The set of papers in this section of PHD arose out of a conference session organized at the Association for Social Anthropologists of Oceania's annual meeting in Auckland in February, 2002. At that meeting, we focused on how to talk about changes in health among Pacific Island populations from a perspective which recognized the existence of general trends in health, but which did so from a Pacific-oriented perspective. Much has been written about the specific health status of Pacific populations, but we question the ability of the dominant health transition model to adequately explain Pacific experiences. This set of papers attempts to critique the premises of health transition models, and to move beyond them to suggest more effective ways of understanding changes in health in the Pacific.

Health transition models attempt to explain patterned changes in health from a social and behavioral perspective. Health transition draws from existing models which posit universal trends in population and disease changes. The global mortality decline that has occurred during the twentieth century has been seen by many as a remarkable achievement. The almost universal decline in death rates led demographers to coin the term "mortality transition." This term refers to the passage of societies from high mortality rates, to lower mortality, stemming mostly from the control of communicable diseases. These changes in mortality patterns are also accompanied by changes in disease patterns, known as the "epidemiological transition". This second, concurrent transition is characterized by declining effects of communicable diseases and increasing effects of chronic and non-communicable, "human-made" diseases.

## Health Transition draws on cultural, behavioral, and structural factors to explain changes in health that fall outside trends in mortality or disease epidemiology.

Both epidemiological and mortality transitions, it has been noted, do not occur evenly or predictably across the globe. On the contrary, it has been argued that 'developed' nations experience the trends first, with 'developing' nations following behind. In addition, not all groups within a nation or a region experience health changes at the same rates. Differences in speed and characteristics of health transition vary by ethnic group, by economic status, and by cultural factors. Questions about why health transformations occur unevenly prompted scholars to coin a third term, the "health transition." *Health Transition draws on cultural, behavioral, and structural factors to explain changes in health that fall outside trends in mortality or disease epidemiology.* Those cultural, social and behavioral determinants of health, argue health transition theorists, have a potent effect on how and when societies experience the health transition.

The idea that cultural practices affect how communities respond to new medicines, ideas or technologies is widely acknowledged. Many scholars sensitive to the nuances of health changes have noted this. In order to show why we consider this analytic approach to be problematic, we highlight here the work of one of the leading proponents of health transition studies, John Caldwell. Through several examples, we show how culture, politics, and economic histories take second place to generalizations and simplifications about behavior in Caldwell's work. Caldwell defines the "transition" as occurring when biomedicine becomes increasingly influential and pervades social and cultural realms, accompanied by behavioral changes. This positive behavioral change results in better health, over a longer life span. This transition varies with the degree of exposure to biomedical systems, access to these systems, and a limited set of cultural factors such as education, degrees of medical syncretism, and cultural values about life and death. For example, Caldwell argues that parents with education, particularly mothers, are more likely to use modern health centers for curative treatment for themselves and their families. They do so because "that is how educated people behave."<sup>6</sup> In other words, the educated "just obey the dictates of modern medicine"<sup>6</sup> and this has a significant effect on mortality rates.

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In another example, Caldwell simplifies the role of traditional healers in communities. Caldwell argues that differences between "traditional" and "modern" medical systems overall do not affect transitions in health because many traditional healers use modern medicine. This syncretism means that many sick people also make use of both systems which ultimately leads to reduced mortality outcomes.<sup>6</sup>

In a final example, Caldwell specifically addresses the importance of culture. If cultural values promote dangerous infant-rearing behavior, for example, these are much more likely to persist and help sustain high mortality rates whether traditional healers use modern medical technology or not. Conversely, in areas where cultural values support healthy infant-rearing patterns, communities are more likely to experience reduced mortality rates, irrespective of healing practices. In short, cultural values that complement provisions in modern, biomedical care are more health-inducing than any form of traditional healing.<sup>6</sup>

As is obvious from these examples, specific cultural processes are given less credence than measurable changes in health. In doing so, *health transition models make many assumptions about unilinear progressions of health*. As Kielmann notes, transition models fail to capture the complexity of health patterns and uneven distribution of health within, and across, nations. Models privilege

"modernization theory and the conviction that modernization ultimately has a positive impact on the health and welfare of individuals. The premise of all these models is a positivist view of 'health' that sees both health and illness as universal, objectively verifiable, and measurable states of being."

It is this simplified view of health which is widely used by policy makers in critical agencies such as the World Bank, the World Health Organization, and specific donor country agencies. Yet, despite claims by WHO and other groups to know what health "is", definitions are typically made meaningful by referring to what health is not. Health is the *absence* of disease, infirmity and anguish, in the famous WHO definition, which leaves us with a sense that decision- and definition-makers think of health as a cold and sterile state of being—a condition of fully-operational corporeal stasis knowable by an absence of maladies which would make a body different from another. For the contributors of this session, such claims to define health are absurd. What is absent in an understanding of health here is the situatedness of a person's sense of well-being in cultural context. For us, health and well-being are about the presence of culture. Health for us is something that is broadly inclusive of the person in a social and cultural

environment, which is negotiated and negotiable, and which is affected by power relations (writ small or large), and effects of inequality (writ small or large).

Our papers challenge the health transition model in two major arenas. The first takes issue with a simplified understanding of culture. Culture is portrayed as, on the one hand, an irrelevant trace element remaining from once-traditional societies, and on the other hand, as a stubborn obstacle slowing down "progress." Almost all of the papers here challenge this model by showing the intricate connections between culture, health and healing. Mahina's paper deals with the failure of cultural explanations concerned with modernizing trends to even begin to explain states of being which are widely understood in Tonga. In Tonga, for example, health is a formal embeddedness that is balanced, in symmetry, which spans far beyond the physical to include the social, spiritual and more. It is an anti-absolutist framework, negotiated and negotiable, which allows room for ill-health being, among other things, "less than well in the mind".

While we have some knowledge of the context for disease patterns in the Pacific we know very little about how Pacific Islanders react to, explain, and cope with transformations in health from a cultural position. Kielmann has coined the important term the "conceptual health transition" to look at individual and community interpretations as a crucial factor in evaluating change on the ground<sup>7</sup>. Papers by Henry, Torsch and

Young Leslie deal explicitly with conceptual changes within communities, among healers, and among caregivers. Henry argues healers respond to globalizing forces and biomedicine in different ways, depending on where they live. There is no evidence in Tahiti that biomedicine has eroded indigenous medicine; rather it has given shape to different conceptualizations of healing which are highly context-specific. Torsch describes how the elderly Chamorros in Guam deal with chronic illness and changing social networks from a grounded cultural perspective. Young Leslie shows the extent to which expectations about behavior in rural Tonga, in the context of changing health patterns, get assessed, interpreted and incorporated into culturally-specific ways of thinking. In each case, cultural values profoundly inflect understanding of changes in health and healing

Our second concern lies with the role of political and economic transformations. We note in the Pacific that inequalities in health persist within regions and between groups in areas where the transition *should* have leveled out differences. Effects of nutrition, exposure to pollut-

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ants, ecological change, exposure to new pathogens due to increased mobility, and intersectoral violence: all affect health in Oceania in potentially significant ways. In this issue, Finau et al. offer the outlines of a health transition model for the Pacific. They argue imperialism and globalization need to be understood as the primary shapers of health patterns. Instead of reworking health transition models, they suggest new, more realistic ways of looking at Pacific health from a political economy perspective. Pollock critiques the notion that modernization is ultimately a positive trend. She explores the nuclear test on Bikini atoll and its health effects to argue that no health model in the Pacific can ignore the effects of mid-century nuclear testing. Her model of "infectious cancers" encourages us to look to the agents who cause disease, not to reactions to it. Evans et al. describe consumption patterns among Tongans most attuned to positive health messages, challenging the notion that individual choice and education levels determines healthy food consumption patterns. Butt et al.'s paper explores inequities along racial and class lines in AIDS prevention efforts in Papua, suggesting claims about culture that conform to health transition approaches actually detract from problems of service imbalances.

Together, these papers make a strong case for the need to explore models of health transition which are specific to the Pacific. We do so without disputing that the grand narrative of health transitions may apply to many parts of the world. Nor do we deny the importance of the categories of mortality and morbidity within the field of biomedicine. However, our papers challenge the claim that morbidity and mortality should be the dominant indicators of health transitions. We assert that a Pacific model must recognize the critical importance of culture in any discussion of health change. We further set out the challenge of understanding the region from a perspective attuned to inequities generated by imperialism, colonialism and the global economic networks within which the Pacific is enmeshed. These are big questions, and we offer only small answers. It is hoped that others will take up the challenge of imagining and understanding health in the Pacific in ways that continue to empower and sustain the well-being of Pacific peoples.

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