

Producing *what* in the transition? Health messaging and cultural constructions of health in Tonga

Abstract: This paper asks: what have the health promotion campaigns in Tonga actually produced, and what does this imply for our understanding of the "health transition?" Examination of villagers' responses to health messaging reveals an efflorescence of ideas about health, including a re-conceptualizing of the formal Westernized terminology of health promotion messages into concepts more aligned with traditional Tongan ways of being well. This implies the need for a model of the health transition process in which mutual shifts in understanding must be recognized by all parties, traditional villager and medicalized health professional alike, before new ideas of 'health' are actualized.

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Introduction

Current morbidity and mortality indicators in Tonga indicate that non-communicable diseases have replaced communicable ones as the main causes of mortality and morbidity. Thus Tonga is described as having achieved a modern health transition (see Butt - Introduction, this volume), partly through the effects of sustained health promotion efforts begun in the aftermath of the influenza epidemic of 1918. After decades of health messages focused on sanitation, reproduction, child health, nutrition and, most recently, exercise, it seems time to ask: what have the health promotion campaigns actually produced, and what does this imply for our understanding of the "health transition?" Here, I argue that while the morbidity scenario which currently describes Tonga may be similar to that of industrialized nations - illnesses such as diabetes type II, cancer, hypertension and cardiovascular diseases predominate in health statistics- another less obvious product of health promotion messaging has been an efflorescence of ideas about health and, at least in some areas, a re-conceptualizing of the formal Westernized terminology of health promotion messages into concepts more aligned with traditional Tongan ways of being well. What this means for our understanding of health promotion and the health transition is that a unilinear model (from communicable diseases to non-communicable diseases) attained through

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core to periphery, top to bottom, messenger to recipient style campaigns, in which the authority to decide what the message is rests with biomedical professionals, while the recipients are expected to listen and follow instructions, is impoverished. Tonga's example demonstrates that *any health transition is better understood as a process of give and take, in which mutual shifts in understanding must be realized by all parties, before new ideas of health can be broadly realized.*

Elsewhere, I have drawn on examples from registered nurses' public health training, health promotion radio broadcasts, nutritional advice, the king's personal fitness regime, and a mothering manual to demonstrate the style and type of health promotion messages to which Tongans have been exposed over the past decades. I argued that as a concept, 'health' is more semantically variable and polyvalent than Tongan health professionals seem to recognize, and that the term used to translate 'health' -

mo'ui lelei- is being re-invented to refer to cultural ways of being a good member of society, rather than its more restricted medical application². Here, I briefly outline some of the key health promotion themes, then examine how those messages

'fit' within the lifestyle of residents of one outer island. Examining the notion of health as lived on a small, peripheral island reveals distinct differences between 'health' as a concept in biomedical discourse and health promotion models, and 'health' as a lived cultural experience in a traditional, conservative Tongan village. The differences point to the failure of Western biomedical models for health to accommodate the various cultural realities extant at the community level, and the possibility of variability even within one linguistic group. The ramifications of such a failure are, clearly, that health promotion campaigns figured on a homogeneous, non-local community and culture-specific model are unlikely to be successful. At the micro level, this means health promotion campaigns in Tonga must shift to a model in which community members' perception of healthy living is

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accepted, and the local community members are involved in designing the appropriate health promotion targets, methods and milestones. At the broader level, this means that the single model of health endemic to biomedical training fails to fully include other cultural perspectives. The evidence from Kauvai indicates that in such cases, culture is stronger than health promotion dictums.

The kingdom of Tonga

Tonga is a small Pacific nation of roughly 108,000 people, mostly homogeneous Polynesian. They make their lives on or around a series of coral atolls and volcanic islands that lie near the Tropic of Capricorn, along the International Dateline. Migration, remittances, agriculture, and bureaucracy are key features of the economy³. Tourism is becoming more significant but does not dominate most people's lives. Tongans are very highly educated, with one of the highest percentages per capita of post-secondary and graduate level education in the Pacific. The Kingdom is a constitutional monarchy, in which key positions of power, namely the ruling monarch and the Prime Minister, have consistently been appointed from immediate members of the royal family, and where other family members are key investors in government business ventures. Tongans take pride in both their strong Christianity and the fact that while a long-time British Protected State, they were never a colony and never lost indigenous governance of their nation.

I have been conducting research under permit from His Majesty's cabinet since 1991, most recently with Tongan physicians, but originally on an island locally referred to as

Kauvai. Kauvai is in the Ha'apai region, located at the geographic center but political and economic periphery of the nation. There, a simple commodity production lifestyle dependent on farming, fishing, pandanus textile plaiting, and gift exchange predominates, with some, mostly opportunistic, exploitation of agriculture, fish and textile/handicraft markets. This lifestyle, described as *angafakatonga* - the Tongan way- emphasizes the importance of *va lelei* - good social relations- and *tauhivaha'a* - looking after social ties. All are key aspects of what is widely understood to be 'traditional Tongan culture,' and figure significantly in the re-interpretation of health promotion discourse to align with more traditional social practices.

In a nation of over 170 coral atolls, the problems of servicing far-flung island residents are not confined to Kauvai, nor even Ha'apai, and so it is likely that much of

what I say about medical services for Kauvai is true of other rural and peripheral communities. But it is also true that, as anyone from Vava'u will say, "Ha'apai people and Vava'u people are different." Thus, while much of which I write may be applicable to other parts of Tonga, I wish to reiterate a key point of this paper: that local, cultural and community differences must be recognized, and homogeneity must not be assumed.

Promoting 'health': the official definition in the Tongan medical system

For the most part, health promotion strategies have consisted of relatively straightforward translations of Western-based biomedical information, disseminated mainly through state sources, with an emphasis on didactic methods in which people are instructed to change their behaviour. 'Health' as a concept employed in biomedical literature did not exist in the Tongan lexicon⁴, creating something of a problem for health promoters of the past century. A neologism, "*mo'ui lelei*" (literally "living well") was coined for use in translations and health promotion material. That the term is as new as the World Health Organization's definition of health may be imputed from its absence from the glossary provided by William Mariner⁵ or the excellent dictionary compiled by Churchward⁶. *Who* actually coined the term and *when* is a bit of a mystery that even the long-standing and original

Minister of Health, and staunch advocate of WHO programs, Dr. Sione Tapa, has been unable to solve. Nevertheless, the neologism "*mo'ui lelei*" has been useful for ensuring that official medical and health promotion materials are comparable to that found in any 'modern,' industrialized (English speaking)

nation. It is this term that, at least in some contexts, is being reformulated to reify traditional notions of good social relations.

The Tongan medical system is considerably influenced by the various British, New Zealand, Australian, Canadian, and American medical and nursing practitioners and consultants who have either worked in Tonga, or trained Tongans to be doctors and nurses. Since its inception in the 1920's, it has been intended to be fully contemporary (re: training, diagnostics, treatments), while adhering to culturally traditional ideals of *'ofa* (generosity/love), *tauhivaha'a* (tending social relationships) and *fa'iteliha* (free choice). Thus, Tongans enjoy a socialized system where medical services are mostly state-funded and managed. Physicians, nurses, assistant medical practitioners, nutritionist, and health promoters are themselves Tongans. While health promotion has consistently been

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important in medical services, rising costs, in conjunction with the increase in morbidity due to the 'modern health transition,' have placed extra emphases on prevention and cost-reduction through health promotion. I briefly outline some of the key health promotion themes in the following paragraphs.

Maternal-child health messages:

Mother and child health promotion has been a major theme from the earliest sanitation and inoculation campaigns of the 1920's and 30's, through the family planning and maternal-child health programs which dominated the 60's and into the present. Radio programs describing healthy foods for weaning babies are augmented by community-based public health/maternal-child nurses, who conduct well-baby clinics, give inoculations, and lecture on hygiene and breast-feeding. Public health nurses' training sessions offered by the Tongan government under the auspices of the WHO and funded by the United Nations Population Fund (UNPFA) emphasize the nurse's role in pregnancy, infant care, promoting hospital births, and contraception⁷.

Fertility reduction is promoted as birth spacing, in recognition of the strongly pro-natalist orientation of the values of the Christian majority of the population. Non-surgical contraception methods are prioritized by state policy and a variety of options are available free of charge to women living in or near the capital. On outer islands, oral contraceptives are not available, nor considered advisable. According to locally stationed medical personnel, women would forget to take their pills; children might play with or eat them; lack of electricity also makes it difficult to keep pills fresh. While outer island women are well informed about condoms and had heard of the IUD, spermicides are not recognized. Withdrawal method is generally discouraged as being ineffective, breast-feeding is officially considered ineffective after 3 months, and cervical caps or diaphragms are considered culturally inappropriate. On Kauvai, the nurse encouraged women to use Depo-provera injections as the most dependable method for birth spacing.

A Tongan language mothering manual called *Fa'e mo e Fanau* - Mothers and Babies - has been available since 1977⁸. The manual was sold at a very low price through the Wesleyan Church's bookstore, and features an endorsement from the Queen and her daughter, extending the government emphasis on maternal child health matters through the two most influential mediums in Tongan society: the church and the royal family. The manual depicts human anatomy, biological reproduction, preg-

nancy, birthing and early infant development, including diet, hygiene and childhood illnesses, as derived from English-language texts. As I discuss below, Nance uses a biomedical model to describe child health and training about fertility, which does not match with village women's definitions of healthy children or reproduction.

Food and exercise messages

Given the predominance of non-communicable diseases related to obesity, overeating and malnutrition are probably the most significant factors in Tonga's (indeed, the entire Pacific's) health agenda of the late 20th and early 21st century. Health promotion personnel offer radio broadcasts on, for example: infants' weaning foods, feasts and food poisoning, food categories (proteins, carbohydrates, fats, and vitamins), and diabetes⁹. In the radio broadcasts, the message is of food consumption and obesity as mainly a physiological and mechanical relation. Food is described as fuel that needs to be spent. If there is too much taken in, it is stored as fat and the result is an unhealthy, ugly, heavy body. The ramifications are said to affect other aspects of one person's corporeal body. Backaches, foot problems, difficulty with the blood (which is described as too 'high' or too 'sweet'), and illnesses of the heart are directly attributed to overeating. In addition, nutritionists' broadcasts categorize food as carbohydrates, proteins, leafy vegetables, fats, vitamins, and minerals. Special diets are advocated, based on putting these constituents into individual bodies.

These food and exercise messages are accompanied by other more unorthodox campaigns, including the Healthy Weight Loss Competition¹⁰ initiated by the Central Planning Department and the Tongan Food and Nutrition Committee and the king's own very public and high profile attempts to exercise and loose weight¹¹. In the former, people and teams are awarded prizes for weight lost and kept off. In the latter, the once hugely overweight monarch's health is explicitly linked to his physical fitness regime, change in diet, and weight loss.

In the following section, I re-examine these messages, but from the perspective of the residents of Kauvai. I have two goals: I offer ethnographically informed interpretations of these local perceptions so to insert the voice of outer islanders into a discourse from which they have been excluded. Until now, few examples of this type of information are available to help health messengers understand local responses. Secondly, a localized, rural perspective demonstrates that the biomedical categories, and the gender stereotypes of the health promotion messages, are not congruent with village practices or

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principles for being well. It is important for health promoters to recognize that because these are *not* the ways in which health, mothering, childhood, food and eating are constructed in the everyday practices codified on outer islands as tradition –*angafakatonga*– health promoters themselves must begin to conceptualize ‘health’ and ‘health transition’ differently, if they are to be successful in their goals.

Living well: the view from the village

My ethnographic work on Kauvāi made one point very clear: villagers pick and choose *which* aspects of the official health promotion messages they actually adopt, and *how* they will apply or adapt those ideas. The keys to adaptation and acceptance of new ideas are the principles of *angafakatonga* (tradition/ the Tongan way) including *tauhivaha’a* (tending social relationships), *va lelei* (good social relations), *’ofa* (generosity/love) and *fa’i teliha* (freedom of choice). In reviewing the reception of key health promotion themes outlined above, I begin with the emphases on food and eating, and then discuss fertility and mothering. In the final section I show how local definitions of the healthy baby demonstrate a re-invention of the health promotion message for ‘health.’

Categorizing food: nutritional and traditional distinctions

The radio broadcasts and weight loss competitions emphasize a mechanical relationship between food, exercise and illness, wherein illness is considered as affecting a single individual. However, the emphasis on nutritional constituents disregards what may be the most important aspect of food and eating in village life: the social and ritual importance of food. Food is used as a medium of exchange, to maintain good social relations (*tauhivaha’a*), to demonstrate social weight through physical weight, and to demonstrate male cultural competence.

Food is the most frequently used medium of *’ofa* – generosity– and for ensuring people stay *va lelei* –on good terms– with each other. The initial statement visitors will often hear when entering someone’s house is “*na’a ke kai?*” – Have you eaten? Children are constantly being offered bits of food, and food often figures in the game of ‘take and give’ played between adults and toddlers, an early and significant lesson in generosity and reciprocity. Likewise, plates of food go back and forth between households on a daily basis (with an increased intensity on Sundays). The importance of food as a medium for generosity is also demonstrated in the term for selfishness –*kai po*– which literally means ‘eating at night.’

Gender stereotypes that *may* pertain in the urban areas, but are incongruent with rural practices, are also perpetuated through the radio broadcasts. The broadcasts are

directed at a ‘mother/housewife’ who is assumed to be preparing the family’s meals. However, that did not tend to affect the actual meal preparation or food consumption on Kauvāi. Unlike the assumption in the food program transcript, food preparation in traditional communities tends to be age and gender segregated. Teen boys and young males are expected to cook their own food, and may be commanded to prepare food for the entire household. Even when women cook (i.e: when there are no younger adults to pass the chore to), food –*me’akai*– and other edibles –*kiki*– were usually selected by men, on the basis of what was available for harvesting (from land or sea).

Traditionally, food production serves to demonstrate that a man is fulfilling the duties of father, brother and son. Through over-production, men can publicly demonstrate their (masculine) capabilities as farmers and/or fishers. Having enough food to give some away, whether as a sign of affection, in times of need, or by sponsoring a large community feast, also allows men to demonstrate their *’ofa* (generosity/love), and that they have been blessed, i.e., that they stand in good stead with the Creator.

Finally, the nutritional advice disregards the degree to which abundance is culturally prescribed, for both the producer *and* the consumer. In addition to the pleasure and satisfaction it brings, eating is a culturally recognized way of both valuing a gift and the skill required to produce the food. To refuse to eat something – even on the basis of it being bad for one’s health – is profoundly rude and ungenerous. While much of the nutrition-focused health teaching concentrates on diets for young children, Kauvāi parents are interested mostly that children eat *something* and come to recognize that food is the medium for demonstrating personal generosity. What they eat is less important than that they have ready access to as much food as is wanted, and will give food freely as well as receive it. The large body produced by eating well thus demonstrates good, strong family and cultural values. Weight loss, on the other hand, may be interpreted as a public signal of family distress, or individual illness. People who are too thin are thought to be unloved, or members of an incompetent family. It is a recognized given in Tonga, as in many Polynesian societies, that social weight is demonstrated physically, in bodily bulk¹².

Thus, rather than something which needs to be apportioned out, watched lest it create an illness, and gauged according to invisible (nutritional) characteristics, on Kauvāi, food is part of what people use to create and maintain appropriate social relations, to *tauhivaha’a*. To construct food as simply a constellation of nutrients designed to construct a physical body is to deny most of the importance of food. It is not surprising that, of the key public health themes described here, weight loss has been the least successful.

Fertility and choices

Nurses are taught that fertility is the result of natural bodily processes, and that these processes are independent of human interaction, except where that intervention is in the form of an approved barrier or drug, i.e.: condoms or contraceptives. Non-human interaction, such as the influence of prayer, the interests of ancestors or other spirits, and home-produced medicines such as 'blossoming water' – *vai fua* – are officially derided as superstitions or ignorance. Yet, Kauvai women feel keenly the interest of neighbors, kin (alive or deceased) and God in their reproductive status. That others' pregnancies (or lack thereof) fill people's gossip, and extensive pregnancy taboos are still discussed with young mothers, clearly indicate the importance and value of producing children. Fertility is assumed. Failure to conceive is met with concern and a series of treatments, from prayer, to herbs (such as the *vai fua*), to requests for forgiveness. Infertility may

be interpreted as a sign from God that the marriage is inappropriate, and is an acceptable rationale for divorce. Tongan Methodism is pro-natalist, and rural life also encourages large families. While the national agenda of population limitation is motivated by land shortages, the isolated out-islands suffer more from a shortage of labor than a shortage of land¹³. Given these conditions, limiting pregnancy is not something done lightly.

On Kauvai, the minimum number of children considered to be ideal for a family was five to seven, with many parents (men and women) suggesting an ideal family size of ten children. Common also was the notion that every household needed a range of children's ages: adult children provided labor and income; school-aged children were useful with gardens, livestock, and errands; younger ones brought joy. Elderly people lamented the lack of a young child in their house, and people commonly expressed great pity for households without young children. For this reason, it was normal for grandparents to foster and raise one or two of their grandchildren. Current trends towards small family size are viewed with some suspicion. Urban families, in particular, are seen to be producing selfish, greedy, and badly behaved children. Equally, parents with only two or three children ponder the difficulty in teaching their children a fundamental aspect of Tongan culture: how good sharing *feels*.

In contrast to their culturally learned ideals, Tongan public health nurses' training encourages them to exploit any opportunity in a campaign to limit the fertility of the population. Kauvai's public health nurse follows the official health promotion and recommends contraception

strategies closely. She holds quarterly meetings at which she emphasizes the need for family planning, proper nutrition, inoculations, and household sanitation. At the first post-partum visit, she asks women to discuss the manner of contraception with their husbands, and tells them she would return for their answer a week or two later. On those visits she describes the available family-planning options for Kauvai: condoms or quarterly injections of Depo-proveraã. The Medical Officer and the nurse both prefer Depo-proveraã because, as an injection, it is the least susceptible to failure or mishap. It gives nurses a record for tracking purposes and it is not subject to the whims of human emotion or carelessness. However, as Kauvai's nurse told me, and as women I knew confirmed, in practice, condoms are the option of choice for family planning.

The reasons women give for selecting condoms demonstrates the fine cultural play between official policy and its actual reception, in particular how Tongan women

resist official sanctions while appearing to be compliant. In this respect, family planning choices resonate with other forms of dissimulation intended to preserve appropriate relations (*tauhivaha'a*) and accepted as part of traditional Tongan behavior (*angafakatonga*). Such dissimulation is necessary because, as a health professional, the nurse holds a position of authority and is therefore, in certain situations, 'higher' than her clients. According to principles of good *angafakatonga*, this means that what she suggests should be obeyed, or at least seem to be obeyed.

Kauvai women often choose a condom as the contraceptive of choice because it gives them an option that injected contraceptives do not. Of the women who chose condoms for family planning, many did so because they wanted to *portray* themselves as obeying the nurse while retaining the ability and freedom to control the realities of contraception themselves. Choosing condoms meant they could do both. When they next became pregnant, women told me they could say to the nurse "my husband didn't like the condom," or "we used the condom, but it broke." Either statement showed the woman as willing to comply with husband, nurse and state. The nurse, of course, recognized this strategy, and accepted it, both as obfuscation, but also as a sign that the family was being respectful to her. She consoled herself with the thought that at least she was getting them to talk about family planning, and that maybe after the next pregnancy, they would be more compliant. Condoms then, give women a kind of leeway between the public prescription from government officials for limiting pregnancies, personal desires, material necessities, and cultural expectations.

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Kauvai women's contraceptive choices demonstrate a concern with social relationships (*tauhivaha'a*), rather than just their own bodies.

Mothering advice

Nance's manual for mothers is very clearly a well-meant attempt to pass on 'modern' knowledge about female anatomy, gynecology, pregnancy, and infant development⁵. More subtly, it promotes a non-Tongan notion of the person as an individuated body, rather than as a member of an extended family (*kainga*) and a resident of a society which is preoccupied with producing and managing children over generations.

The manual's subject matter of pregnancy and the first three years of a child's life replicate a socially constructed definition of the individual and of gender. This definition is more congruent with Western constructions of infant development. Tongan constructions of childhood, in contrast, begin with a *pɔpɔ* (baby) followed by a child who is *kei 'iiki* or *tei ki'ai poto* –still little, not yet smart–. The latter stage ends sometime between age four and six¹⁴. Similar to the stereotyping in the food broadcasts, gender is also being constructed in this manual. Throughout, it is assumed that women, as mothers and health watchers, will be caring for the infant, even after weaning. The text and endorsements (all female royals) again link mother and child in one seamless gender role of woman-as-mother. Yet, in contemporary Kauvai, neither men nor young boys eschew baby care, nor is it considered unmasculine for males to be affectionate with, or responsible for, babies or small children. On Kauvai, boys can be seen vying for opportunities to play with babies, husbands have acted as midwives for their children's births, and maternal uncles are culturally prescribed as a child's favorite, most trustworthy, and nurturing kin member – the *fa'e tangata*.

To summarize to this point, the health promotion messages attempt to impart a rather verbatim transliteration of Western biomedical ideas about mothering, food, and fertility to the Tongan public. In these scenarios, 'healthy' equals 'freedom from illness,' and biological processes are privileged over social relations. Health in these contexts is mechanical in nature: eat, maintain proper hygiene and personal habits, inoculate children, and take them to the doctor or nurse for checkups for good health. These ideas bring with them stereotypes of gender, individuated instrumentality and social disconnectedness that are not part of traditional Tongan cultural practices. The messages are important, but are not producing the intended result, because while translated into Tongan, by Tongans, they are not grounded in local practice. Given the regional diversity and burgeoning rural-urban divides, they are also responded to differently throughout Tonga. However, something is being

produced, and I would like to end this article with a discussion as to what that is.

Health as appropriate social relations: mo'ui lelei = tauhivaha'a

Kauvai parents' perspective on health differs from the principles underlying the health promotion messages. One place this is demonstrated is their definitions of "healthy children." Below I offer two quotes (my translations) which show that the signs Kauvai parents use to determine that a child is healthy expand upon the information presented through the official health promotion discourse. However, they merge the biomedicalized notion of health-as-physical with traditional signs of living well. Key here are the importance of creating and maintaining good social relations (*va lelei, tauhivaha'a*), freedom to choose for themselves (*fa'iteliha*), the construction of children as members of a wider family (*kainga*), and the ethic of responsibility that family members have to each other over the course of a lifetime and through the generations (*fatongia*). The result is a culturally meaningful reformulation of the concept of *mo'ui lelei*, from health as 'free from illness' to health as 'appropriate social relations.'

The first speaker is a woman who was raised a Methodist and converted to the Latter Day Saints (Mormons) in the 1950's. She is the mother of nine children, one of whom is adopted, and four of whom died. Her description of the healthy child is typical of most I received:

What are the characteristics of a healthy child?
Behaves nicely, active and busy, respectful, do the right things, obedient, learn their prayers and God, lots of energy, work often, strong of body, good appetite, eats freely. (F.A., while weaving, 2/7/92)

The second speaker is a divorced mother of three teenaged sons, all of whom are currently attending school away from Kauvai. She is a lifelong Methodist, and lives with her elderly mother and a handicapped sister. She described how she knew when her niece, a *pusiaki* (adopted) to their household, was *mo'ui lelei*. Many parents echoed her perception that scholastic performance, appropriate behaviors and health are linked:

You can tell when a child is healthy, because they do well in school, and they go to church [*lotu*] and they run and fetch water and help around the house. She doesn't speak badly, and isn't very naughty. She pays attention and she learns and she knows to pray to God. (M.N. 12/12/9)

These mothers were using the term *mo'ui lelei*, but their words show it is a mistake to assume that the use of a term means that its meaning is universal. What *mo'ui lelei* means for Kauvai mothers is not the same as for health professionals. Clearly, on Kauvai, *mo'ui lelei* is not a single construct. The signs (*faka'ilonga*) of a healthy child were

good behavior, being helpful and active, eating the food they were given, worshiping at church, and doing well at school. Not getting sick figured in descriptions, but was not the key element. It is very interesting too, that despite the nurse's quarterly well-baby checks and well-regimented inoculation routine, not one parent connected inoculations with children's health. While no one, to my knowledge, refused to allow their children to be inoculated, it was never spontaneously mentioned as a means to make children healthy. When I asked women why they went to the well-baby visits and why they let their children be injected, they spoke of "pleasing the nurse" and "having a break from other things."

Conclusion

In asking the question, "what has health promotion produced, and what does this imply for our understanding of the health transition?" I am able to answer that, in general, the official messages have privileged a unilinear, didactic approach. The transition has thus been conceptualized as a top-down process whereby people's practices are changed by particular messages, delivered in particular mediums. The authority to determine and deliver the message draws on biomedical models of sickness and health. The expectation is that the message recipients will listen and comply. However, Kauvai's residents are more creative than this. The ethnographic data demonstrates that the health promotion messages are re-invented, re-fashioned to comply with cultural practices, and in the process producing at least one notion of "health," which differs from that of biomedicine. The implications for health promoters are clear: Simple translations of Western-style health promotion messages into didactic messages are insufficient. Culture is vital and resilient. Villagers are active, creative agents, manipulating, re-interpreting and even ignoring health promotion messages, as they see fit. Thus, the key to health promotion must lie in working *with* local community members and localized cultural idioms, rather than simply attempting to bypass or alter them. Hopefully, this knowledge will encourage health promoters to revise their processes, their mediums of communication, and the content of their health messages. We need to see a shift to a more participatory process that includes Tongan health professionals, other collectivities (e.g. churches, men's agricultural groups or *kautaha*), and especially, local villagers and out islanders working together to create new models of and for health messaging. The implications for our understanding of the health transition are also clear: A localized view reveals the need for a model of the health transition process in which mutual shifts in understanding must be recognized by all parties, traditional villager and medicalized health professional alike, before new ideas of 'health' are actualized.

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