

## PRODUCING *WHAT* IN THE TRANSITION?

### Health Messaging and Cultural Constructions of Health in Tonga

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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 and Henry, 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 messaging 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, ‘from communicable diseases to non-communicable diseases’ model, attained through 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 application (Young Leslie 1999). 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 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 which lie near the Tropic of Capricorn, along the International Dateline. Migration, remittances, agriculture and bureaucracy (Bertram and Watters 1985) are key features of the economy. 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<sup>2</sup>, 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 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 lexicon (Parsons 1984, 1985), 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 Mariner (Martin 1819), or the excellent dictionary compiled by Churchward (1959). *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 (p.c. 2002). 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 which, 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 in which medical services are mostly state-funded and managed, and physicians, nurses and assistant medical practitioners are themselves Tongans. While health promotion has consistently been 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) (Tenn 1991) emphasize the nurse's role in pregnancy, infant care, promoting hospital births and contraception (Tenn 1991, Annex 7 pages 71, 107).

Fertility reduction is promoted as birth spacing, in recognition of the strongly pronatalist orientation of the values of the Christian and fairly conservative 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, and lack of electricity 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 employ injectable Depo-provera as the most dependable method for birth spacing.

A Tongan language mothering manual called *Fa'ē mo e Fanau* – Mothers and Babies – has been available since 1977 (Nance, 1977). 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, pregnancy, birthing and early infant development, including diet, hygiene and childhood illnesses, as derived from English-language texts. As I discuss below, Nance's biomedically based descriptions of child health, and public health nurses' training about fertility do 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 20<sup>th</sup> and early 21<sup>st</sup> 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 diabetes (Ministry of Health Radio Program Transcripts). In the radio broadcasts, the message is of food consumption and obesity as mainly a physiological and mechanical relation. Food is described as fuel which 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 too: 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 (Ministry of Health, Radio Program transcripts).

These food and exercise oriented messages are accompanied by other more unorthodox campaigns, including the Healthy Weight Loss Competition initiated by the Central Planning Department and the Tongan Food and Nutrition Committee (Engleberger 2002) and the king's own very public and high profile attempts to exercise and loose weight (described frequently over the past decade, most recently in the Pacific Islands Report, Dec 12, 2002). 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. This is because there are very few examples of this type of information available to help health messengers understand local responses. Secondly, a localized, rural perspective demonstrates that the biomedicalized categories, and the gender stereotypes of the health promotion messages, are not congruent with village practices or 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 as tradition –*angafakatonga*– on outer islands, they 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 Kauvai 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 *tehiha* (freedom of choice). In reviewing the reception of key health promotion themes outlined above, I begin with the emphases on food and eating, 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 & Traditional Distinctions*

The radio broadcasts and weight loss competition indicate a mechanical relationship between food, exercise and illness, wherein illness is considered to be an individuated event. 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 as medium of exchange, in the maintenance of good social relations (*tauhivaha* ‘a), the way in which social weight is demonstrated through physical weight, and how food production factors in demonstrations of (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. But that did not tend to affect the actual meal preparation or food consumption on Kauvai: 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 selected by men, on the basis of what was available for harvesting.

Traditionally, food production serves to demonstrate that a man is fulfilling the duties of father, brother and son. Through over-production, men can publically 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. 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. While much of the nutrition-focused health teaching (radio and the mothering manual) concentrates on diets for young children, Kauvai 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 as well as receive it, freely. The large body produced by eating well thus demonstrates good, strong family values. Weight loss, on the other hand, may be interpreted as a public signal of family distress, or individual illness, and people who are too thin are thought to be unloved, or members of incompetent family. It is a recognized given in Tonga, as in many Polynesian societies, that social weight is demonstrated physically, in bodily bulk (see Pollock, and Young Leslie, n.d.).

Thus, rather than something which needs to be apportioned out, watched lest it create an illness, and gauged according to invisible (nutritional) characteristics, on Kauvai, 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 and thereby miss the opportunity for encouraging a truly appropriate dialogue about enhancing population health. I'm not surprised that, the king's personal fitness program notwithstanding, of the key public health themes described here, weight loss is 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 neighbours, 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 indicates the importance and value of producing children. Fertility is assumed, and 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 land (Evans 2001). These factors being considered, limiting pregnancies 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, while 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, especially as urban families are seen to be producing selfish, greedy, 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 it *feels*, to share. Previously, people now living in the capital have said, the large families meant no one had to teach kids to share, or to take pleasure in giving. But now, with so few children, it's a real problem.

In contrast to their culturally learned practices, 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 recommended 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-provera. The Medical Officer and the nurse both preferred Depo-provera because, as an injection, it was the least susceptible to failure or mishap, it gave them a record for tracking purposes and it was 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 were the option of choice for family planning.

The reasons women give for selecting condoms had little to do with contraception, the negative symptoms associated with Depo-provera, or prevention of STDs. Their rationales demonstrate the fine cultural play between an official policy and its actual reception, and the potential for resistance to the official sanctions, even while appearing to be compliant. In this respect, family planning choices resonate with other forms of dissimulation intended to preserve appropriate relations (*tauhiava'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). Sometimes the requirement to be obedient is gainsaid by another objective. In these cases, dissimilitude is relied upon.

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, if the nurse chastised or even questioned them, they were free to say “my husband didn’t like the condom” or “we used the condom, but it broke”. Either statement represented the women as willing to comply with both husband, nurse and state. The nurse, of course, recognized this strategy, and accepted it, both as an 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, gave women a kind of leeway between the public prescription from government officials for limiting pregnancies, personal desires, material necessities, and cultural expectations. Rather than failure to comply with the agenda to limit population growth, or a misunderstanding of how conception happens or how to use a condom, Kauvai women’s contraceptive choices demonstrate a concern with social relationships (*tauhiava*), rather than the functioning of individual bodies, and a desire for freedom of choice (*fa’i teliha*).

#### *Mothering Advice*

Nance’s (1977) manual for mothers is very clearly a well-meant attempt to pass on ‘modern’ knowledge about female anatomy, gynecology, pregnancy, and infant development. More subtly, it promotes a non-Tongan notion of the person as an individuated body, rather than 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 which is more congruent with Western constructions of child carer, ‘baby’ and early childhood than is traditional in Tonga. Tongan constructions of childhood begin with a *pēpē* (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 six, not three (see Morton 1996, and Bott 195?). 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 traditional Polynesian child rearing practices, and contemporary Kauvai practice too, neither men nor even 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 birth, paternal sisters have more authority than mothers, 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 which 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, and because the assumption is that all Tongans live in the same way. Given the regional diversity and burgeoning rural-urban divides, this likely is not true. But 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 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, but merge the biomedicalized notion of health-as-physical with traditional signs of living well. Key here is 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 parents retain over their children and grandchildren, over the course of a lifetime, and through the generations (*fatongia*). The result is a culturally meaningful refiguration 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, raised as a Methodist 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 have 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 life long Methodist (Chiefly church denomination), 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*. Her perception that scholastic performance and health are linked was echoed by many parents:

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).

**Tongans Construct Health Culturally**

These mother's words show it is a mistake to assume that the use of a term like *mo'ui lelei* implies 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, worshipping 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. Though no-one, to my knowledge, refused to allow their children to be inoculated, neither was it 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".

Tongan cultural constructions of health emphasize ideals and practices coterminous with prioritized aspects of *angafakatonga* (the Tongan way/tradition), most importantly, *tauhivaha'a* (tending social relations), *va lelei* (good social relations), *'ofa* (generosity/love), *fatongia* (familial duty/obligation), *talangofua* (obedience), *fa'i teliha* (free choice), and *tau'atā'ina* (independence).

### **Conclusion:**

In asking the question, 'what has health promotion produced'? I am able to answer that, in general, the official messages intended to enable a health transition 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 messages is biomedicalized. The expectation is that the message recipients will take in the information provided and comply, producing a general morbidity and mortality shift congruent with standardized models in population health literature. Rather than assuming that the targets of health promotion messages are mere recipients, waiting and willing to accept and implement the proposed new ideas, a local view reveals need for a model in which villagers are understood to be active agents, manipulating, re-interpreting and even ignoring health promotion messages as they see fit. Hopefully, this knowledge will encourage health promoters to revise their processes, their mediums of communication, and content of their health messages. We need to see a shift to a more participatory process which includes Tongan health professionals, other authorities (eg: churches, women's groups), and, especially, local villagers and out islanders working together to create new models of and for health messaging. Cultural practice is stronger than simple translations of Western-style health promotion messages into didactic messages. The key to health promotion, and to understanding real health transitions, comes from working *with* local community members, and cultural idioms, rather than simply attempting to bypass them.

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<sup>2</sup> The monarch is assigned by primogeniture, and the current king inherited from his mother, Queen Sālote. He is expected to be succeeded by his eldest son. The Prime Minister is an unelected position, appointed by the monarch. The current Prime Minister is the king's youngest son. His predecessor was the King's younger brother (now deceased). The current king was Prime Minister during his mother's reign. This process has generalized support among the Tongan populace, despite a small pro-democracy contingent. The current PM, in fact, is very popular, partly for his attempts to promote government accountability and efficiency.