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Double Epistemologies and 'Respons-ability' in Public
Healthcare:

Talanoa with Tongans in New Zealand

A thesis presented in partial fulfilment
of the requirements for the degree of

Master of Arts

in

Social Anthropology

At Massey University
Auckland, New Zealand

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2017



Abstract

Pacific health policy in Aotearoa/New Zealand focuses on reducing health inequities between the majority population and Pacific Islander communities. At the same time, the public health system increasingly promotes a neoliberal form of ‘responsibilisation’ that emphasises individual self-help, risk management, and risk reduction. This research engages with Tongan epistemological scholarship to ask: how do concepts central to contemporary western public health philosophy and practice, such as personal health management, individual risk, or managing increased genetic risk, factor for New Zealand Tongans? Using the talanoa methodology of Pacific research, this thesis investigates how members of the Tongan community in Auckland understand the divide separating biomedical models of genetic risk and their own cultural views of health, relatedness, and responsibility. I argue that responsibility-focused public health policy in A/NZ, despite effort to create culturally responsive ethnically-targeted health messaging, can have unintended pathologising consequences for Tongan people. The focus of A/NZ public health policy on ‘reducing inequalities’ makes it harder for the health system to fully recognise the cultural and ontological embeddedness of Tongan models of health. Acknowledging that many Tongans do move within the ‘interstitial space’ (*vā*) between epistemologies I ask how Tongans and their public health practitioners can be ‘responsible’ to one another if they do not understand each other’s realities.



Acknowledgements

Undertaking this research thesis I have benefitted enormously from the support and interest of several people some of whom I already knew and others whom I met on the way. Discovering others' understandings of being human is inevitably enriching and this *talanoa* leaves an impression on me. I trust that the bringing together of these ways of knowing is helpful to those who read it.

Firstly, I offer *fakatapu*/acknowledgement to elders and those in higher authority who are connected to this study, who have gone before me, and to *tāngata whenua*/ first people of this land which I and many others also call home. I share the findings of this Pacific enquiry with Māori and welcome your interest. I also acknowledge the Massey Pacific Research and Policy Centre who connected me to cultural advisor, Dr Sione Vaka. Thank you sincerely to Dr Sione for making connections into the Tongan community for me, encouraging me, giving practical tips to start the writing journey, and for simply trusting me to go *talanoa* to listen and gather Tongan knowledge.

My supervisors, Dr Barbara Andersen and Dr Alison McEwen, wisely guided me through the whole evolving gestation by which this study got to birth. Dr Alison McEwen encouraged my initial interest in Pacific perspectives around genetic healthcare, welcomed an anthropological study in her field of genetic counselling and then also co-supervised and encouraged me as I journeyed, for some part, towards an uncertain destination. Thank you for your wisdom in conversations shared and drafts read. Dr Barbara Andersen's influence on my thinking materialises within this document and beyond. Thank you for your contribution to the eventual direction of this argument, for challenging me to explore pathways along which I was hesitant to venture, for being patient, for reading and commenting on several attempts whilst I found my way, and for your positive, helpful feedback as the chapters grew.

Thank you also to the Social Anthropology staff at the faculty of Humanities and Social Sciences at Massey University Albany, Professor Kathryn Rountree and Dr Graeme Macrae, for whom their students are a passionately pastored family of 'anthro-kin'; also to Manawatū campus Social Anthropology staff, particularly Dr Carolyn Morris, for early support in how my project might be scoped. I especially thank Dr Eleanor Rimoldi for her written support and for reviewing and commenting on the thesis draft, her interest and encouragement constant even in her retirement. To my fellow Master's students: we are a



unique bunch, I appreciate knowing you and thank you sincerely for your encouragement online and look forward to keeping in touch. I would also like to acknowledge and thank Massey University's outstanding distance library service.

I am grateful to the team at Genetic Health Services New Zealand Northern Hub who welcomed the idea of an anthropological study, then supported and participated in my project. Particularly, my thanks goes to genetic counselling team leader, Kim Gamet, who also advocated for me to obtain ethics approval for this research and also gained approval for me to access genetic counselling participants. To Dr Waiora Port, who first argued for culturally appropriate genetic services in Aotearoa New Zealand, thank you for pioneering the way and also for extending warm hospitality when we eventually met.

I am enormously grateful to individual participants who are the voices of this *talanoa*. All of you made a distinct, lasting impression offering me frank *talanoa*. I continue to feel your Tongan *'ofa*/generosity long afterwards and I hope we can *talanoa* again. I express thanks also to the Tongan Health Society Inc. who welcomed my interest and permitted my *talanoa* with their Langimalie staff, and to the Tautahi Fakataha Navigator Team of the Auckland and Waitemata District Health Boards whose *talanoa* with me was revelatory and generous at a critical time. I was also delighted to *talanoa* with artist Semisi Potauaine, who kindly created *amoamokofe kupesi* to illustrate this thesis and I thank him for his *'ofa*.

Thank you to friends and family who supported with interest and help, especially to Sharon Sawyer and my sister, Fiona Duckworth, who each commented encouragingly on the draft of Chapter Six and proofread it. To my dear daughter, Kirsty Storey, thanks for your helpful comments on Chapter Seven from your genetic counsellor viewpoint and for proofreading a few more chapters as well. To my patient husband Phil who first suggested I pursue postgraduate study, my deep gratitude for giving me space to make it happen within our journey through life together. Also our younger daughter, Sarah, thanks for your genuine interest and encouragement of my projects. And lastly, to my ever supportive parents, who have affirmed me for a very long time now; thanks for still doing that.

This study was assisted by the Kate Edger Educational Charitable Trust Master's Degree Award for 2016 for which I am most grateful. And also my thanks go to Massey University for conferring and deferring the Massey Scholar Award 2013 which I was finally able to put to use.



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1. Introduction

This study, exploring perspectives on genetic testing and associated risk among Tongans in Auckland, identifies epistemological and ontological distinctions between Tongan cultural frameworks of disease and the dominant biomedical, secular health system in New Zealand. Biomedicine, which offers physiological and secular interpretations of disease, is viewed by some Pacific people as culturally alienating because it fails to recognise the interpersonal, intergenerational, and often hierarchical relations between people, and ignores the spiritual dimensions of illness. These connections form the basis of agency for many Tongan/Pacific New Zealanders, who understand that people act according to how they see their priorities and obligations to others, including supernatural beings and deceased relatives. Genetic counselling and testing, which reproduce Western¹ cultural understandings of risk, relatedness, and individual choice, do not always sit comfortably with Tongan ways of understanding the world. At the same time, both Tongans and *Pālangi* may reify their differences in ways that limit the possibilities for communication in the clinical setting. As I listened to participants discuss their perceptions my project became less about perspectives towards genetic testing and counselling, and more focused on how multiple and competing epistemologies generate challenges for equitable health care delivery in Aotearoa New Zealand (A/NZ).

When a client's epistemological paradigm is unknown to, or misunderstood by, medical practitioners, deep differences can be mistaken for ignorance, unconcern, or resistance. Likewise, when minority populations such as Tongans presume their own beliefs about knowledge are not valid or appropriate in a medical environment, they may choose to remain silent. Participants in this study reveal a complex epistemic gap which challenges the 'doing' of public healthcare in A/NZ. Echoing Smith (2012), I use this study of NZ Tongans accessing genetic healthcare to ask: whose knowledge is at work here? My inquiry reveals some of the difficulties of serving "other" cultures within a biomedical health system that depends on the epistemological hegemony (Brough, 2013, p. 34) of the

¹ The Māori word to distinguish white/Caucasian/western New Zealanders from Māori New Zealanders is Pākehā. The equivalent Tongan term is *Pālangi*. In the field I referred to myself as *Pālangi* as it is normal practice in New Zealand to accord with the language of culture addressed, and I use it throughout this document when referring to Western/European/Pākehā/*Pālangi* cultures generally.



majority *Pālangi* culture. Acknowledging the western world's place of epistemological privilege in health research, Mark Brough continues:

With such privilege comes responsibility, since the power to conceptualise health problems and their solutions deserves considerable critical, historical, and political reflexivity, particularly at the boundaries between dominant and oppressed cultural spaces. (p. 33)

The term 'responsibility' is significant to this study, especially with its heavy application in liberal democracies like A/NZ, a nation that seeks to be responsible under its Treaty of Waitangi with its first people, NZ Māori, and yet also, in the present era of (neo)liberal governance, increasingly divests responsibilities to citizens, promoting self-responsibilisation. Listening to Tongan people I found my participants drew from other ontological and epistemological frameworks in representing themselves and their agency. This influences how they engage with biomedical services. Despite efforts to accommodate cultural differences among minority and indigenous populations, A/NZ public health care is based on the assumption that recipients see themselves as autonomous and self-responsible (Humpage (2017); Spoonley (2017, p. 109)), for example, in managing increased genetic risk. Individual responsibility has been the subject of biopolitical and bioethics discourses as to social implications with monogeneic conditions, in moral responsibility to be responsible citizens, for example in A/NZ, Fitzgerald, Legge and Park, 2015, on Down syndrome. However, I am not looking at personal responsibility in society in being accountable as good citizens rather I address capacity to respond due to differing ontology and varying knowledge systems, for both practitioners and Tongan/Pacific patients/clients.

Susanna Trnka and Catherine Trundle (2017) gather a collection of claims and challenges viewed through the lens of 'competing responsibilities', including that of care for one another, as in state to/with citizen and corresponding expectation placed upon citizens of personal responsibility for self-health-management in liberal democracies. My thesis follows their theme as I introduce a minority population's epistemology which has its own expectations of responsibilities which do not prioritise what a liberal democracy such as in A/NZ presumes of them; for example to be self-managing for increased genetic health risk (Chapter Six). And I note their clarification that even the most idealist impression of a self-managing westerner is actually deeply entangled in various social and kin others (p. 10).



References I make here to western ideology as individualistic also recognise this generalisation.

The origin of the word *responsibility* is French and Latin rooted in the Christian liturgy as those able to make the *réponse*, those capable of reply from within the congregation to God's representative, the priest, on behalf of the congregation (Trnka and Trundle, p. 4). Thus it can be construed 'respons-ability'; not *all* the congregation but those able to understand and respond on behalf the gathered community.² Listening to participants reveal something of themselves and their worlds caused me to ask: how can responsibility be enacted, for example, in public health service delivery when one does not know the world of another one seeks to provide service to?

I suggest that neither health practitioners, nor many of A/NZ's Tongan/Pacific population, are in a position to respond, as in 'respons-ability', without better understanding each other's worlds. There are, however, Pacific New Zealanders who possess 'doubled' epistemologies and daily live multiple realities. Some participants in this study speak to me from that position, an interstitial gap, to draw on Homi Bhabha's concept (1994) of people labouring back and forth across cultural boundaries. Aware their training and/or employment places them in this location, one participant in particular speaks to their own sense of responsibility to other Tongans. Others in the Auckland Tongan population are less able to respond to the expectation of NZ's public health system on them because their cultural worldview is drawn from another epistemology and ontology in which, although western medicine has long been part of life in Tonga, cultural beliefs and responsibilities can take precedent.

Mindful of 'respons-ability', I ask where do concepts central to contemporary western public health philosophy and practice, such as personal health management or managing increased genetic risk, factor for NZ Tongans? How might heredity be viewed? Does Tongan social ranking impact on Tongan people's engagement with medical /healthcare? To address these questions I engage Tongan scholarship as a *Pālangi* New Zealander in an attempt to negotiate an interstitial space for inter-cultural research and dialogue (Mila-Schaaf and Hudson, 2009).

Tongan philosophers have theorised this type of space through the concept of *vā* which I define further in Chapter Four. Rather than offer a traditional account of Tongan culture or

²Responsibility was presented by Susanna Trnka as an emerging key theme in Medical Anthropology at the SOMAA Symposium Wellington at which I was present, February 15, 2017.



epistemology, I experiment with both a politics of research and challenge politics of responsibility in contemporary healthcare. I take up a Pacific research methodology, *talanoa*, which I introduce in Chapter Two and Chapter Three reviews scholarship from several disciplines: Pacific epistemologies, medical and social anthropology of Tonga, genetic counselling research in multicultural settings, and local health promotion discourse. In Chapter Four I introduce major elements of Pacific/ Tongan ontological and epistemological realities which participants raised in *talanoa*. The role of spirituality and spiritual beings within concepts of social and physical wellbeing, disease and its causality is identified. Also identified within contemporary culture are concepts of *tapu* and *mana* enfolded with Christian belief and with medicine.

I further explore this in Chapter Five focussing on collective relatedness in a ranked social order, using two examples: perceived relationships with medical professionals and the place in the family of the *mehikitanga*³/ father's eldest sister. I also show dilemmas of familial obligations around collective and hierarchical expectations to be seen to show 'ofa/love and *faka'apa'apa*/respect as above individualistic focuses, such as prioritising self-management of one's health risks. Some participants mention burden of monetary and gifting responsibilities for special events in this contemporary Auckland setting, some expressing agency to make changes, others not.

From the framework of this pair of chapters, Chapter Six then argues that, Tongan New Zealanders are assumed to be able to participate within a public health system which is marked by divestment of state care into assumptions of self-autonomous responsibility including management of risk. Secular/physical health care service neglects important non-biological aspects of humanness for Pacific/Tongan people. This section raises too the predicament for Tongan and other Pacific people of being stereotyped subjects of health messaging which, these *talanoa* indicate, leads to pathologised identities, and challenges unintended consequences of public health policy in A/NZ.

Lastly, in Chapter Seven, I offer similarities located during this study between Tongan knowledge and that of genetic counselling practice which can perhaps be utilised for empathetic encounter honouring of both epistemologies. Taking up the Tongan weaving style, *kupesi amoamokofe*, I suggest first steps towards sharing and learning one another's

³ Also spelt *mehekitanga* by several scholars cited here: Thaman, Herda, Douaire-Marsauldon, Völkel and Mills.



epistemologies in multicultural A/NZ is to acknowledge and encourage empathetic approaches.

Site and Significance of this Study

Aotearoa New Zealand (A/NZ) can be distinguished by both its singular all-encompassing Te Tiriti o Waitangi/Treaty of Waitangi of 1840 and its placement on the contemporary political landscape as a liberal democracy employing neoliberal economics in government policies (Bell et al (2017); Kelsey (1997; 2015); Signal et al (2015, p. 177)). This nexus is an intriguing site anthropologically within which to raise health-related experiences of a particular Pacific ethnic population. This is because the principle of (re)distributive equity in service provision comes into conflict with a neoliberal economic agenda that emphasizes individual self-management and opportunity. Some ethnic populations—namely, Māori and Pacific Islanders—are sectioned under Treaty principles to address lower health status statistics. These populations are most negatively affected by growing inequalities in NZ society resulting from the devolution of state welfare responsibilities, among other factors (Signal and Ratima, 2015, p. 8; Signal et al, pp. 169, 175).

Within A/N Z's state-funded health care system, the Genetic Health Service New Zealand (GHSNZ) serves all residents and citizens. This study was initiated because I learned that genetic health professionals were interested in how Pacific people view inheritance and genetic services. However, the project was expanded to consider broader cultural perceptions about health. International genetics literature pertaining to specific cultural perspectives towards genetic testing and cultural competency in genetic health services is still small (Warren, 2011 (USA); Kowal et al, 2015 (Australia); Morris et al, 2015 (South Africa)). Ethnic disparity has been previously noted in studies of participation in genetic screening in international and local research (McEwen 2011, pp. 10, 11). Addressing culturally appropriate approaches has been taken up in A/NZ by Port (2007) embracing Māori frameworks (kaupapa Māori); also Port et al, (2008), highlighting consideration be given to serving the needs of collective family groups and collective decision-making. And Taupo (2012) asserts that genetic testing and biobanking with her work with Māori groups is an interface of multiple knowledge systems. She acknowledged that no one clear Māori epistemology existed in her study although they were ontologically spiritual and cultural in content, and thus distinct from the knowledge systems of biotechnologies under discussion in her small three group study.



Counselling principles and praxis of empathy suggest where to begin to understand Pacific people for who they are, how they perceive themselves. This is the intent with which this research is offered back for further *talanoa* to members of the Tongan community who shared something of their knowledge to create it, for dissemination to health practitioners, especially genetic counselling practitioners wanting to better know and understand clients' worlds, and Medical Anthropology discourses.

Snapshot Aotearoa New Zealand

Why do institutions in Aotearoa New Zealand worry about 'Pacific Health'? Like many settler colonial nations, A/NZ has a history of ethnic reification through statistics and health indicators. Whether this is for the general good or further promotes racism has been debated by sociologists, such as Stephen Epstein (Lock and Nguyen, 2010, p. 351 cite Epstein, 2004).⁴ A/NZ's specific historical and political situation, defined by the Treaty, is believed to justify the continued division of the population into ethnically-defined groups with differing needs, entitlements, and obligations. Acknowledged interpretation of Treaty obligations is for both partners in the relationship, Māori and all other New Zealanders, to fully participate in society including through access to state-funded health services, which includes Genetic Health Services New Zealand, for example. Thus government bodies, including health providers, in A/NZ continue to record patient ethnicity⁵ to measure its progress in seeking to improve, for example, the wellness of disadvantaged population groups, particularly Māori and Pacific populations. New Zealand's Asian, immigrant, rural, and refugee populations are also sectioned. ⁶

A/N Z's obligations to all its people is seen to validate sectioning by ethnicity, not as a colonial hangover but as a progressive and positive effort towards the principles on which it founds its national existence. This can be contrasted with other Western liberal democracies, such as France, which reject as a matter of principle the collection of statistics

⁴ The reification of ethnic groups through statistics has also been critiqued by Caulfield in the *Health Law Review*, 16:3 (2008); Finlay (2014) *Ethnic statistics: Ringelheim, reification and the residuary method*, *Ethnic and Racial Studies*, 37:5, 753-756, (DOI: 10.1080/01419870.2013.870666); Watson 1981 *Canadian Review of Sociology/Revue canadienne de sociologie*, Volume 18, Issue 4, Version of Record online: July 14, 2008.

⁵ As opposed to colour or race. See Epstein and others interested in classificatory practices; Tutton et al 2010. Rapp and other northern hemisphere ethnographers choose to use 'colour' as a descriptor, A/NZ doesn't, although ideologies of descent, blood, and phenotype are in many ways similar.

⁶ <http://www.health.govt.nz/our-work/populations>, [accessed July 7, 2017].



on ethnicity, and other former British settler colonies, like Canada, where the collection of ethnic and racial statistics is optional, irregular and controversial.⁷

Nationhood Under the Treaty of Waitangi

The Treaty of Waitangi underpins how this nation continues to build itself. It undergirds all legislation and public policy. Māori, together with other New Zealanders, regard it as precious taonga/gift, a covenant between two peoples under God, Māori and Pākehā, an ongoing relationship (Metge, 2010, p. 5) and the basis on which New Zealand stakes its nationhood: kāwanatanga (good governance), tino rangatiratanga (self-determination) and ōritetanga (equity), (Delany et al, 2015; Sullivan, 2005, p. 123). Importantly, the Treaty is a partnership, thus as relationship it enables and equips this nation's people to face and act on issues of colonisation, decolonisation and beyond. Sullivan clarifies that the Treaty principles of partnership include responsibility, which requires both parties, Māori and the Crown, 'to act reasonably, honourably, and in good faith' (p. 123).

Initiated by activism around historical grievances and articulating insistence for self-determination, Māori, the first people /tāngata whenua, have led the way over the past thirty years or so resulting in A/NZ governments recognising and creating legislation which honours and accords with this treaty: the Waitangi Tribunal to address Maori historical grievance claims against the Crown, incorporating Māori concepts into education, environmental resources, business, and in health whereby the New Zealand Public Health and Disability Act 2000 'provides for the recognition of the principles of the Treaty of Waitangi in health and disability support. With the aim of improving health outcomes for Māori, the Act also provides mechanisms to enable Māori to contribute to decision-making and the delivery of health and disability services' (Human Rights Commission, Human Rights in NZ, 2010⁸). Thus an emphasis on culturally attuned, holistic policies such as 'by Māori for Māori' initiatives have and continue to be brought into being.⁹

⁷ For example, <http://www.dlsph.utoronto.ca/2015/10/should-we-routinely-collect-data-on-race-canada-at-a-crossroads> [accessed July 7, 2017].

⁸ https://www.hrc.co.nz/files/2414/2388/0497/HRNZ_10_Human_Rights_and_the_Treaty_of_Waitangi.pdf page11 [accessed February 21, 2017].

⁹ For example, New Zealand Health Research Strategy 2017–2027: Summary of submissions and consultation. Wellington: Ministry of Health. February 2017, key theme # 28, page 7.



'New Zealand has a special relationship with Pacific people'¹⁰

Guided by this bicultural Treaty which accords place for non-Māori, A/NZ endeavours to become a multicultural nation by extending the principles of the Treaty to all who live here, each wave of migrants, including waves from the Pacific Islands. This has not always been the case. One of New Zealand's darkest race relations episodes was the 1970s 'dawn raids' on Pacific Islander migrant workers who had allegedly overstayed their visas, which proved to be unjustified targeting of particular ethnic groups.¹¹

Since 2000, Pacific people have been constitutionally accorded a special position in A/NZ due to 'historical relationships', there being 'high proportions of Pacific peoples in New Zealand', and also due to the geographical proximity of their homelands.¹² Pacific people made up approximately 7.4% of New Zealand's population in the 2013 census. Along with Māori and Asian, they are the fastest growing population within New Zealand (NZ Statistics). However, Pacific New Zealanders are over-represented in many government statistics relating to low socio-economic status, including lower life expectancy and ill health issues. Thus disparities in health status among (Māori and) Pacific peoples makes equity in health care a 'high level government priority'¹³ as A/NZ attempts to provide equity in health status across its population groups (see also Signal et al, 2015: 169).

Unhealthy People

Generally, public discourses about Pacific health in New Zealand are heavily laden in negative language and "deficit talk", associating Pacific people with high levels of chronic ill health, poverty, and social marginality. (For examples see: Tu'itahi and Lima, 2015; Health Research Council website: <http://www.health.govt.nz/new-zealand-health-system/new-zealand-health-strategy-roadmap-actions-2016/section-action-areas/people-powered>; and <http://www.teara.govt.nz/en/pacific-island-health>). At time of writing the current Ministry of Health website page for Pacific Health concludes 'the health system is responding inadequately to the health needs of Pacific peoples', that 'preventative measures and

¹⁰ https://www.hrc.co.nz/files/2414/2388/0497/HRNZ_10_Human_Rights_and_the_Treaty_of_Waitangi.pdf.

¹¹ <https://nzhistory.govt.nz/culture/the-1970s/1976> [accessed July 7, 2017].

¹² Section One – General 4 - Human Rights and the Treaty of Waitangi, p.49 [accessed February 23, 2017].

¹³ <http://www.health.govt.nz/publication/new-zealand-health-research-strategy-2017-2027-summary-submissions-and-consultation>; <http://www.publichealthworkforce.org.nz/public-health-employment-workforce-tuk.aspx>



treatment [be] tailored so that they are more effective for Pacific peoples’¹⁴ an ongoing acknowledgement of state inability to make a significant change in spite of large scale efforts to resource Pacific primary healthcare providers, to train a culturally competent workforce in Pacific Public Health implemented by various NGOs such as *Te Pou*, formerly *Le Va*, and *Te Uru Kahikatea*¹⁵, and to prioritise Pacific issues in public health research.¹⁶

Politically/historically this situation converges with A/NZ’s devolution of state responsibilities in favour of increased NGO and community involvement and the era of ‘health promotion’ (Kelsey, 1997; 2015). A/NZ moved towards a diminished role of state through lessening a sense of entitlement and interventionism in favour of more personal responsibility, a trend which Lock and Nguyen describe as beginning in the 1970s in North America (2010, pp. 80,81).

Since 2008, the tenure of the most recent centre right National Party led government, a narrower focus towards self-responsibilisation in the form of ‘healthy lifestyles’ has been evident (Tu’itahi and Lima, pp. 71, 78). Whilst many Pacific communities embrace this by encouraging their people to improve their physical, emotional, and spiritual health and well-being, health disparities remain. Moreover, the discourse of ‘healthy lifestyles’ may reinforce the association of Pacific populations with ill-health and lack of responsibility. Despite the mainstream representations of Pacific communities as ‘unhealthy’ or insufficiently concerned about health, community initiatives are not new. A/NZ Pacific leaders initiated their own NGOs and societies promoting and supporting health and welfare during the first major waves of immigration in the 1970s. For example, the Pacific Island Health and Welfare Society, established in 1978, and the Tongan Health Society Inc., whose Auckland medical centres, Langimalie in Onehunga and Panmure, bilingually offer a holistic range social services which extend beyond the norms of a General Practice surgery.¹⁷ Pacific churches have also been utilised as suitable settings for health promotion due to their prominent and importance place in both leadership and regular gathering of Pacific people. Targeted campaigns have included being offered morning tea with your vaccination after church on Sunday (pp. 67-72; Walton et al, 2015, pp. 251, 252). Thus

¹⁴ <http://www.health.govt.nz/our-work/populations/pacific-health/tagata-pasifika-new-zealand> [accessed July 15, 2017].

¹⁵ ‘The Public Health Workforce Development Plan (2007-2016) (TUK) is the national strategy to guide public health workforce development in within Aotearoa, New Zealand, over the next 10+ years’.

¹⁶ <http://www.health.govt.nz/publication/new-zealand-health-research-strategy-2017-2027-summary-submissions-and-consultation>

¹⁷ <https://www.healthpoint.co.nz/doctors/gp/langimalie-health-centre/>



biomedical promoters and practitioners, both Pacific-identifying and not, over a considerable period of time have encouraged and facilitated Pacific people to engage with biomedical services and to manage their health and wellness, to the point that Pacific people might rightly see themselves as a stigmatised population group whilst others perceive them as a ‘problem’ or burden on the health system.

Tongan New Zealanders

A/NZ has the highest overseas Tongan population (Addo, 2013, p. 18 cites Lee). Tongans make up approximately 20 per cent of A/N Z’s Polynesian population — 60,000 people, of whom 60% were born in A/NZ; 80 per cent of NZ Tongans live in the Auckland region.¹⁸ Other significant Tongan populations are located in Australia and the western USA but due to previous immigration laws in those nations and, although the traffic headed there has increased, New Zealand remains the ‘developed nation’ destination of choice for most Tongan emigrants (ibid). The royals and elite of Tonga sent their children to A/NZ for education starting in the early twentieth century followed by major waves of ‘commoner’ Tongans during 1970s and 80s migrating for education and employment that would offer them a higher standard of living and, importantly, income with which to support their families back home. Skill acquisition was particularly encouraged by their then monarch, George Tupou IV, who recognised Tonga’s need to be able to participate in a globalising environment (Hau-ofa, 2008, pp. 167, 168). Many Tongan families are now entering their second or third generation in A/NZ.

Today more Tongans live outside the island kingdom than in it with the total population around 106,000.¹⁹ The 150 Tongan Islands in the western Pacific, of which thirty six are inhabited (Völkel, 2010, p. 7), were gathered into a nation from scattered tribal settlements by an ambitious chief Tāufa’āhau. With support from British Christian missionaries between 1831 and 1875, he proclaimed himself King George Tupou 1 and then set up his Westminster style constitution, complete with regalia; his descendants continue to rule today. To use Niko Besnier’s terms, Tonga straddles the edge between local and global, unavoidably participating in modernity whilst also trying to preserve the dignity of Tongan decorum and values (Besnier, 2011, pp. 29,240).

‘Eveli Hau’Ofa argued that the rise of many of the commoner class to noble status due to education gained in places like New Zealand has eroded the influence of Tongan

¹⁸ <http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-culture-identity/pacific-peoples.aspx>

¹⁹ <http://countrymeters.info/en/Tonga>



aristocrats, strengthening democratisation and the advantages of commoners (2008, pp. 167,168). What is of note for this introduction to Tongan New Zealanders is that, Hau'Ofa's 99% of Tongans being commoners, bring something of this sense of lower status with them to their new country, and those who are looked up to recognise their status also. This means that 'Tongan culture' and 'Tongan values' are highly politicised, as they are deeply linked to this ongoing realignment of noble/commoner relations. Vaka raises this shift from monarchy to democracy, 'letting go of one's original knowledge' being a key disruption of social structure which Tongans face which, in losing, threatens their very identity (2014, p. 56). In a diasporic context—New Zealand—where Tongans are also a racialised ethnic minority, these cultural politics become even more complex. In her ethnographic study of women adapting the production of woven mats for exchange between New Zealand and Tonga, Ping-Ann Addo identifies the need for further study into how Tongan–NZ communities live out the complexity of their identity (2013, p. 29). This enquiry adds to that discourse.

Genetic Services in Aotearoa/New Zealand

People are referred to genetic counselling for a range of conditions including cancer, cardiac, neuro-genetic and pre-natal, in most cases by specialist or GP referral. Genetic counsellors must be knowledgeable about an extensive range of genetic conditions and diseases to effectively support their clients. In Australasia, genetic counsellors and clinical geneticists are distinctly different roles but work together as part of multi-disciplinary teams to serve their clients/patients. This is not necessarily the case elsewhere. For example, in the Netherlands, genetic counsellors were all physicians in Taussig's ethnography of genetic practice (2009, p. 69); and Elackatt (2013) calls for genetic counselling to be recognised as a distinct profession in India where various other medical professionals continue to take the role. The profession's evolution to a specialist role albeit historically via multiple pathways, was also noted by Rapp (2000), of becoming a genetic counsellor in the USA.

Operating out of three hubs, Northern (Auckland), Central (Wellington) and South Island (Christchurch)²⁰, genetic counsellors in A/NZ are allied health professionals trained in genetics and counselling, who work as part of a healthcare team to inform and support clients who are seeking information about inherited conditions and how they might affect them or their families. They interpret complex genetic test results and assist clients

²⁰ <http://www.genetichalthservice.org.nz> [accessed January 7, 2017].



understand 'how family and medical histories may impact the chance of disease occurrence or recurrence, which genetic tests may or may not be right for them, and what those tests may or may not tell'.²¹ In these ways, genetic counsellors empathically support clients to make informed choices about conditions.

Process and Consent

GHSNZ referrals are triaged according to urgency. Information about family tree and medical history is sought prior to the appointment although only some clients manage to complete them. Genetic counsellors construct a family tree using the information the individual/family provides. HGSA regulations (2015) state it must be sensitively and confidentially recorded. The more information that is provided on the family history the more specific and accurate genetics professionals can be in their assessment process. Consent forms are required to be completed when permission is sought to release medical information about family members. Appointments are up to an hour's duration and clients are welcome to bring relatives or friends. The majority of people referred for genetic counselling are seen once although some individuals and families return and are seen over a span of years. Consistency of practice among the hubs is important as different members of the same family might well be seen in different clinics in the country. GHSNZ try hard to make sure they are giving families consistent information.²²

Professional Training

To train to become a genetic counsellor in Australasia, a two year clinical Master's degree is available out of Sydney or Melbourne. This is followed by several years of clinical work and completion of a portfolio of work to become fully certified (McEwen et al, 2013). Because training is delivered out of Australian universities, the Treaty of Waitangi is not formally addressed in their curriculum. However, an A/NZ practicum enables emphasis on cultural competence in the teaching curriculum. Students get to work alongside Māori and Pacific families, where possible, to learn different ways of thinking, for example, about taking family trees.²³ Once genetic counsellors are employed in A/NZ, they have the opportunity to attend various types of training through the District Health Boards which include aspects such as Te Reo/Māori language and cultural competency. GHSNZ would like to employ ethnically Pacific genetic counsellors to cater for Pacific populations in ANZ; presently all

²¹ <http://www.nsgc.org/page/whoaregcs> [accessed February 23, 2017].

²² Telephone interview with Alison McEwen, Senior Genetic Counsellor CCDHB and Chair, Australasian Society of Genetic Counsellors, September 20, 2016.

²³ Alison McEwen, September 20, 2016.



are of European descent. The offshore training location (Sydney or Melbourne) may contribute to inequities in training.

Cultural Considerations for Māori and Pacific in A/NZ Genetic Counselling

GHSNZ recognise and accommodate cultural preferences in working with families of 'collective cultures' such as Pacific and Māori. They facilitate family group consultations as well as individuals. Logistically and professionally group counselling in itself brings challenges to make sure each individual's questions are heard and needs met in group environments. Counselling more than one or two people at once makes it increasingly difficult for the genetic counsellor to fully individualise the situation and needs of each individual participant, so their challenge is ensure all receive due appropriate attentive counsel.

On occasion GHSNZ is involved alongside large family groups working through a genetic condition over lengthy periods of time and in different locations. This can be over several years and with several generations of the family group hence the need for service, information and its dissemination to be consistent across the nation.²⁴ Genetic counsellors find that communication with Māori or Pacific families is often through one person who 'naturally' becomes the lead contact, although this happens regardless of ethnicity. Once rapport with the client family is established, GHSNZ tries to accommodate and support Māori or Pacific families talking together in their culturally appropriate place to meet. However, due to resource constraints of the public health system, this isn't always possible. They do, for example, use whānau/family care rooms at the hospital. Occasionally, a visit to a private home or marae/community meeting place is arranged. Genetic counsellors have facilitated situations where one collective decision is made for the entire family, even though this is not a cultural norm for them personally. For example, a top-down decision made by one elder on behalf of all to test and, if positive, all will undertake preventative surgery.²⁵

Genetic Services Northern Hub

In Auckland, home to most of New Zealand's Pacific population, genetic counsellors find Pacific people 'usually compliant and don't arrive ready to ask questions, more to receive information' (Northern Hub Team leader, September 9, 2016). Counsellors are aware that even if Pacific clients take a test, they don't necessarily want to know the result. When I asked, genetic counsellors explained they are aware of some 'cultural' commonalities

²⁴ Phone interview with Alison McEwen, September 13, 2016

²⁵ Ibid.



among Pacific clients. Consistent examples of Pacific ‘characteristics’ were their compliance; they don’t like to say ‘no’ to people they perceive to be in authority. One explained that at a consultation, she might infer from a Pacific client’s body language that they might not want to proceed to testing but isn’t saying so. She then suggests they go home and think it over with their family with the result she doesn’t hear from them again.²⁶ In such ways these genetic counsellors try to act with cultural sensitivity but they explain to me they are not always confident they offer best care and cultural competency when they are uncertain about impact of clients’ cultural perspectives on their relationship and service provision.

Conclusion

My aim here has been to introduce for a range of readers, the site and the people of this study, initiating an intercultural enquiry into the challenges faced in the delivery of biomedical services (focusing on genetic health services) in contemporary, multicultural societies. In a politicohistorical era which places increasing emphasis on individual responsibility, and Treaty-principled public health policies aimed to redress inequity for Māori and Pacific, I introduced ‘respons-ability’ to argue, that in spite of acknowledgment and provision for dual/plural knowledge paradigms in A/NZ, public health providers and Tongans can still misunderstand or overlook one another’s realities and priorities. I outlined that my discussion draws on concepts from Tongan epistemology/Pacific theory and use my informal *talanoa* data to discuss whether Tongans or biomedical health providers can be ‘respons-able’ across the gap of each other’s realities.

²⁶ Interview with a genetic counsellor, Northern Hub, September 9, 2016



2. Methodology

Overview

For this study I initiated contact with five Tongan participants: Siosifa and 'M' I met through my own contacts. Reverend Simeone and nurse Faleola I met through project cultural advisor, Dr Sione Vaka. When permission was eventually granted for me also to contact seven clients of Genetic Health Services Northern Hub through Auckland DHB, one, 'Ana, also became a participant. My information and consent forms reflect the intention to engage with primary participants (as those connected to Genetic Health Services NZ) and secondary participants (those who were not). However, with only one participant a genetic health service client, *talanoa* with Tongan participants ranged around their perspectives of illness, hereditary conditions, engagement with health services, and their families.

Therefore, this study was not *talanoa* about the actual experience of genetic testing or genetic counselling. For most of these participants, our meeting was one off, average time was 1.5 hours, and other than M and 'Ana, I met them at their workplace. I met 'Ana at a cafe near where she lives. 'M' and I met on several occasions in a variety of situations (her home, church, and other public spaces), the multiple 'hanging out' together being encouraged by her. Towards the end of my field time I also met members of Pacific Health Tautai Fakataha Navigator Team at Auckland City Hospital, two being Tongan, who I also consider to be primary participants. Thus all seven Tongan participants became primary informants as they offered me their perspectives and experiences as Tongan people contributing their views and stories.

Secondary participants were not Tongan. They include four genetic counsellors (three face to face and one by phone), a General Practitioner who attends 100% Tongan patients at Langimalie Tongan Health Centre (*talanoa* was with the Tongan nurse included above), and by telephone, a high school nurse who works with Tongan students and colleagues. In each *talanoa* or meeting permission to audio-record was obtained in writing, enabling me to fully engage without being distracted with note-taking.

In recent years academics have formalised and theorised *talanoa* as a Pacific-appropriate research construct which can encompass several cultural levels; be formal or informal. Ease encountered in *talanoa* with these Tongan New Zealanders, I take to be because we



all were accustomed to day to day cross-cultural interactions in this city we call home. Participants recruited through introduction by others were obliging in sharing themselves and their time, as was the genetic counselling client whom I cold-called and was willing to share. As I will explain, I lacked sufficient culturally appropriate introduction for most Tongans presently referred to genetic counselling services. Two said yes to me when I first rang, but I was unable to arrange to speak with them in spite of several attempts and some I failed to speak with altogether.

Talanoa, within this small study, is more an ideal reflecting my intentions and desire to conduct responsible research: intending empathy in engagement, intending appropriateness in intercultural research, and which proved to be an unfulfillable ideal in such a short time. Whilst I aspired to enter an 'empathetic apprenticeship' of *talanoa* (Farely and Nabobo-Baba, 2014), the gap between expectation and reality has been wide. Nonetheless I believe the place in which my participants and I meet in *talanoa* here is a small but positive negotiation of *vā*, that is towards a Tongan sense of relatedness.

This study illuminates the complexities of attempting intercultural research, particularly in the A/NZ health research environment. For example, following cultural protocols does not instantly grant access to intercultural dialogue, although it is an important first step; possessing an empathetically-attuned heart does not necessarily unlock barriers but one's attitude throughout is equally important. To perceive ongoing silence as a 'no', as I did, was possibly unfair of me. However, the scope of this study was too small to better negotiate these perceived barriers, such as by engaging a cultural mediator to assist in person with some introductions, and also too short to better develop relationship with those who did participate. I suggest it does illustrate the value of an anthropological perspective on issues for all those engaged in Pacific health, genetic health and public policy in A/NZ.

Methodology Paradigm: Towards *Vā*

This thesis attempts to negotiate a research pathway to connect with another's culture as far as I am able as an outsider. I utilise Pacific research frameworks to undertake the study (research method) to engage with another's way of knowing and their reality in life as lived (ethnography). In so doing I draw on scholars who have long urged the acknowledgement of other's realms of reality and knowledge, to address ongoing disparities faced by Pacific Islanders in A/NZ (Thaman, 2003; Cram et al, 2013, p. 22). In places like A/NZ the existence of dual/plural knowledges and realities might be acknowledged as belonging to certain



people but impact is lost or misunderstood or incompatible with the system of the majority (Reynolds, 2016, p. 197). Although I can't claim to represent Tongans or their culture I believe this piece of research is nonetheless valuable as it attempts to listen carefully and to make a space for consideration of this gap/*vā*. I also acknowledge that this project, uninitiated by Tongan people themselves, is not self-determined indigenous research as called for by Smith (p.187), which is usually interpreted to include Pacific research. Nonetheless I hope to justify its worth as a contribution to A/NZ Pacific research in spite of my position as a *Pālangi* researcher. It may be more valuable as autoethnographic *Pālangi* research with Pacific people.

As *Pālangi* seeking to undertake research with a Pacific population, I was wary of being viewed as undesired researcher, particularly an anthropologist, as perpetuating 'colonial pasts' which A/NZ, nationally including within academia, continues to make efforts to move on from. Positively acknowledging scholars who urge Pacific people, as indigenous people, to interpret their own history and culture (Smith, (1999)/2012; Thaman, 2003; Sanga, 2004; and others), I began this journey hesitantly, humbly deliberating how I might engage another's knowledge system to make a positive contribution towards an intercultural conversation (Mila-Schaaf, 2006; Cram, Chilisa, and Mertens, 2013). Thus the paradigm for this study is to initiate intercultural conversation, employing a Tongan/Pacific method to reveal Tongan perspectives to reveal and validate Tongan/Pacific thinking and edify those of us outside this community.

Theorising *Vā*

Vā, the Pacific term which sums ideas pertaining to socio/spatial relations, is half of the binary of Tongan *tā/vā* reality of holistic connectedness recognised within Pacific Studies and Pacific anthropology as a theoretical construct since it was first advanced by Mahina (1992) and developed by Ka'ili (2005), Mila-Schaaf (2006, 2009), and others. In Pacific theory all things hold together through *vā*: people, natural environment, spirit and time (Wendt, 1999; Mila-Schaaf, 2006; Vaioleti, 2006 all quoted by Reynolds, p. 194). Whilst *vā* can be understood differently across different Pacific cultures, Tongan understanding particularly emphasises interconnections which balance and hold everything in place (Reynolds, p. 194, 195; Ka'ili, 2005, cites Mahina, 1999) and Poltorak (2007, pp. 12,13) uses Wendt amongst others to prefer the sense in English of 'relatedness' over 'relationship'. As a conceptual tool, *vā* and also *tauhi vaha'a*/the nurturing and maintenance of the related harmony among kin being integral to healthfulness (Ka'ili 2005, p. 92; Poltorak, 2007, p. 12), have been used in recent years to frame and theorise Pacific healthcare in A/NZ such



as within mental health (Mila-Schaaf & Hudson, 2009; Poltorak, 2007). I adopted the concept of *vā* for this project, creating relational space between two knowledges, where shared universality of being human was expressed in talking within experiences we already shared: parenthood, family life etc.

The essence of sharing *vā* with an outsider in this enquiry is the gift offered of opportunity for relationship, to listen to lives and to listen for knowledge imparted in the *talanoa* defined below. I suggest I am recipient of Sister Nokise's wisdom (Mila-Schaaf, 2006, also cited by Reynolds, 2016, p. 200):

When you live *Vā* as a Pacific person you are always aware of your standing with others "how we understand ourselves in relation to the existence of other people. This perception is something we Pacific people know well. But the challenge for us is to expand it to include others in our community who are not of Pacific origin. We need to display in actions and attitudes that we are not primarily individuals but parts of a communal whole. We are creatures within a connect of relatedness."

Strategy: to *Talanoa*

Literally, *talanoa* is to talk about nothing in particular (Vaiotei, 2006, 'Otunuku, 2011). I use *talanoa* for my enquiry as it belongs to the cultural system of the people concerned. *Talanoa* captures Tongan worldviews like collectiveness and circular ideologies not found within the individual and linear ideologies behind conventional research (Vaka, Brannelly, & Huntington, 2016; 'Otunuku, p. 43). Informal *talanoa* communication is used as a methodological tool from which to later think and write, and create opportunity for cross-cultural interface grounded in Pacific ontology and epistemology (Fairbairn-Dunlop and Coxon, 2014, p. 19). In the last decade, *talanoa* as both theory and tool has become increasingly prominent methodology across the Pacific (Vaiotei, 2013; and especially in Pacific education: Farrelly and Nabobo-Baba, 2014, p. 321). Consequently, a growing literature exists on *talanoa*:²⁷ its definition, relevance and utilisation as rigorous methodology for research with Pacific participants. As it is derived from oral traditions, *talanoa* is deemed more culturally acceptable than western research methods because its processes recognise subjectivity and thus facilitate more meaningful engagement (Vaiotei,

²⁷ For example, 'Otunuku and Vaiotei proponents for education, Halapua and Farrelly in development, Meo-Sewabu and Vaka in health research, and Nabobo-Baba and Suaalii-Sauni in social science.



2006, pp. 22, 23, 32; Meo-Sewabu, 2014, p. 347).²⁸ It is used by Pacific for Pacific as an indigenous research paradigm in A/NZ just as Kaupapa Māori research, by Māori for Māori, is recognised and validated as appropriate and authentic for tāngata whenua/A/NZ's indigenous people.

Talanoa belongs to several Pacific languages and cultures: Tonga, Fiji, Samoa, Solomon Islands, Niue, Hawai'i, and the Cook Islands (Farrelly and Nabobo-Baba (2012, 2014) cite Prescott (2008); Havea (2010)), although variations between islands, disciplines and individuals exist. Vaioleti (2006) states that *talanoa* sits in the same family of enquiry as ethnography although more recently he has distanced ethnography as being insufficiently empathetic to the senses of spirituality, culture, and sense of place/*fonua* implicit in *talanoa* (2013, p. 196). Similarly, Farrelly and Nabobo-Baba point out *talanoa* principles extend beyond that of ethnography if such is reduced to merely the activity of open, informal interviews. For them, *talanoa* is not just what or how communication is conducted, it requires a deep engagement, like understanding that silence is also an expression of knowledge in the Pacific (2014, p. 321). Good ethnography in social anthropology ought to always involve deep engagement; produced from authentic relationship grown in a suitable space of time.

Based on both relationship and values of collective storytelling, the *talanoa* interaction enables challenge and legitimisation of what is offered by participants. Thus the *tala*/talking is open and heartfelt; it 'holistically intermingles researcher's and participants' emotions, knowing and experiences' (Vaioleti, p. 24) whilst the situation of *noa*/nothing is about making conducive space and conditions. What Vaioleti, Vaka et al (2016, p. 2) and others emphasise is the facility for *talanoa* to be multi-levelled and multi-layered explorations in which people converse freely for a previously introduced purpose. Potential 'layers of meaning' can be a challenge for the outsider who does not possess the cultural knowledge ('Otunuku p. 50). Usually *talanoa* is undertaken orally, in the community's particular language, for the benefit of the community and is implemented to work through many types of issues. Consequently, *talanoa* is used in a range of environments for disseminating and collecting information from Pacific communities by their governments and NGOs etc in formal and informal situations by Pacific people for Pacific people (Vaioleti, 2013, 2006).

²⁸ This is important to Pacific populations and scholars in environments such as A/NZ where Pacific people have been often subject of disempowering conventional western research approaches causing reluctant participants (Vaioleti, p.22).



Empathetic Feet-wetting Across Boundaries with *Talanoa*

Clery (2014, p. 121), states *talanoa* research is ‘... choosing research methods which care for relationships between people, the cultures in which they live, and then spaces between them’. He recognises *talanoa* as means for storing and listening, for opportunity and challenge. Havea (p. 12) considers engagement and interaction are essential components significant in effective *talanoa*. Anae et al (2010) claim that *talanoa*, amongst other purposeful uses, is now synthesised to provide a space for interaction across cultural and disciplinary borders which enables and encourages deeper understanding and takes intellectual inquiries in new directions (p. 8). All these descriptions fit my research intent enacting *talanoa* and its principles which I define further using Vaoleti.

Vaoleti (2006) sets out five traditional concepts which underpin *talanoa*, whilst ‘Otunuku (2011) splits them into ten. For a *Pālangi* researcher in Social Anthropology, these guiding principles align to ethics of Social Anthropology in A/NZ in how one goes about ethical research with others so the interstitial gap is not wide. A close alliance is evident too with the fundamental principles of genetic counselling where respect and empathy are paramount based on the principles of ‘interpersonal empathy’ coined by Carl Rogers (1961 – as cited by Farrelly and Nabobo-Baba 2014, p. 323). *Talanoa* principles also accord with the Health Research Council of New Zealand’s foundational *Guidelines for Pacific Health Research*, 2004 (cited by ‘Otunuku p. 44). Here I paraphrase Vaoleti’s list of *talanoa* concepts (pp. 30, 31):

Faka’apa’apa – to show respect, humility and consideration by being closely engaged but not dominant, making face to face first contact, dressing appropriately, being mindful of behaviour around older family members

’Anga Lelei – to be generous and helpful to the participant by helping them with something while talking, taking a little gift of food though not to offend or give the idea of creating dependence but making participants feel that their contribution is worthwhile

Fekau’aki/Mateuteu – to be prepared culturally and professionally by bringing one’s own family background knowledge²⁹ and looking for points of ancestral connection, knowing as much as possible about theirs and their social standing so as to act appropriately

²⁹ Vaoleti chooses the Māori word ‘whakapapa’ here.



Poto 'ianga – wisdom and competency as a skilled and accountable exponent, to maintain relationship well as a duty of care, to protect participants' interests during and after the fieldwork to reciprocate the knowledge gift that has been given

'Ofa Fe'unga – to show appropriate compassion and empathy for the context which includes the wisdom of maintaining integrity throughout

In their article, “*Talanoa* as Empathetic Apprenticeship”, Farrelly and Nabobo-Baba (2014) suggest *talanoa's* potential, if correctly used, for decolonising research in the Pacific, particularly in the arena of development practice which was their concern. To be correctly used, it must be ‘undertaken with the understanding that it is a culturally and emotionally embedded reciprocal exchange between researcher and participants’ (p. 321). I heed Farrelly and Nabobo-Baba’s caution that diminishment of what is involved in real *talanoa* can potentially be detrimental (p. 324). I acknowledge that the scope of my programme struggles to do justice to the time requirement for real empathy of ethnographic or *talanoa* fieldwork.

To *talanoa* empathetically, it is essential for the researcher to develop ‘a nuanced understanding of the cultural milieu situated by the research participants’ (p. 324). Participant observation ethnographic research suits the ideals of empathetic *talanoa* being distinguished by its extensive time spent on field site. However, as outlined earlier, my ideal of being an empathetic apprentice in an ideal intercultural space was challenged by the simple logistics of making contact by technological media rather than via cultural etiquette (in person introduced by an intermediary), and then visiting some participants in their time-scheduled workday world.

As I knew none of the participants prior to this study, contact was initiated by others and so introductions weren’t put as *talanoa* initially, nor were they face to face initial contacts. For example, a *Pālangi* friend contacted his colleague on my behalf, who by email I arranged to meet at his workplace. I timidly avoided mentioning bringing refreshments in my email to an unmet, busy manager, who was already making space in his day for me. On that occasion, and also when I met the Reverend, I arrived empty-handed, not in accord with *'anga lelei*/reciprocal generosity. To arrange *talanoa* with the Reverend, contact was also made by email whereby I took up the attitude of *'anga lelei* by asking for a task he might have me do while we conversed. He didn’t take me up although at the end of our extensive time together we each spoke of wanting to offer the other hospitality by way of



refreshments but our available time was over. For other initial meetings at workplaces I offered to bring lunch or took a small gift/*koloa*. In all *talanoa* I put a sincere effort into respectfulness in approach, in speech, in dressing modestly, particularly when I attended a Tongan church service. With every contact, I stated my willingness for them to meet me before they decided to participate or not. Participants not connected to GHSNZ all took up our first (and usually only) meeting as fulfilling their contribution to my research enquiry.

Establishing contact with GHSNZ prospective participants was a different challenge. By phone call I clarified that I was not connected with the hospital genetic service but was interested in learning about them as Tongan New Zealanders with respect to this topic. I had been provided cell phone numbers for the referrals from GHSNZ and, of the seven, three women initially responded affirmatively asking me to ring again at a more convenient moment as they were at work etc. These three women happened to be in their twenties which I intuited as being hopeful for their interest in my study. When I got no response calling cell phones I would text message. Mostly there would be no reply to texts either. I have no way of knowing what that meant, but I considered the following possibilities: a rejection of me/*Pālangi*, disinterest or sensitivity to genetic testing topic, possibly on advice of elders, possibly other priorities such as being at work and unable to respond, or the pragmatics of not having phone credit. Thus, setting up first meeting with participants spread across weeks rather than days. With one, after several days of fragmented texting, we confirmed to meet at her place that day at 1pm and I would bring lunch. I drove to her suburb (1.5 hours), had just bought some food for our meal, (again not sure what to choose for someone I had never met) when I received her text asking to postpone for five hours. I suppressed my frustration that I had just travelled a distance and my return trip would take longer; it was my choice not to have revealed this detail. So I left the meal and paperwork (in the hope it was helpful) with a positively worded note on her doorstep to the effect that we could try again and I followed this up with a kindly text message offering to meet in whichever way best suited her. After a silence of a few days I received her reply: she would like to meet me and she would let me know when she was ready to do so. I was excited. Since then I have tried to connect but I have not had a response. Of these three women, one ('Ana) eventually participated positively and generously and I later learned that her non-responses to my texts was due to her long shifts as a flight attendant.

The unsuccessful attempt above exemplifies the importance of appropriate introductions, even when I am pretty confident that text messaging is the standard mode and that



language was not the barrier as I had heard her voice mail message and read her texts in English. I suspect that this might be a cultural barrier that I failed to negotiate but I don't know. A Tongan mediator would have been helpful to initiate our first meeting in this instance. I share this experience as it speaks volumes towards the importance of appropriate initial introductions to Pacific people and the place for Pacific support roles in the public health setting such as, Auckland Hospital's Tautai Fakataha Navigator team. It also indicates to me the dilemma and sense of defeat for *Pālangi* health professionals genuinely desiring to serve, such as genetic counsellors, whose initial communication attempt with Tongan/Pacific clients is thwarted from the outset by limitations of telephone communication which is a major communication tool and used to follow up letters of invitation to potential clients.

***Faka-talanoa* Discourse**

I have introduced *talanoa* as used in group situations, often a platform, an arena to discuss and gather consensus (Meo-Sewabu, 2014, p. 348). In my study, *talanoa* can be classified as 'first *talanoa*' or *faka-talanoa* as coined by Manu'atu (2000 as cited by Fa'avae et al, 2016, p. 140). The following chapters offer a few threads of Tongan world-making in A/NZ as expressed in the *faka-talanoa* level of participants' discourse; it does not attempt to describe the Tongan community and culture as a whole.

I acknowledge this *talanoa* was not undertaken in the Tongan language as is usually appropriate (and compulsory according to some, for example Clery, 2014, pp. 112-114). Using the mother tongue of *talanoa* participants has been seen as an important first step in postcolonial and indigenous research as it helps construct the reality of the people who speak it (Chilisa, 2012, p. 19; Smith, p. 57). However, to share the *talanoa* outcome with non-speakers, dissemination into the language of the majority (English in A/NZ) for others to benefit or learn is ultimately required. Translation never entirely does justice to the nuances in meaning, large and small (which New Zealanders know all too well from their own Treaty history). Either way once the language is changed, transformations in meaning inevitably occur. I was aware that my participants would not expect me to be competent in Tongan language and I was aware they, bilingual, largely live in English, though at least one participant gets to use Tongan in their workplace. Because I am monolingual, there was no discussion about language choice; I contacted them in English (attempting no more than a greeting: *Mālō e lelei*) and English it remained.



Puipuitu'a: Establishing My Background

On meeting for the first time Tongans, like other cultures, attempt to establish relationship by locating one another to any pre-existing connection/*fekau'aki*. Several quizzed me about my married surname but its line claims no German/Tongan connection to establish and nurture existent relationship/*vā* in places and time past. When questioned why I had come to this research topic, I answered I had no prior personal experience or even knowledge about genetic testing and counselling but my curiosity, as someone interested in other New Zealanders' worldviews, was sparked by a daughter becoming a genetic counsellor. To recognize and offer my sense of pre-existing connection/*fekau'aki* to Tongan people, I reveal my interior and background/*puipuitu'a* in a Tongan way.

During the nineteenth century when British churches expended much effort and resource taking the Christian Gospel to colonies including those in the Pacific, a young English Methodist preacher and his wife, concerned about their denomination's neglect of their own local urban poor, began a 'mission' at home in London.³⁰ Their mission, eventually known as The Salvation Army, rapidly spread globally with a strong social justice as well as evangelistic focus. Responders to that movement included my own British forebears—all four sets of great grandparents, three already seeking opportunity in A/NZ later followed by the fourth. Thus I identify with my Tongan friends in this thesis as also being descendent of people who responded to the Good News of the Gospel brought to the islands in the Pacific, those of New Zealand, from Britain, and to God, creator and sustainer of all. Missionising colonisation as it was, the Christianisation that resulted became and continues to be a major aspect of Tongan culture and is also part of my heritage.

During this research I encountered two Tongan pastors, both of whom affected me at a deeper level. One (of the Free Church of Tonga) had prepared to meet me, the other (of the Methodist Church of New Zealand) just happened to have this one *Pālangi* seated in her congregation when she preached that Sunday. She flipped momentarily into English on several occasions as she delivered her sermon and I suspect this was solely for my edification whilst the sedate, brass-accompanied, harmonious hymn singing resonated in a deep place within me that only certain music can. A few months prior to that Sunday I met the Tongan pastor participant, Reverend Simone, who, admitting his sense of awkwardness, wanted to preface our *talanoa* by sharing something with me. I thought it

³⁰ https://en.wikipedia.org/wiki/William_Booth



was rather odd considering we had just met that moment. When he shared his story I didn't see how his words bore any relevance to me. However, as this intercultural experience unfolded over months, his telling me of how he offered words of wisdom over a Tongan man taking the *pe'a*/Samoan tattoo, the marks of another culture, eventually took on meaning for me. I realised I too had, in a small way, entered another culture which would leave its mark on me and also echo my own religious heritage reminding me of my own genealogy.

Design: a Fluid Topic

When I sought full human ethics approval for this study my research question asked: How does Tongan culture inform perceptions about heritable disease? However, my data and discussion do not directly answer that question. This was not unexpected as qualitative research is often fluid and open to contingencies. Only one participant was connected to GHSNZ. Consequently *talanoa* focused largely on general perceptions of disease attribution—rather than specifically heritable disease—attitudes to managing health and other topics participants raised. These data reveal participants' perceptions and priorities which I will argue challenge the approach of A/NZ public health delivery focused on risk- and self-management. I also suggest that Pacific-targeted health messaging has the unintended effect of pathologising Pacific cultures and bodies, with potentially serious consequences. Nonetheless I also attempt to demonstrate symmetry amidst different approaches to health and its care that are revealed here.



3. Literature Review

This chapter topically reviews scholarship from several disciplines to locate (find space/*vā*) and base my argument concerning the challenges to public health care delivery in multi-cultural contexts. I argue that these challenges impact how members of non-dominant cultural groups engage with biomedical services. For Pacific people, genetic health services can be culturally troubling. I use scholarship on Pacific epistemologies, medical and social anthropology of Tonga, genetic counselling research in multicultural settings, and local health promotion discourse to consider limits to responsibilisation as a key challenge.

Pacific Corpus: Tongan Epistemology and Social Anthropology

In English-speaking settler colonial societies in the Pacific—namely, Aotearoa, Australia, and Hawai'i—there is increasing recognition of the responsibility for health agencies to understand, acknowledge and apply indigenous, non-western knowledge. To use the most prominent example, New Zealand public policy explicitly incorporates kaupapa Māori, categorised an 'indigenous' approach to research grounded in Māori needs and Māori epistemology. In other multicultural Anglophone settings, including the UK, such explicit incorporation of alternative worldviews is more novel. British anthropologist Joy Hendry has explored efforts to gather widely from diverse human knowledges to learn and apply these 'other' 'wisdoms' to contribute ideas for global environmental sustainability issues, (2014). Hendry and Fitznor (2012) bring together scholars from diverse disciplines to address the gap perceived by 'indigenous' scholars of minority epistemologies 'seeking to identify common ground' (p. 2) for their work within the hegemonic Eurocentric framework. They note that indigenous research and knowledge is often aimed at the local site, often in a decolonising situation, highlighting difference. However, the purpose of their collection is to suggest ways towards positively focussed convergence of epistemologies.

The brief opening chapter of their book was written by Tongan scholar Tēvita O. Ka'ili who describes the Pacific sense of the interweaving of indigeneity with anthropology. He relays the concerns he has held about how, historically, elements of his culture were repackaged



or language meanings misconstrued by western anthropology to suit western theories (2012, p. 22, 23; Ka'ili, 2005). Ka'ili optimistically considers these resolved as he personally considers that indigeneity now drives the shape and patterns of the discipline. Ka'ili, based in Hawai'i, promotes Pacific knowledge of the world through the aesthetics and forms by which *tā*/time is marked, such as in performance rhythm, or is drawn in patterns (2005). He states, 'Tauhi va, the Tongan art of sociospatial relations, also marks time (ta) in a symmetrical form in space (va). Specifically, it arranges time through the mutual performance (ta) of social duties (fatongia)'.³¹ Ka'ili visualises symmetrical coming together of knowledge systems with the symmetrical spatial concept of *kupesi* weaving patterns as a means to validate Pacific knowledge in a culturally meaningful way. I draw on this metaphor later in Chapter Seven to suggest symmetrical recognition of western with Pacific (or any other) people's worlds and beliefs as a concept of acknowledgement of others' beliefs.

Tongan philosopher and anthropologist, 'Okusitino Mahina (1992, 2002, 2004), first translated the Tongan *tā/vā* into a general theory of reality. He provided a deep and complex analysis of the social construction of time (*tā*) and socio/spatial relations (*vā*) which form a Tongan worldview (Ka'ili, 2005). Ka'ili, Mila-Schaaf (2009 etc), and Vaka (2014) all draw from Mahina's work on *tā* and *vā*. Vaka uses Mahina's thought to explain deeper meaning within Tongan words to set up definitions for his current research with Tongans on mental illness in A/NZ. According to Mahina, Vaka states, 'maintaining good behaviours and attitudes maintains good *vā* within the Tongan society, disruption of *vā* on any level - individual, family, community, and so forth - will create disharmony and chaos and contribute to triggering and causing mental illness' (pp. 63, 64). Setting up Tongan foundational ideas about the world and how people relate and operate in society, theories of *tā* and *vā* form the basis of Chapter Four in which I gather Pacific and Tongan scholars to outline some of the aspects of Tongan culture of which my participants speak.

New Zealand-born sociologist and poet Karlo Mila-Schaaf applied the theory of *vā* to contribute to development of Pacific health care frameworks (Mila-Schaaf & Hudson, 2009a) and to Pacific identity and integration, especially for second generation Pacific people in diaspora (Mila -Schaaf, 2013). She explains the use of the term 'Pacific' in A/NZ identity as being a relational construction—relational to both Māori and Pakeha (2009, p. 21), clarifying that 'Pacific knowledge' refers to 'ethnic-specific Pacific knowledge' (p. 23).

³¹ <http://gradworks.umi.com/33/03/3303375.html> [Accessed June 12, 2017].



Mila-Schaaf (2009) combines Okere's (2005) African epistemological perspective with Foucault's (1972/1989, p. 24) comment that only by experiencing another's knowledge system does one recognise peculiarities in one's own knowledge system. Alongside other Tongan/Pacific philosophers referred to here, Mila-Schaaf's work on nurturing intercultural 'negotiated space' or *vā* is foundational to my thesis.

Konai Helu Thaman's unpublished Education PhD thesis (1988), considering Pacific teachers' perceptions of their role from their cultural standpoint, remains a seminal work not only for educators³² but for scholars of Tongan ontology and epistemology more broadly. To argue for a Pacific form of teaching and learning, she introduces the circular and collective way Tongans perceive the world, explaining rank, the hierarchical order of family and society, and ontological self-perception, amidst not only elders but ancestors and many other specifics of Tongan/Pacific culture. By championing Tongan thinking Thaman has also argued (with others, such as Linda Smith) for decolonisation of the mind (2003). Her (1997) indigenous methodological framework, *Kakala* (the Tongan flower garland), was adopted as a culturally-inclusive research framework in A/NZ public education of Pacific students. It incorporates Tongan holistic conceptual thinking using the garland-making metaphor of: design, material selection and collection, work process, then dissemination—how and to whom the *kakala* is given. Thaman describes *kakala* as a non-reductionist, non-western approach to facilitating learning. Along with the concept of finding and nurturing space in relationship/*vā*, this metaphor also influenced my thinking in preparing Chapter Seven.

I also draw heavily on the work of Tongan midwife, nurse, sociologist, and lawyer, Siosiane Fanua Bloomfield (2002). Her research into maternity care in Tongan society in the 1980s articulates the importance placed on social and spiritual aspects of illness and wellness. Her aim was to improve child and maternal welfare, and also reduce Tonga's reliance on foreign aid, by arguing for recognition and promotion of traditional healers and birth attendants in Tongan primary health policy design (p. 125). Relating experiences of healthcare delivery in Tongan communities she writes across two epistemologies, drawing them together which is not only significant for this thesis but Bloomfield's style provides accessibility, particularly to *Pālangi*/western researchers of Tongan health and healthcare.

³² As Vaka notes (2014, p. 37) most of the literature about Tongan conceptual constructs is written within the field of education.



Non-Tongan medical anthropological contributors to the Tongan health care corpus include Barbara Burns McGrath (1993, 1999, 2003) who has researched death and dying, and the role of spirits and spirit possession. She discusses (2003) the Tongan body as a site for resistance, arguing that community is located in the body and also through the bodies of spirits who play a very lively role in the Tongan social field. Wendy Cowling (1990) also investigated spirit-caused conditions in mental health, categorising types of disease and mental illness in Tonga and eclectic approaches to treatment, which operated within a classifiable system. A classic reference for the importance of belief and the non-material nature of Samoan and Pacific medicine is Cluny and La'avasa Macpherson's work (1990), which is described by Mike Poltorak (2010, p. 5) as an exemplary examination, noting that Samoan and Tongan traditional medicines have shared and continue to share many common features.

Poltorak, researching contemporary Tongan healing and public health policy (2007, 2010, 2013), criticises Macpherson and Macpherson and others (including the WHO) for being too simplistic in treating traditional healing as structured systems. In one study of the work of five popular but diverse spirit healers, he observed their 'capacity for creativity and also interest in biomedicine, and thus the possibility and different degrees of collaboration' (2010, p. 17). He argues that wider social dynamics of healing should be acknowledged by medical doctors and policy makers to 'better appreciate the way that most people navigate pathways through the choices of treatment' (p. 18) to not only acknowledge efficacy of non-biomedical treatment methods but to work with them, as people continue to resort to them. He challenges the non-engagement and lack of formal recognition granted to 'traditional' healers by the Tongan public health sector, stating that the time has come to implement an epistemological dialogue with policy makers in Tonga, a nation where, he states, 'healing is woven into the social and religious fabric of a Christian constituted Tongan society' (p. 18).

Niko Besnier (2011) describes the changing situations which are 'producing' modern Tonga, people taking up linguistic practices, activities, and roles that are globally connected. He argues against simplistic and local ideological opposition to 'modernity' as an 'intrusion' upon an 'otherwise tranquil tradition-steeped society' (p. xiv). Rather the tensions perceived to result from 'outside influences' are more complex as Tongans participate and generate modernity themselves. For example, precious cultural textiles (*koloa*) are commoditised at market stalls, pawned for cash and stolen (pp. 106-116). Besnier



concludes both that tradition and modernity are produced by many types of encounter, often competitive, sometimes anxious, as people in Tonga negotiate life in ongoing uncertain political times (p. 234). In the A/NZ setting Tongan culture can be viewed as possessing a greater sense of certainty because it can be made to appear more concrete, more ideologically bound in small communities such as church congregations, and less permeated by the flux of everyday life issues. Besnier's research provides useful background on the nation from where participants in my study originated. Like Besnier's subjects, my participants tended to represent their island homeland to me as fixed in time, traditional and un-modern, whereas A/N Z is considered unambiguously modern.

Helen Morton Lee (2004) argued that transnational ties would continue to weaken 'over time' as the Tongan diaspora widens (p. 133). Her view is disputed by Ping-Ann Addo (2013), who followed for several years the exchange of prized labour-intensive *tapa* cloth/*koloa* between Tonga-based craftswomen and New Zealand Tongan purchasers for weddings and other special life events. In her ethnography, Addo documents the creativity and agency, globalising ambitions, and diasporic nation-building expressed by these women through their textile transactions. She depicts people's desire to maintain connection with the idea of home when life is lived in diaspora, wherein New Zealand is the new *fonua*/location. She discusses the crucial role played by women in modern nation-building, noting they continue the historic movement of gift exchange and the powerful roles women perform through creating value-laden textiles and engaging back and forth across the Pacific. Addo sees 'the gift as a tool for Pacific modernity' (p. 191). As much of Addo's ethnography is spent with Auckland Tongan families and communities, it provides helpful context for my study, particularly the burdens of obligation to contribute to the costs of events at which *koloa* are presented, which I discuss in Chapter Five.

Heather Young -Leslie (2004, 2005) identifies the irony in Tonga for women raising children under competing epistemologies. She discusses this through the lenses of globalisation and modernity. Like Addo her ethnographic work also followed Tongan mothers, weavers whose lives, she argues, were made more painful by the pressure to uphold maternal obligations in raising good Tongan children in an era of globalisation. In particular, she notes the burden of globally circulating health promotion messages, which punish rather than help (2004, pp. 402, 403).³³ As providers and producers of textiles and 'responsible

³³ The WHO World Health Assembly president who championed the WHO's international campaign, 'Global Health for All by the Year 2000', was Tongan Dr Sione Tapa. Tapa was Tonga's first indigenous Chief Medical Officer then Tongan Minister of Health and is the recognised 'architect' of



for cultural and domestic reproduction' (p. 410) her ethnography identifies early mortality as a consequence of mothers' work juggling their concepts of wellbeing/*mo'ui lelei* - to maintain and protect 'real Tongan traditions'/'*ulungaanga faka-Tonga* (pp. 400, 403) at the expense of their own physical health. She relates how one middle-aged, industrious mother succumbed to diabetes-related death and another to amputation as they strived to weave textiles (to be sent to unknown New Zealanders) to both embody Tongan culture and fulfil the expectation that they pay for their children's school fees (p. 410). In the practice of these 'traditional' activities, like Besnier's argument, she argues they also participate in being 'modern': in western education for children; in transnational exchange of textile gifts/*koloa* for cash: and as targeted recipients of global health campaigns.

Her emphasis on life lived within cultural norms of everyone knowing their place, duty and obligations, girds, with others' work, my discussion in Chapter Five. Young-Leslie's work is pertinent to this study as it raises expectations of responsibility placed on mothers by internationally-messaged public healthcare programmes (to breastfeed, vaccinate and provide a nutritious diet etc) which were not the maternal responsibilities necessary to create wellbeing/*mo'ui lelei* Young-Leslie heard when she surveyed 81 women (p. 402). She recalls:

... no one indicated that she made her children healthy by the activities associated with health promotion measures. Neither inoculation, balancing the nutritional component of their food, or complying with the advice of the local maternal child health nurse were mentioned as a means to ensure a healthy child. Instead, mothers cited cleanliness, obedience, prayer, eating freely and maternal behavior as keys to a healthy child.

Overall, living well for women depends on fulfillment of their maternal obligation. Part of her obligation is to enrich her family.

Differing understandings about what constitutes health and healthcare priorities in face of international public health direction towards health promotion will be discussed Chapter Six, where I raise issues for New Zealand on addressing different concepts people hold towards risk, priorities and how Pacific Islander bodies and cultures are pathologised by state policy in health promotion messaging.

Tonga's WHO-prescribed modern medical principals (Young-Leslie pp. 398-399; Wood-Ellem, 1999, p. 316).



Following earlier anthropologists intrigued by Pacific kinship, Françoise Douaire-Marsaudon (2015) (France) demonstrates a more traditional style of anthropological approach to the study of Tongan kinship. She has continued to investigate the complexities of kin relationships as they apply to personhood and the effect on *kainga*/kin group politics and beyond (p. 203). I use her work in Chapter Five to background the magnitude of *tapu* and importance which is traditionally placed on the brother-sister relationship in Pacific societies and, especially in Tonga (p. 186), the power of the *mehikitanga* or father's senior sister and the obligations around that relationship/*fahu* (pp. 201, 202). Douaire-Marsaudon claims this complex *fahu* relationship is still very much alive in Tonga, which reinforces *talanoa* data from participants recounted in Chapter Five.

Genetic Counselling in Multicultural Environments

How people of Pacific Island heritage perceive and experience genetic counselling in A/NZ was the original idea for this study. Although the data I gathered is not about people's experiences of genetic counselling and testing, my research explores Tongan perceptions around heredity as a health field, and I use genetic counselling as an example of public healthcare throughout.

International genetic counselling literature about cultural difference and culturally-derived perceptions of genetic counselling remains small, particularly within predictive genetics (Port, 2007). Port et al (2008) pioneered genetic counselling literature on the need to adapt the Eurocentric model of genetic clinical services (which favours individual autonomy) to meet the needs of indigenous people with their New Zealand Māori study which acknowledged traditional and spiritual beliefs towards genes and genetic testing (p. 132). Penn et al (2010, p. 18) cite this study for highlighting the significance of the role the 'collective' family group plays in decision-making within some cultures.

In South Africa, Penn et al (2010) argue for introducing grandmothers from ethnic communities to assist in genetic counselling sessions as mediators, 'cultural brokers' (p. 18), suggesting these women are able to facilitate 'cultural safety' (p. 19). In a 'Coloured, African and Asian' setting (p. 10), one multilingual interviewer and fifteen grandmothers participated in three focus groups divided by home language. They explored 'traditional beliefs regarding common childhood genetic disorders' to 'address potential barriers to effective genetic counseling' (p. 9), considering what roles grandmothers perform in these families and what causal explanations the grandmothers gave for different genetic



disorders as shown by photographs. Their responses were summarised into themes: lifestyle (i.e. consuming forbidden food), behaviour (i.e. inappropriate laughter), social (i.e. domestic violence), familial (i.e. incest and consanguinity), cultural (i.e. not fulfilling rituals), religious (i.e. punishment from God), and genetic (i.e. maternal age or heredity). The researchers noted ‘overlap and differentiation’ between lay knowledge and scientific knowledge for causes of disorders.

Their study is significant for what it did and didn’t ask. Importantly, they argue for the potential mediating and informational role grandmothers might provide in genetic counselling, enabling counsellors to better respect and understand their clients and their beliefs (p. 19). The study acknowledges other ways by which people know things to be true. It asks what is effective genetic counselling? And how is its success measured? Rather than measurement by ‘service uptake’ they argue for ‘cultural safety’, challenging fellow genetic counsellors ‘to adapt their approach to counseling to include the client’s family in the counselling process and adopt a group rather than individual counseling approach’ (p. 18). However, this study fails to identify whose traditional beliefs, merely that participants ‘reflected a wide cultural and geographical mix’ (p. 11) with Sesotho and Afrikaans languages used in the focus groups. The researchers do not identify the ethnic and cultural groups involved, rather it seems assumed that ‘grandmothers’ can offer assistance with any ‘traditional’ knowledges and also presumes their willingness to do so.

Also in South Africa, Morris et al (2015), studied “Black” mothers’ satisfaction with receiving genetic counselling services. Their participant group already had children with inherited conditions such as Down syndrome. Although most did, some participants had no understanding of genetic science or counselling. They also note (p.165, citing Christianson and Kromberg, 1996, and I suggest similarity with Rapp, 2000, in New York with other cultures) that in their participants’ culture, there is no word or recognition, generally, of the disorder known in the West as Down syndrome. This is pertinent to challenging cultural conceptions of who is ‘normal’ and why biomedicine categorises some to be abnormal.³⁴

Saleh et al. (2011) examined cultural beliefs about kinship and hereditary cancer among Arab-Australians. They found that this population, known to have a low uptake of cancer-related genetic health services, was largely unaware of the heritability of cancer. They recommended education in communities and of primary health carers and noted variations

³⁴ For A/NZ research on choice and moral reasoning re Down syndrome, see Fitzgerald, Legge and Park (2015)



between Western and Arabic kinship systems that could have relevance for genetic counselling.

Kowal et al (2014), initiated preliminary studies with twelve Australian genetic practitioners (counsellors and geneticists) to 'identify elements of culturally-competent genetic health service provision in Indigenous Australian contexts'. Participant views varied as to whether counselling needs differ for Indigenous Australians. Most were 'reluctant to generalize' maintaining their professional 'individualized approach' ought to serve all clients whilst some participants were clear that Indigenous people do have different needs to 'the general population' (pp. 597, 605). Some advocated for the value of indigenous support workers as a liaison resource and the importance of 'taking time to build rapport' (p. 605).

Genetic counsellor, Nancy Steinberg Warren (2011), primarily addressing genetic counsellors in the USA, recognises the challenges of working in settings where the client/practitioner demographics don't reflect each other. She challenges genetic counsellors to listen, learn from clients who are not similar to them, to reflect and share with colleagues, 'The goal of providing culturally sensitive genetic counseling may involve a mind-set change', (p. 543). All studies I read called for further research into cultural awareness issues pertaining to their service praxis.

Aotearoa New Zealand: Genetic Health Services

To date two health science PhD theses have been written on New Zealanders' experience of genetic testing/counselling. They each provide important foundations for this thesis, in different ways. First, Waiora Port's (2007) *He whakamatautau pi taua mo te mate pukupuku: nga tikanga a te ao Māori/DNA testing for cancer susceptibility: the needs of Māori* offers a seminal, bicultural research project. She used Māori protocols facilitated by 17 pukenga (persons skilled in tikanga Māori/the practice of Māori culture) and 16 medical practitioners (geneticists, surgeons etc) to bridge two worlds (p. 286). They listened to six Māori kin groups who were already known to have experienced living with a genetic mutation causing increased risk of specific cancers. Her thesis establishes Māori ontology (Te Ao Māori/the Māori world, ways of being), the importance and place of whānau/family and leadership, and Hauora Māori/Māori health philosophy to position her Kaupapa Māori method and then discuss her participants' world views (p. i). These help her 'explain Māori cultural perspectives about predictive/presymptomatic DNA testing' (p. i). She undertook her research following appropriate cultural protocols and, being herself fluent in Te



Reo/Māori language, people were able to participate in Māori, if they preferred, and also, in accordance with their culture, face to face wherever possible.

Her research topic was suggested, funded and supervised by the Māori committee of the New Zealand Health Research Council (HRC), then known as He Kamaka Oranga (p. xii). Her interview content was also written by this supervisor with assistance from her cultural advisor, Prof. Linda Smith (p. 39). Thus this study's content was strongly structured around what the dominant institution wanted to know from their Māori participants even though it was delivered in kaupapa Māori mode. In lieu of a written corpus for Māori she uses her pukenga to support ideas on Māori epistemology (p. 11).

... how one service can provide for the needs of people in a bi-cultural and increasingly multicultural society in Aotearoa New Zealand. Because of their cultural background and health status in Aotearoa New Zealand, it was thought that Māori views about DNA testing as a predictor of familial cancer may differ from the traditional Western model. Although they are 12-15% of the New Zealand population, Māori did not seem to access fully the newly established services provided by the Genetic Service in Auckland... (p. 9)

Her study's intent is to investigate *how* the existing genetic health service is delivered to create awareness of Māori preferences in service delivery; to ensure service is ethically and epistemologically appropriate. Participants were asked to suggest what would encourage them to use the genetic services on offer to them (p.10) and a unanimous response was for service delivery at marae/cultural meeting places where protocols and dimensions beyond the physical, i.e accommodating the spiritual with karakia/prayer, would be in place for Māori people (p. 273). Her study differs from mine in that her participants were families who had experience of genetic testing services and premature deaths of family members of cancers known to be genetically-determined. Whilst I do not intend to reduce the importance of this study, it resembles much research within the A/NZ health sector whose deeper rationale is to find culturally appropriate ways to encourage people to use biomedical public health services in a neoliberal political climate emphasising personal responsibility and prevention.

In her thesis, Alison McEwen describes how genetic health service as positioned within a wider discourse in society characterised by reduced state intervention campaigns of health



promotion for increasing personal responsibility (2011, pp. 16, 48). Working at the intersections of health science and feminist theory, McEwen's is the only other A/NZ thesis on genetic health service to date. She writes:

Genetic counselling, both in New Zealand and internationally, is increasingly situated in a health setting that promotes health and well being and that is overlaid with societal, cultural, political and gendered expectations of individual responsibility. (p. 19)

Her study followed women³⁵ either living with BRCA/ breast cancer or at high risk for it. McEwen argues that their sense of responsibility as wives, mothers and citizens, their perceptions of risk and, for some, decisions to undergo risk-reducing surgery is a symbolic and gendered representation of women as carers and nurturers (p. iv). In setting out her thesis, McEwen highlights the weight (western) society puts on the concept of risk and the presumption that knowledge is power (p. 15) and that client non-interest in self surveillance has negative connotations in her biomedical environment which ought to be questioned further. The observation that inaction and non-attendance may be deliberate forms of resistance can apply beyond women to others such as the population I study here. McEwen argues that A/NZ health policies assume individual and family responsibility, consideration of risk being the dominant measure towards knowledge and decision-making.

This era of self-responsibility came about when A/NZ became a 'post-welfare' society in the 1990s (McEwen citing Kelsey, 1999; McLennan, Ryan and Spoonley, 2000). 'Genetic Services therefore operates within a culture where discourses of individual and family responsibility dominate' (McEwen, pp. 48, 49). Whether or not Tongan/Pacific people align themselves with these assumptions influences their participation in the health system more generally.

Public Health Promotion Research

In *Promoting Health in Aotearoa New Zealand* (2015), Signal et al examine the politics of A/NZ health promotion using four political theories which apply to New Zealand health promotion policy. Their chapter, partly a literature review, lists major ethnic and interest groups involved in or with key interests in health promotion to argue that these groups

³⁵ All Pakehā, although this was not an intentional part of the study design.



need to be more aware of political contexts to be effective. They trace the change in New Zealand's 'new right' political direction (p. 179) that brought a 'post-welfare state' into being. New Zealand politics, they argue, is supportive of neo-pluralistic theory (p. 164) which spreads influence and input across interest parties, i.e. demographic groups like Māori (p. 168) or issue groups like smoking action (p. 169), rather than the responsibility of government. Such neoliberal policies, shifting the state's responsibilities onto the market and the individual, sync neatly with the rise of 'health promotion' and wellness discourse. Interestingly, they note 'a relative dearth of literature that reflects a Māori analysis of the politics of health promotion' (pp. 163-4, 183).

I use several other chapters in this book. I refer to Tu'itahi and Lima (Chapter 4) to describe New Zealand's Pacific communities and history of Pacific-directed health services and Pacific-derived models. In Chapter Six I critique Ratima et al's argument that Māori healthcare is about 'shift[ing] the emphasis ... to health promotion' (Chapter Three, p. 55) to argue that endorsing public health promotion strategies that emphasise self-responsibility is more reflective of Western individualism than Māoritanga.

Medical Anthropology

Medical anthropologists recognise that medical systems are culturally derived, just as what is considered a 'dis-ease' is also 'deeply' cultural (Lock and Nguyen, 2010, p.59; Good, 1994, p. 2). For this study I refer to some prominent anthropologists who focus on validating people's experiences and moral issues in domains of disease and healing. Byron Good's *Medicine, Rationality, and Experience: An Anthropological Perspective* (1994) is an example. He cautions against assuming that medical knowledge is 'true' and culturally determined beliefs 'erroneous' (p. xi), reflecting that anthropologists ought to break down these difficulties which arise with competing epistemological claims between cultures (p. 183). His analysis draws on phenomenological research, on semiotic analysis (of the symbolism of blood, or of hot and cold), and linguistic analysis to demonstrate various experiences of suffering. He argues for the importance of narrating the experience of disease; disease is not something located in 'the body' so much as 'in life' (p. 133). Good argues for the soteriological³⁶ role which biomedicine has taken over from religion over the

³⁶ Soteriology is the study of beliefs about salvation.
<https://en.oxforddictionaries.com/definition/soteriology>



last two centuries, whereby human suffering is now redeemed through science rather than salvation (pp. 85-7). I take this up in Chapter Six.

The major anthropological contributors to ethnographic research within predictive genetic testing for neurological disorders over the last decade or so are Monica Konrad with Huntington's Disease in Britain (2005) and Margaret Lock, researching genetic testing for Alzheimer's across North America and the UK (2005; 2009; 2013 etc). Agreeing with Nikolas Rose, both Lock (2013, p.43), and Konrad (2005, p.16) cite Foucault's teacher, Canguilhem, as the first to draw attention to the direction forged by biomedicine's recent technologies which have created the "pre-patient", and "doctors" who participate in a pathologisation of people who are not yet ill. Rose uses Canguilhem to challenge that it ought to be the individual who judges whether they are normal, but that somehow the health practitioners (amongst others) have come to "acquire the right" to "render the person a 'pre-patient'" (p. 85).

Konrad's project (2005) with families carrying the gene for Huntington's disease followed what this meant for them when this type of testing was in its early stages. She is recognised for developing the term 'pre-symptomatic' to describe people who are diagnosed with a condition before they show symptoms of it. She and Margaret Lock have both noted that new genetic technologies which shift medicine from treatment-based to prevention-based methods challenges anthropology to revisit early themes, kinship and divination, but now in Western, scientific cultures. They cite E.E. Evans-Pritchard's *Witchcraft, Oracles and Magic among the Azande* (1937) of the body's own 'power' (of Azande belief in omens and oracles), to predict futures (Konrad, pp. 2, 3, 18, 19; Lock, 2005, 2013, pp.174-206).

Konrad's research is largely about moral reasoning. She asked pertinent questions about implications of informative knowledge use within families, how they make choices and the subtleties of human communication (p. 147). Her study showed British families discriminating between good and bad information, selectively non-disclosing information to other members, and choosing 'not to know' as an intentional and reasoned act. She questioned the assumptions placed around people's 'capacity for knowledge' (p. 99) as a subject not normally associated with illness and healing in a western context. In her discussion she demonstrates how cultural and complex disclosure issues can be for families (p. 104). Whilst genetic services pertain to largely scientifically-formed health and ethics policies of a science philosophy assuming neoliberal value of personhood as individual



autonomy, Konrad concluded that such policies omit the complexity of genetics ethics, which by nature conflicts with individualism. Kin disclosure and communication is an integral component. She found the ethics people used within kinship disclosure to be very unpredictable and fluid; arguing for 'moral genealogies' continuously 'under construction' (pp. 104, 105). She suggests that further attention be given these areas as predictive testing develops. Konrad also predicted that genes might turn out not to be entirely helpful except in monogenic conditions because of the lack of certainty and complexity which she describes as a 'complex art' (p. 146).

An earlier investigation of moral reasoning is Rayna Rapp's ethnography, *Testing Women, Testing the Fetus* (2000). She labelled women undergoing amniocentesis 'moral pioneers' who, she argued, bore responsibility as decision-makers to choose who belonged in future society (p. 318). Rapp acknowledged communication issues in the multi-ethnic settings in which she researched which remain relevant, such as non-equivalent definitions across different languages. For example, Haitian clients had no equivalent word for Down syndrome, no word for 'retarded' which their medical team used (pp. 64, 225). She also revealed lack of understanding, misunderstandings and cultural differences of participants whose spiritual and religious views did not regard their unborn child in the way the medical team did.

Researchers acknowledge most genetic testing studies thus far focus on discourse among the relatively affluent, are conducted in the northern hemisphere, and do not necessarily reflect the experiences or service delivery systems found in the Australasia/Pacific area. Here there has been activity towards cultural awareness and competency for some while and genetic services are not charged for. Featherstone, Atkinson, Bharadwaj and Clarke (2006), by contrast, claim recognition of lay knowledge in a way similar, I suggest, to recognizing an indigenous or other culture approach with their research in Wales. They argue for pyramidal 'symmetry' which places side by side European/American 'lay' and medical/'professional' knowledges, thus recognising their participants' understandings as other forms of knowledge deserving of their attention (pp. 19, 20). They found their participants' narratives possessed 'well-established arrays of beliefs and practices concerning kindred and inheritance' (p. 141) but they admit there is no sense by which these can be viewed as a "unified 'culture' of beliefs" (ibid), noting that families are not bound entities, unlike the implication of the idea of the word *family* when used in genetic literature (p. 142). Also, they report propensity for moral and social reasoning in



causation, in appending blame and responsibility (p. 147), noting the lack of anthropological analysis of their own culture's perceptions of kinship when compared to studies of other cultures.

Lastly, Susanna Trnka and Catherine Trundle's ethnographic collection, *Competing Responsibilities: the Ethics and Politics of Contemporary Life* (2017), ignited the theme through which I have tied these disparate subjects together. The ideal of responsibility I came to realise, listening to and learning from Tongan people, holds importance in Tongan culture in that nobles and elders are expected to demonstrate responsibility. But it is mistaken to assume this hierarchical ideal is the same thing as ideals of personal responsibility within an individualistic society. I use Trnka and Trundle's starting point, the etymological root of 'responsibility', as the capability of response and accountability (p. 4). In an era which promotes the individual, emphasises self care and self responsibility, responsibility can be presumed and inherent, for example, in public and institutional policy. Trnka and Trundle place together for comparison and contrast 'advanced liberal governments' emphases on responsibilization alongside other prevalent ways that responsibility is enacted: that is, other forms of personal responsibility; care for the Other; and social contract ideologies' (p. 3). Multiple layers of responsibility (state/health practitioner/Tongan person and kin) are activated in my discussion (Chapter Six) of conflicting ideas about personal health risk and its management for a population who has other culturally-derived conceptions of wellbeing.

Conclusion

Although spread over several disciplines and contexts, this selection of sources are all debates about medical knowledge and cultural difference. Different disciplines have different approaches to the place and prominence of cultural explanations. The creation of a cross-disciplinary space/*vā* between them is the locus for my argument, which I trust contributes something worthwhile to each, even though only a light covering is possible here.



4. Respons-ability: Who's Knowledge? Conveying Ideals of a Tongan Reality

As the poverty gap between Māori, Pacific and the rest of the A/NZ population remains 'massive' and 'enduring' (Kelsey, 2015, pp. 87, 102), it might be logically assumed by public health practitioners such as genetic counsellors that economic pressures are a factor in why Pacific people often do not access assistance and support that can be offered them. Government health policies continue to focus their efforts on inequity, using statistics to measure disparities in the health status of Māori and Pacific compared with the rest of the population. Tupeni Baba claimed back in 2004 that a whole industry has developed solely around the poor health of Pacific and Māori in New Zealand, which researchers and health personnel benefit from within the safety of bureaucracy (2004, p. 96).

Real as poverty might be for some Tongans, economic barriers to accessing any form of healthcare were not raised by my small group of Tongan participants. They chose other stories to share with me to approach my topic as Pacific people: how they locate themselves in the universe and within their own society, referring to a prevailing reticence towards accepting some biomedical care due to culturally-derived causality of illness and disability, and implicitly their non-confidence, in biomedicine (Hardin 2016, p. 1).

Listening to participants' stories I heard a shared reticence around biomedicine generally. This has been noted by others. I quote here Dr Tukuitonga's concise summary of a Pacific outlook from the NZ government encyclopaedia website Te Ara³⁷, which points to Pacific ontological beliefs as contributing to avoidance tendencies around biomedical services. His second statement includes the suggestion that Pacific people also lack confidence in hospitals. Although this is not explained, it concurs with what I have been told by some participants:

All Pacific cultures have a holistic view of health with a strong spiritual dimension. This asserts that good health is the result of a balanced relationship between

³⁷ 'Pacific Island health - Risk factors and health service delivery', Te Ara - the Encyclopaedia of New Zealand, <http://www.TeAra.govt.nz/en/pacific-island-health> (accessed 3 April 2017)



humans and their environment. Disease, injury and even death can occur if this balance is put out of kilter, sometimes as a result of wrongdoing by the victim or a family member. These beliefs may contribute to the tendency for some Pacific people to avoid doctors' visits and health interventions...

These problems [high hospital admissions for preventable diseases] probably stem from delays in seeking care, compounded by traditional beliefs about health and illness, poor access to primary care providers and lack of confidence in hospital services.

My hunch is that cultural beliefs factor to a greater level than is recognised by prevailing systems which continue to lament poverty levels and number-crunch attendance and finite resources. As this pertains to the level of Pacific engagement with services on offer, these cultural beliefs do not deserve to be relegated to 'health illiteracy'. The degree to which spiritual and moral beliefs are implicated in determination of wellbeing and disease within a household unit or extended family can be a difficult area for NZ Tongan or other Pacific families to address openly, as even discussing such might also tend to be avoided for respect of higher ranking extended family members.³⁸ Experiences of conflict and confusion when traditional Tongan and western methods converge was expressed by the two youngest participants and mentioned by another.

It is well documented that in Tonga heritable conditions, mental illnesses, some cancers and other prolonged or unexplained unwellness are traditionally recognised as spirit-derived (Bloomfield, 2002; Cowling, 1990; McGrath, 1993; Parsons, 1985; Vaka, 2014). Raising such subjects with Pacific people can be sensitive because they implicate concepts of *tapu*/the sacred/ spirit involvement in certain conditions or disease. I will define *tapu* further on in this chapter. 'Western' clinicians (in this case within public healthcare), I suggest, rarely perceive the implications in Dr Tukuitonga's cultural explanation.

For some areas, such as genetic illnesses, engagement becomes immediately delicate or awkward for Pacific people, right from the initial referral and how that is communicated, which is often via telephone or written notice. Despite the existent role of a genetic counselling practitioner, as empathiser and acknowledger of pre-existing belief, to be the

³⁸ Participant Siosifa speaks to this in our talanoa 27/10/2016 and Vaka (2014) finds that those in authority, leaders and status-bearers, were more likely to hold a Tongan perspective/tufunga faka-Tonga on mental health causality and that perpetuates stigma and shame (p. 179) than those not in authority.



helper for best outcome for specific family needs along a genetic health journey, I suggest (along with a long line of indigenous and Pacific scholars) that ‘we’ *Pālangi*, even with A/NZ’s attempts towards inclusive participation and cultural competency, often don’t understand even where to begin when clients are Pacific families. We do not and cannot possess the “Pacific Touch”³⁹ if we are not Pacific people but we can open a dialogue with each other to begin to learn. Therefore, and keeping in mind my initial challenge of being responsible - *able to respond* or not, my first section sets out some basic principles of Pacific/Tongan ontological thought by which knowledge is founded, at times demonstrating through participant *talanoa*.

Pacific Reality and Knowledge

Pacific writers of Indigenous Pacific literature generally claim no extant single body of Pacific⁴⁰ thought but many common traits and much overlap enable presuppositions to promote a coherent voice for Pacific Epistemology (Huffer and Qalo (2004, pp. 87, 108); Hereniko (1999); Sanga (2004, p. 43); Helu Thaman (2006, p. 10)). This dialogue nowadays forms a considerable corpus.⁴¹ I ask, as Halvaksz (2006, p. 109) asks, how do people know what they know and what dimensions of culture constrain it (Gegeo and Watson-Gegeo (2001)? I do not pretend to know as Pacific people do how knowledge is constructed in their cultures. And I recognise, without the defining language of that knowledge, the limitations and shallowness of an ‘empathetic apprentice’ attempt (Mutu, 2004, p. 56). However, as Thaman suggests one of the positives of recognition of Pacific cultures’ epistemologies, besides actual uptake of the knowledge, is edification and mutual benefit of the non-Pacific people with whom they live (2006, p. 12). Hence I ask to be a small but synergising voice negotiating the epistemological space between cultures in A/NZ without

³⁹ [a] Samoan nurse once explained to me about “the Pacific touch.” What is the Pacific touch? It is taking the time to stop and pray with a family. It is taking the time to teach a young mother to cook. It is being committed and dedicated and passionate about our people. The Pacific touch is that quality that sets a special few of our nurses and health workers apart.’ Attributed to Dr T Percival ‘Pacific health in New Zealand: our stories.’ Ministry of Health, n.d.

⁴⁰ Sometimes termed ‘Oceanic’ following Hau’ofa 1976, 2008 etc and ‘Moanan’ in language of Polynesians

⁴¹ I acknowledge Pacific epistemic dialogue (now written) by scholars who have claimed and argued for recognition and re-establishment of their various Pacific societies’ conceptual frameworks post colonisation (in Tonga’s case, post Western contact) for several decades now in academia and elsewhere, (i.e. Anae, Fairbairn-Dunlop, Gegeo, Hau’ofa, Helu, Mead, Meyer, Qalo, Sanga, Smith, Subramni, Teaiwa, Thaman, and many others including the work of ‘white’ Pacific scholars such as Bennett, Borofsky, Chapman, Crocombe, Hvarding, Huffer, Thomas and Salmond).



applying a construct or theory from within my own discipline. Rather I attempt to share others' constructs.

This chapter sketches the Pacific relativist construction of knowledge premised by *tā* and *vā*, which, like many other indigenous knowledge systems is, 'inseparable from the context and the social realities of Pacific peoples' (Sanga, 2004, p. 45). I draw on mostly Tongan scholars as my participants speak and act out of Tongan ontological roots. They are being themselves, Tongan people, acknowledging relationship with me and for the edification of this readership.

Foundations of Reality: *Tā* and *Vā*

Dr Tukuitonga's description above of 'balanced relationship between humans and their environment' succinctly summarises traditional Pacific central realities of *vā*/sociospatial connection (Mahina, 1992; Ka'ili, 2005). Tongan ontology's tangible and intangible, intrinsic linkage of sociality with spatiality (Ka'ili, p. 90) is an expansive concept extending beyond people relatedness to the cosmos, multi-layered yet central to all things (Reynolds, 2016, p. 195). Referring to Mahina (1992, etc), Ka'ili (p. 91-93) explains how these layers encapsulate both the kin group/*kainga* and the *fonua*/homeland where one's ancestors are.

A person is connected and positioned through these dual social and spatial connections which encompass both physical and metaphysical realms. Physical expression of *vā* as sociospatial in Tonga is evidenced in laws of land tenure through inheritance, in ceremonial seating arrangements such as kava ceremonies, all of which sociolinguist Svenja Völkel (2010) describes as being the symbolic sense of space of Tongan culture. As Ka'ili continues to explain, a close-knit Tongan extended family is described as spatially close in a Tongan conception of *vā*: 'Tongans experience social relationships spatially and come to know space socially' (p. 90). This socio-spatial concept is also found in Young-Leslie's description of Tongan maternity: if a child is not behaving well, their mother must not have slept close. That is, a mother is criticised for not having taught their child well enough, through stories at bedtime, to know their 'place, duty, and personal obligations' (2004, p. 401) with the implication that the mother was selfishly pursuing other activities as more important (Bloomfield, p. 28). Poltorak (citing Wendt, 1991) highlights the comparison with the western connotation of space as 'empty'; Tongan *vā* is full as it holds all and gives meaning to everything (2007, p. 13).



Tauhi vā/good nurture of these multi connections through performing duties of obligation maintain *vā*, *fatongia*/communal duties of service circulate, weave and affirm the entire genealogy, even though physical distance often disperses Tongan families (p. 92). Vaka explains that within this concept of *vā* flows the spirituality between the living and the supernatural necessary to maintain good relationships (2014, p. 83). According to Thaman (1988), Tongan society upholds *vā* through interrelated 'emphases on the role of the supernatural, concrete contexts, conformity, rank and authority, social relationships, kinship relationships, Tongan traditions, the concept of '*ofa* [love/ generosity/empathy], restraint behaviour and tendency to discourage overt criticism' (p. 92). Her list contents overlap considerably and I am only able to consider here what I see as key to a few of these areas consequent of the *talanoa*, suffice to say upholding a state of balance in all things and persons requires attention to tend and care to maintain harmony, of upholding the *vā* in appropriate behaviour (Ka'ili, 2005).

Affirmation of *vā* is expressed in the daily lives of Tongan people. As Ka'ili recounts in his personal experiences (p. 97), often this is shown in generosity/'*ofa* by being particularly hospitable. The contemporary importance of living out *vā* through expressions such as financial generosity and hospitality as part of obligation to *kainga*/kin and to upholding these cultural ideals were priorities for Tongan New Zealanders in this study, priorities which can take precedence over other concerns such as personal health management.

Tā/time encapsulates the cyclical and collective means by which everything operates (Mahina, 1992, pp. 38, 39). Conceptually universal among other indigenous cultures according to some, Chilisa's (2012) definition concurs with *tā*:

This circular and cyclical characteristic emerges from a worldview that recognises the interconnectedness and interdependence of all things and from the integration of spiritual beliefs, values, and experience as valid ways of coming to know a reality. (p. 182)

In the cyclical nature of a traditional Pacific world (Hereniko, 1999, p. 140), 'Eveli Hau'ofa⁴² dubs 'ecological time' to describe reliance on regular physical rhythms of nature to punctuate life's various productive and religious activities. His concern was the disengagement of these rhythms and resultant environmental damage by modernisation

⁴² Ethnically Tongan but raised in what is now Papua New Guinea, Hau'ofa (2008) theorised 'Oceanic' notions of ocean people to whom sea was home.



(2008, p. 67). Therefore, time passing is not lineal as in evolutionary or progressive perspectives. Rather the future is seen through the past. The phrase for 'past' in Tongan, *kuonga mu'a*, is literally *time ahead*. This notion of cyclical time helps explain why ancestors are considered so close: they have gone ahead, and being in front cannot be forgotten or ignored, claims Hau'ofa (ibid). Historic events in times before the western emphasis on calendar time took over, was more about where and how, rather than when (p. 68). *Tā* patterns the historical narrative which is 'inscribed on the landscape', Hau'ofa describes how ancient Tongan seafarers navigated sea routes by chants which 'identified sequences of landfalls' (p. 73). In his research, Vaka (2014) finds *tā* to still be the preferred conceptual 'lifeway' in *talanoa* with sixty two Auckland Tongans. Using *talanoa* in itself reflects collectiveness in how life is approached (pp. 228, 235). A Pacific knowledge then is made and justified through these *tā* and *vā* interconnections, amongst persons and their environment.⁴³

Mana, Tapu and Traditional Truth Production and Justification

Within the overarching realities of *tā* and *vā*, Tongans like many other Pacific people place emphasis on the concept of *tapu*/sacredness incorporating spiritual components and upholding *tapu* human relationships (Thaman, 1988). Special knowledge, as distinct from everyday knowledge, is *tapu*/kept sacred and regarded as *koloa*/precious gift to be known by just those who hold it and pass it down. In Tonga, with its particularly stark (for the Pacific) hierarchy between nobles and commoners, 'the aristocracy controlled all the important knowledge in the society. Keeping ordinary folk in the dark...' (Hau'ofa, 2008, p. 4).

To understand *tapu* one has to first grapple with the concept of *mana*, which westerners, particularly in A/NZ, have long adopted in vocabulary but often without understanding its origin in spiritual powers (Metge, 2010, pp. 62, 125). Traditionally *mana* is intrinsic to nobility, reflecting and conferring status, whilst also 'tied to the powers of the gods', the divine and human exchanges between which Pacific people placed a lot of focus (Shore, 1989, p. 139): 'Implicitly, then, precontact Polynesian religion was an economy of *mana* in which generative powers were appropriated, channelled, transformed, and bound' (p.

⁴³ Salmond (1982), describing Māori epistemology, helps here. She states the most valued forms of knowledge were intimately associated with ancestral power and efficacy – thus truth was often connected to situational factors '... in Māori thinking, truth is always contingent upon situational factors, knowledge claims are tied to power, the environment has a right of reply and one is vulnerable to its rebuttals' (pp. 82, 85).



143).⁴⁴ It covered all human needs: biological reproduction, food resource and sociocultural reproduction (ibid.) encompassing all concepts of power and potency, human and divine, human and human, chiefs being the conduit between worlds (Mills, 2016, p. 94). In this way men were *tapu* to women, chiefs were extremely, life-threateningly *tapu* to commoners, and food and sex were conceptually related (p. 163, Shore cites Goldman, 1970). *Tapu* is intrinsic to rituals of life events: birth, puberty, marriage, and death, all having associated appropriate rituals. In general life, touching of heads, hands and eating were ‘metaphysically dangerous activit[ies]’. Mills (p. 84) describes the many and varied consequences of breaching different *tapu* or arousing the anger/*manahi* of one’s superior. Bloomfield states that ‘institutions’ of *tapu* and *mana* as explanations for illness and healing are still evident in Tonga (p. 127).

Of note for A/NZ is that whereas Māori *tapu* of symbolic fecundity was placed on the husband/wife sexual relationship, in Tongan culture this was placed on the noble or chiefly sister (p. 165). The *fahu*/brother-sister relationship remains the most sacred familial relationship for Tongans. The father’s senior sister/*mehikitanga* possesses special rights and she is *tapu* to his children (Mills, p. 87). Put simply, *mana* and *tapu* are cultural principles through which status asymmetry operates. In these *talanoa* participants appeared to speak from these concepts within *vā* when they spoke about spirits and *tapu* situations/special knowledge, and when they talked about dealing with interpersonal relationships marked by authority. One participant, Siosifa, mentioned ‘breach of *vā*’ several times.

Knowing that their ancestors’ spirits are grounded in the land is one aspect of the ways by which Pacific people know the world and what is true. Spirits of the deceased are important, powerful elders who can be active and need attention and quietening (Thaman, 1988, p. 94); they are treated as part of the community (McGrath, 2003, p. 29; Vaka, p. 233). Breaching *vā* by breaking *tapu* can outrage a Tongan ancestor (Gordon, 1996, p. 56), and result in illness, with *tapu* restoration the only appropriate path to recovery (Mageo,

⁴⁴ Binding and girding potency of *mana* was achieved through wrapping persons in special sanctifying barkcloth/*tapa* (Gell, 2002, p. 43; Shore, pp. 151-154). These mats were also offered as gifts to chiefs from the earliest times (Addo, p. 32). Today the work of Tongan women making *koloa*/textiles, Addo describes, as having a ‘very sacred nature’ (p. 68) because they embody ancestors as they perform these skills, which ‘lend[s] *mana*, a non-earthly power, to the objects’. Through *koloa* ‘women value their *mana* and womanliness’ (p. 122).



1996, p. 20). It is in this spiritual area of disquiet spirits and disrespected *tapu* resulting in illness that many Tongans consult traditional healers because they consider a biomedical response and remedy would be inappropriate and ineffective (Thaman, 1988, pp. 93, 94; Cowling, 1990, p. 73). The powerful dead are revered as well as feared. This is described to me in an upmarket office in Auckland's Newmarket by Siosifa, educated in both western and traditional Tongan worlds, who shares his culture with me, a culture nurtured in New Zealand since his family arrived in the 1970s when he was very young.

S: The moment a person dies their status - this sounds very weird – their status goes up. You actually have more status when you die. Because - it's weird - all the honorific language that's used for the chiefs is used for you on your final day on this planet. So, at your⁴⁵ funeral you're often given all the old honorifics.⁴⁶ It's an old Tongan thing of honouring your dead because they are about to walk into the afterlife. And so your organs and your body becomes *tapu*, even more so than when you were alive. So to remove them and to do all that sort of medical sort of stuff, autopsies, you know. Not areas that Tongans want to go because of superstition around not going complete into your grave. And so that sort of view is still very strong in traditional Tongan families.

H: Right, so we've got traditional Tongan that's a traditional and pre-Christian blend and

S: Blend yep

H: Where all this is coming from is that after death, spirits can be discontent

S: Yep

H: And that's behind some of your *'avanga*

S: Yep all the other because when you die there is that spiritual element and not just a Christian thing

⁴⁵ Honorific language, originally only used for chiefs and monarchs, is now also pronounced at funerals for educated elite (Bloomfield p.3). Unclear here whether participant is referring to a cohort of educated men generally or himself personally.

⁴⁶ 'Honorifics are special words and sometimes constructions that a speaker employs to denote the hierarchical relationship between, for example, the speaker and the interlocutor or the speaker and the referent of talk' (Besnier 2004, p.113).



In spite of Christianisation, the work of sustaining *vā* maintains the ideals of societal moral order in which Tongan ancestors' spirits play an important role. Their influence potentially affects the health of the living, physically, spiritually and mentally. In line with what Siosifa describes here, McGrath (2003), states that when someone died their status/*mana* increased to that of ancestor and much care was required to ensure their contented entry to the next life, that the deceased would leave the living in peace and not bother them in the future. As McGrath points out, 'No one in Tonga jokes that it is too bad that the deceased is not around to enjoy his or her moment of glory and fame, because the person is present in a very real way' (p. 41).

Truth in Faith and Forgiveness

Poltorak (2010), researching diversity across 'spirit' healers in Tonga, argues against health policies which tend 'to homogenise and stereotype a diverse body' (p.1), and quotes a healer telling him:

The most important thing about healing is ones faith in it. The power of that treatment comes from God.... The most important thing about Tongan healing is that it is divine. That is something Tongan people still have faith in. I am merely the instrument. God gives me the power to do his work. (p. 6)

Layered, pluralist, or overtly Christian, his healer view accords with nurse manager, Faleola, who declared during our first conversation on the phone, 'Belief is massive for Tongans!'

A Tongan concept of health, according to Bloomfield, is 'freedom from bad feelings held by others and freedom from holding such feelings towards others. Others would include those of the world and those not of the world' (p. 34). Medical science is not dismissed by belief; rather, faith in the role of the spiritual is simply integral to the Tongan cultural world. Illness can be attributed to the loss of *mana* of people in authority when someone under them breaks the *tapu* of their *mana* thus keeping social controls in place (p. 127). God and other people are involved in unwellness, not just the individual who is sick. When an individual sees themselves as part of a bigger whole, their wellness or illness is dependent on *vā*/relatedness being restored to those physical and spiritual realms. Both the GP and a hospital Navigator raised forgiveness as closely connected to healing for Tongans. Participant M brought this up in one of our dialogues which here reinforces delicately balanced Tongan dynamics and personal and spiritual danger when balance in *vā* breaks.



M is a young married woman who has lived in New Zealand for a couple of years. Her immediate family all live in Tonga. She met her Caucasian Australian husband via social media and they now await the arrival of their first child. Excitedly, they had just moved into their own accommodation after being in a temporary crowded arrangement with another Tongan family. Their former hostess was being difficult over their departure as she was losing their board payments and childminding help. I had become aware this person was the reason M had been upset. While we were out together this time I had asked M about how diseases run in a family. She begins hesitantly and slowly as she considers her response.⁴⁷ It was not the type of hereditary disease I expected.

M: For me how I understand it sometimes it depend on how like um (pause) like if the kids (pause) sometimes they angry with their parents. And sometimes they angry with their girlfriend.

H: So anger can cause something to happen?

M: Yes, in Tongan way.

H: So at the moment you're in a very vulnerable position?

M: Yes.

H: To protect your baby?

M: Yes

H: Because something might happen to him if someone was angry with you or something?

M: Yep

H: You've had a hard time the last few weeks.

⁴⁷ I ponder this carefully considered response by M, whether this is sensitive for her to utter, or is she simply thinking before she speaks, or is she just transitioning her response into her second language, English. Sometimes responses are similarly slowly deliberated by older Tongan participants too and I learned from Mageo, (2010, p. 127) the word 'no' is not used in polite exchanges as people defer status to the other, whether or not it is due. Composing an alternative can take a moment or two. Cowling offers another possibility for M's melancholy this week when we meet. M had been upset, someone is angry with her, and she is pregnant. This is why I asked if she was feeling vulnerable. Cowling points out that Tongans link a moment of anger between household members to 'strong feelings of sadness', embarrassment and shame because of the disruption to relatedness/vā (2005, p. 147).



M: I know

H: Are you worrying about your baby? Or that's where your faith has made a difference?

M: Yes, if the kids why they die from accidents and stuff because if the kids angry with their parents, or they angry with the mum because she's not allowed them to go out with the person they like. Or they angry with their girlfriend or boyfriend.

H: So, have you got examples where this has happened?

M: Yeah, for example, one of my cousins he angry with his mum because she stop him going out with his best friends. So he goes back to his room, opens his wardrobe and hanging, um, himself inside his wardrobe. And when his mum going in and knock on the door and they can't find him and his sister playing outside on the trampoline and his sister saw the wardrobe open and saw his brother hanging inside and yelling to mum and run to her. And they running to his room. But when they go up to his room he already died. So -

H: Oh! So he was so upset with his mother he committed suicide!

M: Yes, that's how Tongan people die.

H: And that's a spiritual thing?

M: Yes

H: Like, do you think it's a little bit even *mahaki faka tevolo* because something had taken control of his decisions?

M: Yep, but that boy, when he die, he can't get out from that house. Early in the morning if you go that house early in the morning you can hear a big bang on his roof.

H: The spirit is still in the house?

M: Yes. And he make someone *puke faka tevolo*.⁴⁸ For me, if the Tongan parents did the right way to their kids there's nothing gonna be happen like that anymore.

⁴⁸ To feel ill via a spiritual power



Workings of *tapu*: Cause and effect morality, stigma, and ‘stratified’ diseases

By putting ‘family’ and ‘disease’ into the one question it seems I unwittingly raised the topic for M of the dangers when family *vā* breaks down, of what can happen when sacred relationship is broken, or spirits are not shown sufficient respect, to which participants in this study account. It is explained to me as ‘cause and effect’, the Tongan axiom that everything happens for a reason for which ‘mostly supernatural forces are responsible’ (Bloomfield, pp. 21, 22); hence the Pacific concept of *faka mā*/being shamed and the possibility of *mala*/curse. Conversely, when *vā* is upheld by harmonious social order, *mo’ui lelei* is enjoyed. Young-Leslie (2004, p. 402) points out that this term gets defined as equivalent to ‘health’ but more correctly is ‘to do with proper behaviour in society than any limited medical application’. Bloomfield (p.33) states *mo’ui lelei* emphasises social aspects of a healthful life, particularly the spiritual; for Tongans, ‘body, brain and spirit’. Nurturing *tā* and *vā* by upholding correct relationality for Tongans is striving for health being social harmony which can be perceived to be outside of a western construction of health, and underlies reticence to respond to health promotion as it is administered here.

‘Proper’ or Thaman’s ‘restraint’ behaviour (1988, p. 92) as listed above remains intrinsic within ideals of contemporary Tongan behaviour and duty. Mageo (2010, pp. 124-6) describes how Samoan children are raised to be collectively responsible through nurturing methods by which children are raised not to show wilfulness/*fai loto* but to learn collective responsibility by knowing to ‘stand by their post’, rather than the western axiom to ‘stand on their own two feet’ for individual responsibility. The word *loto*/will is a morally laden one (ibid.) whereby children learn that their elders will communicate with them through the imperative language tense. Hierarchical social order is discussed in the following chapter.

Cause and effect as the workings of *tapu* was explained to me by the Auckland Hospital Navigator team who took up my ‘genetics’ subject like this:

N1: When you say about genetics maybe each one of us will share about genetic for us – you know how sometimes they say that diseases are passed on through genetic, ah – but for us Samoans, sometimes we don’t believe in that, eh

H: No. There’s another reason maybe

N1: There’s a curse



N2: Yep

H: Some of the people I've been talking to have been talking about the curse. So I'm trying to juggle this, how can we talk about this so that both can understand new ways of knowing? ...

N2: With *tapu* in Tonga way back, if something happened to someone, that someone mostly probably broke the *tapu* or do something that is inappropriate to do. And he didn't share it with anyone else but he keep it for himself. And if anything happened to him, and they find out after that, that's the reason behind what's happened. Most of the time it's true!

N Others: Yeah, yeah

H: And do you think most people living in Auckland today still prefer that set of you know they trust in the traditional Tongan way of thinking about that, more so?

N2: I would say so. I would say so

H: Yeah, so your experience with your people here in this *Pālangi* system is this, yeah, there's a bit of a tension there I guess

N1: Mm

N2: I think it's fifty fifty with those ones born in Tonga and migrated to NZ are still strongly believing that. But those Tongans that were born in NZ and grew up here, they seem more to like the European idea.

H: OK

N1: And for us Samoans it's very hard to get off that mindset of being cursed, you know, because from our parents and other generations, you know, there's always the foundations that they laid for their families to follow and if we don't go through the main process of going back to the island, visiting the grave, talk to the grave, you know like: what do we need to ... That's sometimes what our families do to break that cycle, break that curse. Do you know?

H: Mm



N1: And sometimes perhaps it does recover, people can recover from there. But I tell you that it's still existing. It's the same as in the past, just not as strong as in the past. So when they come to NZ. Some -

N2: It's time, it's a waiting time. The longer they stay the more you lose your traditional mindset

This excerpt indicates 'foundations' laid in the Pacific worldview around the power and consequences of *tapu* and of their experience of continuing to work within the place of dual epistemologies here. For Samoan Navigator, N1, genetics parallels curses. In traditional Tongan and Samoan languages, the closest word for genes, heredity, or genetics is *toto/blood*.⁴⁹ *Toto* encompasses transmission of curse and *mana*, as well as physical characteristics and personality.

The Navigators team say they come across family situations involving curses frequently. If a family want her to and it's feasible, N1 will go to the grave of the deceased deemed responsible and offer a Christian prayer to break the curse. Later in the conversation another Navigator, N3, continues that Tongans categorise families by continuing justification of historical moral infractions: 'you're a good family or not a good family because somebody did something in the past'.

For some Tongans, medical cause and effect reality aligns with God's punishments for sin. This belief is borne out by M who shared about a local family to whom she is connected:

H: How did that baby happen like that?

M: It depends from the mum when she pregnant with the baby because if the mum do something wrong or if the mum keep talking about someone mental like that she gonna born the baby mental. It's important to the lady we stayed before. Her daughter is handicapped. And she said, actually what happened to her daughter she's handicapped. She said it's from God. She had her older son. Then the second one, she take it, so it means she kill it. She kill that baby. And she said when she borned the third one, um, something happened to him and she born her daughter and she handicapped. So she said she know 'cos she killed her second child.

H: So before it was born she did something?

⁴⁹ Heather Young-Leslie, post to ASAONet listserv June 27, 2017



M: No, she just went to the doctor and said she didn't want that baby. So in Tongan way we call that you kill the baby because that's not a Christian way

H: Right. So she went and asked for an abortion early in the pregnancy. But that was against God. OK.

M: Yeah.

H: And because she did that this is against her? This is the payback?

M: Yeah, this is the payback for what she did. That's the present from God you know. She don't want it so she killed it, she killed the baby. So she said that what happened for her daughter. How she is um

H: So the next baby? After the one she -

M: - She killed. Ah something happened with his body. Ah so his feet was like um duck feet

H: Ah? Ooh like a duck, webbed. Yeah ok

M: Yeah like a duck. So the doctor they have to thing it. They had to yup

H: So the doctor did separate the skin, so they did that in Tonga?

M: No in here

H: So this happened in New Zealand this story

M: So after that the next daughter is handicapped

H: On no, that poor woman. So she's feeling guilty -

M: I don't think she's feeling guilty. 'Cos she don't care about that

H: Oh OK. Other people say this?

M: Um, everyone talking about her saying she not a good mother

Whilst I felt concern at the content of what I was being told (as M described further high level disabilities of one in particular of these children), this account exemplifies how Tongan mothers can be judged and stigmatised by their own community and how distant their epistemology is from that which underpins genetic testing, for example. This situation



to my *Pālangi* ears was shocking but M wanted to emphasise that this person accepts each of her children as a ‘present from God’ all the same. This mother seemingly takes her place in the Tongan vertical order that places her on a low rung as a bad mother, and frequently withholds her children from school and church. Young-Leslie emphasises the responsibility placed on Tongan mothers of ‘maternal obligation’ to be the ‘cultural transmitters’ teaching their children ‘how to be Tongan’, and to ensure their health (2004, p. 401). This is encompassed in the ideal of proper behaviour required for maintenance of *vā*.

Most participants appear to support a Pacific/Tongan episteme around truth creation justified through morality. Cause and effect aetiology was particularly emphasised by Siosifa who explained to me the ongoing reliance on looking for wrongdoing to explain illness, particularly when a condition passed from generation to generation, justified through concepts of *tā* and *vā*. Moralistic explanations in relation to other persons and practices accord moral justification for lingering belief in curses and God’s punishment has continued since Christianity arrived in the early nineteenth century as it tended to fit with what was already in place (Gordon, 1996; Halvaksz, 2006). This is supported by Tongan/Pacific health literatures (McGrath, 1993; Parsons, 1985; Young-Leslie, 2002 etc), and particularly Tamar Gordon who states, ‘Polynesian cultures thematize morality as ideal structures, stances, demeanours, and behaviours, and as bringing the inner self into line with the conventional obligations, rights, and duties of social situations’ (p. 570). Huffer and Qalo’s philosophical, truth-creating mechanisms are also founded in morality and consensus. ‘Morality is a kind of truth which western epistemologists avoid but Pacific epistemology engages’, the emphasis here is on ‘being subjective and relational ways of knowing’ rather than on notions of objectivity as usually promoted in the West (Halvaksz, p. 111). Siosifa, who works in the health and disability sector in Auckland, further explained:

S: But the first thing in terms of Tongans’ view on disease and illness: there is almost a hierarchy even a stigma about certain types of disease. So anything to do with your head, like mental illness that sort of thing, is given a higher, - a stigma associated with it, almost. So you could have a number of things that you could be battling, all sorts of types of diseases, but there is a stigma aspect around disease because a lot of it is based on cause and effect. And you must have breached some kind of...this our old way of thinking OK? Particularly around things that are



congenital or you're born with, there is an aspect of stigma and a breach of *tapu* associated with the reason as to why you have that. And even though some families have been raised here for generations here in NZ and you would have thought that would have shifted. And because we're still very religious or associated to a church, often the church, sadly, still have that perception of curses and breach of *tapu* kind of thing. And that's carried on, particularly recent migrant Tongan families that have come here. You will see that manifested in ways they take disabled loved ones out publically. Or they'll keep them hidden at home, particularly if they have a mental impairment, intellectual disability.

Siosifa's reference to the vertical ordering of disease concurs with past ethnographical fieldwork in Tonga whereby researchers have described how diseases are classified (Bloomfield, 2002; Collocott, 1923; Cowling, 1990; McGrath, 1993; Parsons, 1985; Poltorak, 2010). *Mahaki faka-Tonga* are Tongan diseases brought on by *tapu* and *mana*. For example, feelings of great fear and great honour such as the potent presence of the king can cause Tongans to become ill (Bloomfield, p. 127). Breaking the *tapu* of someone's *mana* can cause physical problems of which Tongan culture has a list of symptoms; forgiveness is required for restoration (ibid). Citing Futa Helu's work (1984) on culturally-derived classifications, Cowling, puts 'socially induced disorders' or spirit-caused diseases/'*avanga* into sub categories, most of which would be described within the realm of mental disorder. However, her final category is 'mental disability' which she exemplifies as 'brain damage or conditions such as Down's Syndrome', where a child has been interfered with by a spirit at conception, birth or post-natally and made *vale*/foolish, (pp. 73-76). Retained belief in the cause why, and the significance of that cause, contributes to Tongans heightened concern about certain conditions, especially those, as Siosifa states above, that involve the head. These are seen as having a moral or spiritual cause; someone has breached *vā*. According to Cowling Tongans don't discuss ancestor-caused mental illness and treatment with those whom they don't know. Particularly, 'educated' Tongans may deny its existence so as to not appear as superstitious or ignorant. Yet, amongst those whom they wish to share about it, Tongan traditional medicine is discussed with pride (p. 90). Although Cowling wrote two decades ago, and in Tonga, not New Zealand, I discerned in listening to those participants who spoke to me about Tongan medicine that they were proud of it, just as Tongans are proud of their culture generally.



When I visited Langimalie, the Tongan Medical Centre in Onehunga, two staff participants shared together their experiences with families where children had congenital physical or mental anomalies in Tonga⁵⁰ and here in Auckland.

G: But I am just remembering my very first visit to Tonga there was a baby I was asked to see. I wasn't officially working. And the baby had hydrocephalus. And the baby was kept in this house and not taken out.

F: Aww

G: And I felt like there was a kind of shame thing. And therefore I don't know if that's still around but like with this couple now who had the child a couple of years back. If they needed to say to the family, look we had this child with severe abnormalities -

F: Yep

G: - They couldn't live. It would be wise to get your blood checked or whatever. Are they going to be too shy to do that?

F: Mmm

G: Because it looks like we didn't make a proper baby?

F: Yeah (pause)

H:And it also looks like we didn't have a 'normal' baby because of stuff that happened in the past

F: Yeah.

H: Stigma in this area is quite big?

F: Yeah, it's more like *fakamā* [shame].

G: Yeah stigma for disabilities in children I think is quite high.

F: Yeah.

⁵⁰ The Tongan Health Society Inc. regularly sends a medical team from Auckland to Tonga on outreach for short stints although in this instance the participant was referring to the seventeen year period she worked there as a GP.



G: And even, like, I know in Tonga they seem to get neglected. I mean you think about the possibilities even within the limitations of Tonga. There was a place for the disabled children, sort of a school. But there were still heaps of kids that didn't get what was available. You know. That made me sad. It wasn't that they weren't loved. They were still loved, fed and clothed and cuddled. But just to think: I have to take them out and let it be known at OTA Sale [the market]

F: Yep

G: - that my child is disabled.

F: Mm

G: I think that is – I think we see that a bit here too, I think.

H: And the taking out would raise the *fakamā* attitude, that I have this child because

F: Why my child is like this mmm yeah.

G is not Tongan but as a GP has long attended Tongans in both Tonga and A/NZ. She recalls here a patient family who were offered genetic counselling a couple of years ago and wonders if and how they might have approached their wider family about the situation. Faleola, an experienced nurse who is Tongan, is agreeing sympathetically to the situations by affirming G's statements, but in spite of pauses, doesn't contribute so I make suggestions. Faleola then corrects me, "It's more like *fakamā*" (being shamed) than simply stigma. The last sentence in the passage here, that Tongans would look for 'why', concurs with Siosifa's statements to me that moral explanations of disease causality continue to be preferred.

Accepting her children's disabilities as due punishment to bear, and consequently withdrawing them from activities, the mother M described appears unable to respond at this present time to 'what's on offer' in an era of responsibilised living. In expressing empathy, in honouring her belief, acknowledging her cultural status, it might be argued, it is not for *Pālangi* to interfere or judge her or her family's situation or any other Tongan who prefers to know what is true by their cultural epistemology. In a multicultural society we ask: is this a responsible stance, to accept her stigmatisation by her own family and community? I expect most would answer no. This is where I suggest several participants 'labour' (Bhabha, 1994), as I described earlier. Acting in the interstitial gap between



multiple understandings of illness, I listened to Tongans dedicated to taking responsibility to face the challenge in their own community of cultural dilemmas presented by western knowledge such as new medical technologies whilst also upholding their beliefs.

Enfolded Spiritualities and Enfolded Healing Methods

Many Westerners understand biomedicine to be secular but this is not so for Tongans, who associate Christianity with biomedicine as they arrived together from missionary times. Medicine was seen, in many Pacific territories, as a demonstration of Western superiority that would convince people of the irrationality of pre-Christian beliefs. This paradox of both biomedicine and traditional healing being 'religious' in origin exemplifies the historic plurality that is part of Tongan culture, which continues today in modern Tonga (Besnier, 2011, p. 5). Within this plurality, western medicine is recognised as individualistic (McGrath, 1993) and more useful for tackling imported or 'foreign' diseases. Western medicine is not sufficiently holistic for all ailments or to successfully treat the whole person including their soul.

This is intriguing to outsiders given the importance of religious faith in Tonga, that this God-given science is partial, not a complete vehicle by which God might work; thus the need for continued separation of perceived spiritual illness to be treated in other ways. Tongans consider that God's healing can be worked via several *vaka*/boats (Bloomfield, p. 53, 92). However, this layering of ideologies persists in A/NZ, states Vaka, (p. 242) noting that NZ Tongans resort to 'spiritual interpretations' particularly when hospital treatment is unsuccessful. This is significant to this study because an ontology where supernaturals have capacity to initiate illness or generate anomalies makes selection of western medicine illogical for some situations and conditions.

Tongan/Pacific scholars, often graduates of theological institutions themselves, have tended not to openly criticise Christian missionaries or the Bible as instruments of colonisation, despite how rapidly they eliminated the indigenous religion (Huffer and Qalo, p. 90). Others, for example, Tuwera (2006), have called for more recognition for the place of pantheistic indigenous knowledge of gods within the physical world prior to the Christian God as part of an Pacific cultural renaissance. Vaka (p. 240) notes the rapid transformation of Tonga into a Christian kingdom following the conversion of King Tupou 1 in 1839 which initiated mass conversion and effectively created a state church. According to Levy, Mageo, and Howard (1996) the local spirits in Polynesia were minimised by Christianity but



by allowing them ‘a place in the company of spirits’ gave them a powerful place in colonial (and postcolonial) religious domains ‘producing parallel belief systems in Pacific cultures that exist in dialectical relationship to one another. In some instances the resultant heterodoxy has served to subvert Western cultural dominance’, (Levy, Mageo, and Howard, p. 23). Thaman’s view is that ‘the missionaries simply reinforced traditional notions of spiritual life’ (1988, p. 94). Similarly, Vaka concurs that although Christianity ‘transformed society from top to bottom’, it only relegated previously held beliefs and spirits to a ‘deeper’ level within Tongan ideologies; Christian practices were adopted but spiritual structures remained (pp. 240, 241). Thus, as has been noted before for Pacific cultures generally (Hardin, 2016; Gegeo, 1994), Christianity was ‘enfolded’ into a pre-existent religious belief system.

In A/NZ it is generally known that most Pacific people are devout Christians. Time spent in M’s company and also with some other participants, taught me that reference to ancestors’ and other deceased spirits, their activities and powers, that is, pre-Christian as well as Christian spirituality is normal. I suspect the extent to which this is the case varies from denomination to denomination depending on their pedagogical and doctrinal sway as well as family to family and time lived in New Zealand. From my narrow experience attending Tongan church services, I have come to assume a range in degree of belief in pre-Christian spirituality exists in the NZ Tongan community. At a Tongan congregation of the New Zealand Methodist⁵¹ church which I attended⁵², the pastor preached a strongly New Testament message on the absolute power of Jesus Christ crucified to overcome all sin past and present (1 Corinthians 2:2), leaving no place for actions of other supernaturals.⁵³

M doesn’t belong to a ‘Tongan’ church denomination. She has always attended The Salvation Army, firstly in Tonga with her family, then here in south Auckland. Therefore, it happens we both belong to the same denomination and we attended a service together soon after we met.⁵⁴ Although, having both formally confirmed our belief in the same set of Christian doctrines as teenagers, in listening to M, I discover differences in our perspectives (for example, ghosts banging on roofs and disabled children being God’s

⁵¹ As distinct from the Tongan Wesleyan church denominations.

⁵² I attended February 5, 2017.

⁵³ This might also be the case for more recently arrived Evangelicals and Pentecostal denominations in Tonga who, Cowling (1987, p.73n2) notes, discourage their people resorting to traditional healers, labelling this as Spiritism, instead however, encouraging consultation of Christian healers.

⁵⁴ On September 18, 2016, we attended a regional celebratory worship service at Auckland City Corps, Mt Wellington, a venue to which neither of us had been before but where we both knew others present.



punishments for sin which I have already recounted). Getting to know her revealed for me the enfolded and normalised pre-Christian spirituality that is part of Tongan culture. When I asked M if, in Tonga, the use of traditional medicine was frowned upon, she laughed and exclaimed: 'No, everybody does it. Not just someone. But everybody does it!'

To whatever degree Tongans believe in ancestor spirits and their activities or not, Tongans certainly grow up aware of them. Bloomfield states that the Christian God is the deity 'believed' but in practice, particularly in medicine, 100% of the people she saw during her 1980s study had some involvement with traditional curing grounded in earlier beliefs (p. 32).⁵⁵ A traditional healer's help is often sought in instances of non-recovery as this is viewed as a possible sign of spirit-caused ailment, perhaps when hospital treatment has not succeeded, and sometimes vice versa (Bloomfield, 2002; Poltorak, 2010). Thus traditional healers, of several types for different purposes, continue to serve their people with various (depending on the type of need) and evolving curing and methods: herbal concoctions, massage, card playing, advice, bone-setting, incantations, and Christian faith-healing prayer (Bloomfield, 2002; Poltorak 2010), sometimes simultaneously (Cowling, 1996, p. 73; Gordon, 1996, p. 61). Not surprisingly such syncretic combinations perplex younger generations born here in A/NZ.

Entangled efforts of intercession caused confusion for participant, 'Ana, who was unaccustomed and uncertain about practices used when she rushed to Tonga to care for her dying mother who usually resided in San Francisco but had become very ill whilst visiting her family.

A: So my mum's sisters and her mum and I, we all went over in February this year and stayed there for three weeks. She was in hospital. She was just in so much pain she didn't want chemo, she didn't want any of that. She just had some Tongan medicine like those home remedies I don't know. There lots of people just come in and do whatever they think best for her.

H: So the hospital, which is a Western-style hospital, is happy for the family to bring in a Tongan healer and administer, sprinkle the nonu leaves or whatever?

A: Yeah, she would drink some things. There was this guy who would come with these special leaves and just rubbed it all over where the breast cancer was. Do like

⁵⁵ Bloomfield notes it must be also recognised that in isolated locations such as islands without medical services, people don't have a choice so curers resourcefully care as they are able with whatever is at hand (p. 55).



this slowing motion. Like they're all different kinds of people just like this is silly like you know...

H: So your mum wanted it? Or who was ...

A: Yeah, I think it was just anyone, they were just desperate for anything.

H: It's true isn't it, when you haven't got a good prognosis you try whatever. Though for Tongan people this is the way Tongan people do things and your aunties who went with you, are they very Tongan too? Did they want to have the Tongan healer?

A: It was quite funny because one of my aunties would be like, oh, this is rubbish! I think even some witch doctors or something would come in and say - because I had an aunty who passed away of breast cancer about five or six years ago, and that was my mum's first cousin - and they kept saying that they saw her. And then another lady came in saying that she saw my Dad's parents. And I think my mum was hallucinating at the time.

H: But this is typical Tongan seeing the spirits? They're seeing the dead spirits and...

A: Yeah, yeah, there was a lot of that going on and you don't know who to believe.

H: Did you feel a bit confused?

A: Yeah, absolutely.

H: You're just a young girl yourself. You've been through a lot. You're younger than my youngest daughter so you're young!

A: I haven't even lived in Tonga. But you know, going over from overseas even my sisters who grew up in Tonga they were saying: You know, mum, nothing is going to cure your cancer. Let's be honest here. It's in her liver, it's in her stomach. You should just leave her be. Me and my sisters just wanted her to go away peacefully rather than people coming in and doing their hoo-hah on her. I guess, you know?

H: And what about the Christian side of it? Was there a pastor as well to come and pray?

A: Yep, there was a lot of that. Pastors.



One of my first *talanoa* was a visit with a social worker/pastor in his office at the Mangere Tongan church where he is based. The Reverend has been in New Zealand a long time, though he has also ministered in Tonga in years past. He sees his responsibilities to include encouraging his congregation and fellow pastors to embrace new knowledge and opportunities, as the knowledge found within ‘science is just part of [God’s] creation’. Most important for the Reverend is the nurturing of family relationships. The Reverend explains that balance is required for healing as all health is about relationships, that spiritual health is important for physical health. He considers that, ‘faith and the health team work together nicely’, stating he has seen people restored to health by traditional medicine of faith healing when doctors could do no more.⁵⁶ Both male participants in this study, Siosifa and Reverend Simone, mentioned traditional Tongan healers’ successes when doctors couldn’t, whilst these men also embraced biomedicine themselves.⁵⁷ As I discuss later, Siosifa often states his ‘both and’ maxim for understanding health and healthcare. Simone uses the word ‘blend’ with regard to embracing holistic living which incorporates spiritual/medical plurality. Both these participants are mature, well educated and, like Faleola and the Navigators, they choose to be employed where they can serve Tongan/Pacific people across dual epistemologies. In this way they each respond by ‘labouring’ from interstitial spaces between cultures.

Conclusion

Whose knowledge? A challenge for *Pālangi*, particularly in human services such as healthcare, is to recognise the difficulties posed when dual epistemologies are present, and disconnection is present, even when people are trying to deliver good services. In this chapter I have engaged Tongan scholarship to introduce elements of traditional ontology and epistemology: concepts of *tā* and *vā*, by which people place themselves in the universe and relate with each other as well as spiritual beings and the divine. These realities reveal the importance of spiritual beings and their powers in addressing social and physical health and addressing illness. Pacific/Tongan explanations of illness causality and treatment often have ties to these traditional concepts of reality.

⁵⁶ Knowing of someone restored to wellness by traditional healers when the doctors could do no more is a commonly repeated story in Tonga (Poltorak, 2010, p. 7)

⁵⁷ Contrary to Vaka’s *talanoa* research addressing approaches to mental illness in A/NZ which revealed Auckland Tongan men preferred Tongan concepts to western ones to address the illness (2014, p. 257)



I have also introduced, via the work of other scholars and participant *talanoa*, the concepts of *mana* and *tapu* which underpin traditional concepts of authority and knowledge. Traditionally, these concepts underlie notions of moral or ‘personalistic’ disease etiology, which ‘stratifies’ and classifies conditions and consequent stigma around certain conditions. In the domain of medicine and healing, Tongan people have a long pluralistic healing tradition encompassing Christian belief and practice which has been enfolded into bioscience and these earlier cultural concepts. Prevalent faith in a Christian God as ultimate healer and the upholding of *vā* to maintain family and societal harmony through appropriate behaviours including forgiveness are major factors for consideration for those who work or serve Pacific people.

These *talanoa* indicate a Tongan/Pacific epistemology can transcend the limitations Pacific people attribute to *Pālangi* knowledge, particularly the sciences, due to the role of supernatural beings, including ancestors and the Christian God. Some participants’ perspectives incorporate both bioscience and faith when considering healing, responding across double epistemologies. Having sketched a Tongan worldview using scholarship and *talanoa*, the next chapter unpacks this further by considering Tongan hierarchical kinship connections impacting medical encounters and familial life.



5. Respons-ability: Knowledge for Living Vertical and Collective Kinship

'Knowledge that Counts'

An appreciation of how relatives (the living and the dead) relate to one another via rank is intrinsic to appropriate interaction with Tongan/Pacific families. Important members of a Tongan community, such as pastors and medical practitioners, and important members of the family are revered; each family member is expected to know how to act appropriately to show due respect/*faka'apa'apa*. '[F]or the various peoples of the Pacific, kinship is generally understood to come under the heading of 'knowledge that counts' (Toren and Pauwels, 2015, p. 1, citing Nabobo-Baba, 2006). In this chapter I use *talanoa* data to first draw attention to two different power and status holders, the medical practitioner and the *mehikitanga*/father's sister. When viewed by Tongan ideals: through *vā* and *tā* of reality and within concepts of *tapu* and *mana* of persons, it is necessary to demonstrate proper conduct and regard, each to the other, '*eiki*/noble and *tua*/commoner; important knowledge for appropriate interactions.

The ideal for showing love/'*ofa* and respect/*faka'apa'apa* to others' *mana* and status within the collective group, has played out through obligatory gift exchange. Addo (2013) emphasises the act of gifting being both negotiated and requiring reciprocity operating across diaspora as modern nation-building/*langa fonua*. She and Besnier (2011) have noted the burden, both in Tonga and A/NZ, to continue the level of expected giving, especially for special events and church giving (Addo p. 139). When Tongans choose to withdraw from obligatory giving, they face potential shame/*mā* and criticism. The operation of these behaviours wrought of traditions of social respect and obligation is known as *fai fatongia* (Besnier, p. 70). The degree to which NZ Tongans perform *fatongia* through financial contributions is a burden that female participants wanted to share with me: the expectations and the decisions they are making with their families. So I use the later section of this chapter to reveal these women very briefly as mothers, nieces, sisters and daughters, stratified kin negotiating everyday life in Auckland and occasional life when they go to Tonga.



This pairing helps show the conflict of contemporary Tongan living juxtaposed against the ideal of the self as behind or below others, 'that identity is deeply dependent on others and burdened with obligations, too ashamed to focus on the needs of self, its body permanently stooped in a posture of apology and self-abasement' (Besnier, p. 20).

Altitude

When I pondered aloud to 'Ana about how you know where you belong in the social order she simply replied, 'You'll know if you're living high up there'. Other than 'Ana I didn't enquire into participants' social altitude but most mentioned about the well documented vertical ranking within the Tongan family and of Tongan society (Gifford, 1971[1929]; Bloomfield, 2002; Douaire-Marsaudon, 2015). Social hierarchy is common in Polynesian societies. Most Tongans see themselves as being born with low status/*tua* – being under authority of God, ancestors, the Tongan king⁵⁸ and all other people who rank above them⁵⁹. Very few are born royal or titled (*'eiki, nopele*) but growing numbers of 'educated elite' and wealthy maintain the social and structural hierarchy (Bloomfield (pp.3, 60); Hau'ofa (2008, pp. 167, 168); Macpherson (2004 [of Samoans]); Thaman (1988, p. 233). Seniority and sex determine ranking principles: the older possesses superiority over younger, in chiefly lines this carries through the extended family regardless of age. Sex transcends authority, thus sisters are superior over brothers (and male cousins) by rank whatever their age and father's family group is superior over mother's (Douaire-Marsaudon, pp. 188, 189). There are many further rules and deeper complexities which I have omitted for this primary discussion.

Collectiveness and *Mana* of 'Authority Figures'

As introduced in the previous chapter, like other Pacific and many indigenous societies, Tongan society has always operated collectively. To be autonomous or individualistic is seen as neither a Pacific nor Tongan approach. Within collective *vā*/relationships, illness is the concern of the whole community (Bloomfield, p. 60). Change and decision-making issues are viewed by the *kainga*/family group as something done together to the benefit of the group, always with appropriate *faka'apa'apa*/respect given to persons of authority. Thinking collectively about the other is put by my particularly passionate participant, Siosifa, when I boldly ask him whether he thought Tongans resisted biomedicine. I suspect

⁵⁸ The Tongan monarch is considered God ordained (Bloomfield, 2002: 31) a status evolved from a chief being god-like pre-Christianisation (Besnier, 2004: 112).

⁵⁹ For a more detailed list see McGrath (2003: 44). Mageo (2010) also deals with this for Samoan culture.



he is quite experienced at framing Tongan views into *Pālangi* concepts for beginners.

H: Are the Tongan people saying: We don't want your *Pālangi* medicine? Or, is it recognised amongst the community as, the westerners want us to do their health stuff but we'll die when God wants us to die?

S: There is a little bit of that, apathy, in our communities, I think. It's seen as almost – how do you put it – this is going to sound weird – but it almost seems selfish to try and get yourself good health. It's about the other. Like, for example, smoking, good example. If I was a smoker which I'm not, but if I were a smoker and someone came to me with a programme saying, look you gotta quit smoking 'cos it's going to cause you cancer, you're going to die. I'm hearing: they're telling me to suck eggs, I'm gonna die anyway, it's none of your business (chuckles). That's what a Tongan would think. A lot of others might also think the same way. However, if they reframed it and said: Stop smoking to have more time with your children, that's a very different thing. So we have an outward sense whereby the benefit to others is more important than what it might benefit me personally. And we have a culture that's built around the other. We avoid having those difficult conversations because of respect to the other person. Although the other person knows that there's an issue, we tend to skirt around it and find ways to get there. That could be another way attitudinally that we have resisted medicine and things like that, potentially. But I think overall there are some things that in our Tongan culture we do respect authority figures and doctors in particular. They are treated like gods in the islands.

Although I could examine several elements of Siosifa's response, I take up his last two sentences here. I found this quite paradoxical. As *Pālangi* I would be honoured to be treated by anyone who is so esteemed. I learn this is not a Tongan way of seeing somebody up there 'like the gods'. This person has more special power/*mana*. They are expected to act to suit their status including in the doctor-patient communication situation (Poltorak 2010, p. 2; Gordon, p. 67). Participants, Faleola and Dr G, who both have experience working in Tonga, described their experiences of doctor/nurse-patient communications:

H: I'm interested in the fear of the hospital system...



G: I do think the doctor patient relationship isn't very good in Tonga

F: Yeah

G: Old school, a lot of old school. I don't want to criticise my colleagues but I don't think many of them have got a good bedside manner that I have observed. And I'm sorry to say it but I also used to get bad stories about the nursing side.

F: No, No, it's true.

G: Like they go along to the diabetes clinic to have an HBA1C because when it first came to... and the nurse would be rough with them and say, well why are you going to that clinic? ('cos mine's private), why you going to that clinic? And they're packed! I'm siphoning off just a few. And then they get told off, that sort of thing!

F: Yeah. I agree with G on that because, you know, we have a hierarchy in Tonga. And everyone knows who is sitting here and who is sitting in the middle, or sitting down here. So when they go to hospital the health professions acting somehow acting a higher elevation.

H: OK

F: And the patients look up at them. And G knows the reality. Oh, I'm a nurse, I'm a sister in charge and do this, do that. That's the reality, and sometimes they told off the patient. That's the relationship, of the patient not coming back to see them, and they say whatever problem they have, they believe others, like Tongan medicine or healers, than coming into the hospital... I was working in Tonga for sixteen years OK as a nurse and I came here to start working at Starship and now I'm here. But reflecting back on my journey from Tonga to the public hospital in NZ and the community, going back again to a Tongan outreach I can see that it is still the same.

G: Not changing?

F: Not changing, it is still the same attitude-wise

G: Oh, that's sad

F: It's still the same. Even on the nights that we do our outreach and then we just sitting there and watching the Tongan nurses you know just yelling at those



because they queue all lots of people on one night. And I thought to myself: how can we change this attitude?

This exchange concurs with scholars who have commented on health service outworking in Tonga. Social distance is exhibited by respect to the superior person as in not asking questions about something they didn't understand which would also reveal their biomedical ignorance (Bloomfield, p. 60). And the status holder is expected to express themselves accordingly, sustaining contemporary poor doctor-patient communication due to status bias of a hierarchical society (Poltorak, 2010, p. 2). Discussing agency and will in Samoan culture, Mageo states that to ask is to assert authority by ordering and to say no is to contest authority (2010, p. 127). Thus in polite exchanges, the other is treated as if of higher status regardless and the word 'no' is not used. The status borne by higher ranking kin and community leaders particularly pastors and medical practitioners is attributed to be behind reticence by common Tongans to engage with practitioners of biomedicine because patients' are made to feel inferior (Bloomfield, p. 60).

Turning to A/NZ, an incident was recounted to me by a *Pālangi* participant (D) who is a nurse at an Auckland high school with a high Pacific student population. When a Tongan student fractured his leg on the sports field, Tongan staff avoided involvement in addressing the student's situation when his parents denied him receiving surgical treatment for the fracture.⁶⁰

D: Not one of them wanted to touch it even though they believed he needed treatment, wouldn't touch it with a barge pole.

This participant did not understand why the school's Tongan teachers and social-worker avoided involvement but she was aware the family of the student was 'incredibly scared to go to M Hospital'. I have noted previously the Tongan categorisation of illness, fractures can be seen as *tevolo*/spirit-caused, and thus several possibilities might explain this incident. It might have been this particular family, their social status or role, and staff perception of themselves in relation to those parents, to not contest their authority over their child. But all these possibilities pertain to operation of *faka'apa'apa*/respect being played out in a hierarchical community.

⁶⁰ They were happy for *Pālangi* staff to take up concerns for the boy's welfare so D provided the boy crutches to use during school-time.



A cultural background of social distance is pertinent in A/NZ wherein medical practitioners ought to be aware, when attending Tongan people, to consider how their patient/client might perceive them. (Perceptions of) social barriers can be very real for a Tongan/Pacific patient/client and affect their level of engagement with medical services both in Tonga and A/NZ. This further supports the beneficial role of Pacific intermediary persons in healthcare delivery, such as Navigators and similar support teams who, aware of hierarchical barriers, are able to work across the double epistemologies and cultural expectations.

Fahu/ the Brother-sister Relationship: Meeting the Queen of Narnia

Many scholars have examined the kinship principle of opposite sex siblings in the Pacific. Douaire-Marsaudon (2015) lists: Rivers, 1910, Murdock, 1949, Wood-Ellem, 1981, and Biersack, 1982, amongst others. In Tongan culture the brother-sister relationship/*fahu*, holds the most *tapu*, traditionally requiring appropriate respect and avoidance be properly upheld. At life event special occasions she sits in the place of honour. At funerals it is the *mehikitanga* who represents the living to commune with the dead, and lifts *tapu* (Douaire-Marsaudon, p.197). I was interested in finding out how this brother-sister relationship played out in everyday contexts here, particularly when connected with decision-making in healthcare. So when Siosifa describes his father's sister having absolute rights over him whilst he further explains Tongans' need to look for curse in reasons for illness, I ask him if he seeks her counsel:

S: Our belief systems are built around that cause and effect model in terms of cancer for instance. That could be viewed as a curse as well. If that person's grandmother, mother and children have the same disease something must have been wrong, someone must have done something.

H: So it's a social thinking

S: A social thinking around, yep

H: Not a biological one. So I guess my writing wants to address that people don't think biologically all the time they think socially about these things.

S: They do. They're the cause and effect. So it's a breach in the *vā*, in the relationship somewhere, especially to do with brother and sister. That's the most



sacred relationship there is. So if there was some kind of issue, did not perform his duty to protect his sister, or broke the tapu with his sister, there is a curse that will happen for his children. So the sister has almost a magical status within the family. She has the right to name all of her brother's children. You know the wife has no right at all - in traditional Tongan families. My older sister has the right to name all my children. My father's sister has a special relationship over me, her brother's children. It's called *fahu*. You know, full rights to my person and body. So she could come to my house seize whatever she wants and take it. And I can't do anything about it. That's how strong that relationship is. It has an effect.

H: So, for example, if somebody got a diagnosis say of cancer or something. Say it was you. Would you go to that aunty?

S: My aunty?

H: That person who had authority over your life because you are the brother's son?

S: Not necessarily.

H: I'm just wondering how people talk about this kind of stuff. And make decisions.

S: Yeah again, for instance, it's more about what other people might think, in terms of your social structure. They might say OK, if J's daughter has developed some kind of cancer or something, they'll say: Oh, J must not have looked after his father's sister's family. It's more around that. I wouldn't go to my father's sister's family and say: Did you curse me? I wouldn't do that. It's more what other people might see. They'll look at a reason for that. It kind of sounds a bit silly - looking for a reason.

His response here surprised and enlightened me: a Tongan way of seeing the world, in which the *mehikitanga*, the 'senior sister of the real father', holds special powers (Douaire-Marsauldon, p. 195) even though he wouldn't presume to ask her about activating them. Incorrect was my presumption her authority meant seeking her approval or guidance as an elder. He comprehended that seeking out his aunty was about whether he or his daughter was diseased because she, as *mehikitanga*, had cursed him by reason of the *tapu* of *fahu*. Not that he really believed this might happen to him but that the potentiality of the *fahu* curse is at the root of looking for causality; it is in the sacred moral and kin relationality that lies underneath Tongans' wariness of their behaviour. The capability of the dead or living,



such as the *fahu*, to place curse lingers. In Siosifa's depiction here, what other people might assume of him is seriously important because culturally there is a constant need to be respectful and show it to maintain one's reputation; to demonstrate undertaking and acting out obligation within kin connections on this vertical trapeze of hierarchy and kin powers.

He is also describing being judged by the community who seek moral causality for an illness or condition when he says: 'It's more what other people might see'. Siosifa's hypothetical situation here concurs with M's real description of the mother of disabled children in the previous chapter being judged a 'bad mother' by her community because she has two special needs children, revealing cultural attitudes from which Tongan's conceptualise: the upholding of or breaking of *vā*.

'Ana's impression of *mehikitanga*, given below, provides another perspective. 'Ana, a younger New Zealand-born Tongan, had heard about her mother's fraught relationship with this sister-in-law. As an adult, she meets her father's sister, the *mehikitanga*, for the first time:

H: Your Dad's sister, is she a significant person, technically?

A: She is, because in the Tongan culture it's a big thing. So, my dad's sister they kind of put them up on a pedestal and it's like that for all Tonga. So like your aunty's like Queen of Narnia. I really don't understand it but she holds that quite strongly against my sisters. When they grew up in Tonga she would make them cook this, clean that. Do this and that. And my sisters would do it while her kids are just sitting there. You know? It's like she took advantage of them...

When my mum passed away we heard my Aunty was coming to my mum's funeral, 'cos she and my mum did not get along at all. My mum did not stand for that. My mum was quite out there. My mum tried to fix it... Don't do this to my kids....

H: Your father's sister, this other woman who has rights...

A: ... She was judging me quite a bit, just the way she looked at me, analysing me, I felt like real pressured. But her kids were lovely. It was just her.

H: So there's kind of a barrier there. You're not too sure. You got to watch your behaviour.



A: Ahmm, yes! Even when we had dinner, I remember they were saying well A's going to do the first part. And I was like, what? With me growing up in Aussie, I didn't talk much Tongan. I had so much more freedom when I grew up. My grandma only taught us one prayer in Tongan and that was a song. And I wasn't going to sing that song. And so I kind of just made this small Tongan prayer. And I remember her just glaring at me. I was just so – it was like I was walking on eggshells all the time. When my mum passed away we knew she was coming. She told us off. She told off my other sisters. But me, I try to stay away. You're not my aunty; I was raised by my other aunty. And she will say, you girls are not allowed to wear makeup, or put your hair up.⁶¹ Your hair is supposed to be out... You're not allowed to wear any makeup until she is buried. I don't care... Then I went to her and she kind of just hit me on the forehead. And I went, wow! So rude! So I'm quite modern compared to them. Whereas my sisters, they would shake it off. They are so used to my Dad's life. I'm not... Some families are stricter than others. My mum's family is all about the laughs.

Through 'Ana we glimpse transnational, second generation NZ Tongans grappling with issues around what is proper respect for the status of the *mehikitanga*, and how to negotiate that within their family group. Her *talanoa* here does not show textbook kinship of *fahu* and *tapu*. For 'Ana, *fahu* is strictness; one side of her family practising a more rigid expression of traditional status than the other. It emphasises not only the existence of social roles, such as *mehikitanga*, but the complexities and dilemmas for those unfamiliar operating within them when the occasion calls for it.

Upholding Responsibilities and Reputations

In the previous chapter 'Ana related her account of attending her dying mother, which demonstrated enfolded spiritualities and healing practices. To be in Tonga with her mother she had taken leave without pay from her work in Auckland, flown to Tonga to stay several weeks with two sisters and other relatives from Australia. Together the family also paid the cost of having an air conditioning system installed in the family home in Nuku'alofa so her

⁶¹ Showing grief by not going to effort of good grooming is normal in Tongan mourning and the hair is particularly important in this ritual (Besnier, 2011, p. 166-8). 'Ana had pointed out several times that her mother was always meticulously groomed and beautiful but I didn't ask about any particular motive here. I presume she dressed herself as usual and this caused the aunty's ire.



mother was more comfortable than in hospital. Hardest of all was nursing her mother, keeping her comfortable and dignified: 'It was hell looking after her.'

I was taken by her effort and compassion considering her mother (and father) had 'left [her] to Tom, Dick and Harry' as a baby: 'I had lots of mums growing up'...'she was not part of our lives'. It was not until her teens 'Ana finally met all her four siblings, two younger, two older. She spoke to me about having to deal with her feelings of resentment toward her mother for pursuing a career, of not being there for her. Often referring to her mother's beauty and professional focus, 'Ana mentioned her mother's choices conflicted with her father's family views on how motherhood ought to be undertaken, that she was regarded 'modern' and was criticised. 'Ana recognised that her mother viewed her own absence as ultimately to benefit her family, 'sending all her money' to her husband in Tonga. She explained that she and her sisters had discussed what they might learn from their parents' 'high-school-love-story-gone-wrong' was to be better parents themselves one day. Her resolve to not bear resentment was to respond with 'ofa/love as a dutiful daughter.

This is an example of *kainga*/kin whose various places of birth and upbringing have impacted on family allegiances, appropriate deportment and behaviours, such as at funerals. Even so there remains a strong sense of family collectively doing life together in spite of tensions to do with strictness and protocols when they visit Tonga. For 'Ana, multiple geographic places are central in her world as even her nuclear family have spread their lives across four nations. In some ways the family epitomises Addo's multi-territorial nationals creating valuable movements back and forth (p. 20), not in textile gifts/*koloa* (although this might also be the case), but in trying to maintain their *kainga*/wider family, cultural and religious ties, gathering for family events, and often via social media. Sometimes this too causes conflict. 'Ana described more clashes with her *mehikitanga* pertaining to preparing and facilitating family Bible devotions in the facebook group her family instigated consequent to the mother's funeral. They also fit Besnier's description being contributing players in pluralities of Tongan modernity (2011, pp. 11, 22); of dilemmas of competitive collective and autonomous self for Tonga and Tongans, where Tongans from A/NZ are generally perceived to possess insufficient 'ofa/generosity and respect/*faka'apa'apa*, yet the Tongan-situated members have long relied on money sent from those offshore (p. 43).



'Ana sighed that she was always saving for some forthcoming event in the family, sister's wedding next, and also a cousin's wedding. Therefore, the unveiling of their mother's headstone would probably have to be postponed a year because of the financial burden of the other events upon the New Zealand-based sisters and their family in Tonga.

H: So the mats are still a very big thing in your culture?

A: Yeah, especially in Tonga. Like everything is done in Tonga. It's going to be horrendous. With me not growing up in Tonga I don't really care about that stuff

H: Big events. Some ways I admire it in your culture as we don't make big of things as *Pālangi*, like special events, well weddings yes. But unveilings we don't do, markers in your life story. I like it. But, if you can't afford it...

A: Yeah, that's why we were going to hold off for a while which they weren't happy about. This wedding should have been postponed while Mum is the priority. But you can't do anything about it now. You know. This mother-in-law wants this big Tongan wedding. We just can't do it.

H: So does the bride's family pay for the wedding in Tonga like it has been in western traditions? Or do you share it?

A: In Tonga culture the bride's family do the day of the wedding and then the first Sunday, 'cos that's another Tongan thing, the Sunday after, it's the groom's family.

H: And it's about feasting and –

A: Yeah. But this mother in law wants to party both days. And my mum's family are like, No! 'Cos it's more work. Keep it simple.

H: Especially when you are not all based in Tonga.

Participants in this study raised kinship activities which tend to suggest that gifting, hosting special birthdays and other life events, and donating to church and its missions can be bigger and consuming concerns for NZ Tongans than attention to their physical wellbeing. I posit this because these participants chose to raise these topics in my *talanoa* for which, although totally informal and at their lead, had been set up to discuss perceptions of hereditary disease and healthcare. No mention was made of any conflict or financial juggling with health needs or care, rather conversations simply developed about being



Tongan in Auckland, which involved the topic of kin obligations being high level priorities. Faleola also raised with me her worries in meeting hosting and cultural gifting obligations, especially when raising New Zealand-born children in a society which doesn't share these values. In expressing the burden she feels of finding money for special events (getting told by an appointed elder what amount they are to contribute), Faleola expressed to me that being *Pālangi* was easier because *Pālangi* can save for things they actually need or want like a car as opposed to borrowing for one and paying interest.⁶²

F: This year I just agree with my husband, we will get on into how we think is good for our family. And I feel better doing it that way.

H: Yeah. Good

F: And I always think to myself and comparing western culture with my culture. I thought to myself, if you're not contributing to the community or the extended family they might be say you're a *Pālangi* and not join our Tongan culture. But doesn't matter. I have to do the best for my kids and my grandchildren. But I feel better now and not really join any big birthday or anything like that. Maybe the very closest one we go in.

Reducing her family's involvement in *kāinga* donations to only close family was a positive decision even though Faleola had to contend with the damage to their reputation. This story concurs with Addo's New Zealand informant's dilemma over donations. In assuming agency to choose whether or not to donate, they face the criticism of those who might shame them for not being suitably 'Tongan' (p. 137-140).

Giving can be competitive in some Polynesian contexts (Besnier, 2011, cites Mauss, p. ix); it is transacted according to what others expect. '*Ofa* is the principle virtue by which Tongans bear the burden of upholding traditional duties/*fua kavenga mo e fai fatongia* within the operation of societal and kin, thus hierarchical, obligation (p. 70). According to Besnier, in Tonga, '*ofa* is 'the most overelaborated and hypercognized emotion in the local repertoire' (p. 69). The bearing of the burden of this virtue engenders inequalities at the same time (p.70). Although Besnier admits they have faced criticism from Tongan scholars for their views, he and Addo have each argued that Tongan obligatory giving perpetuates 'systems

⁶² I suppressed a retort that this *Pālangi* also needed a loan to buy a second hand car, and later realised I recognised truth in her words: no relative or church kin of mine would be telling me how much I ought to gift anywhere. Culturally, I did have more choice how I spent my money.



of inequality framed as exchange' (Besnier, 2011, pp. 255n4, 209) and the impetus of generosity, they argue, is more about consequential *mā*/shame than offerings of *'ofa*/love.

In her ethnographic account, Addo describes family reputation being at stake creating tensions and impending *mā* /shame if your family doesn't have enough to donate for a special event (p. 139). This leads to families spending more than they can afford. Likewise with giving to the church, Tongans were pressed back in missionary times to give generously to honour their generous God. Their propensity to give more than they could afford was already noted back in the nineteenth century (Addo, p.170-71 cites Rutherford 1996). For Tongans, actions out of respect connote upholding one's reputation in a competitive community, which in A/NZ is likely to be one's church community and the kin group. Emphasising cultural protocols in New Zealand through funerals, celebration feasts, and church fundraising are means to retain cultural identity and raise younger ones to follow through with the same values. However, as 'Ana has described, the manner and timeliness of expressing these values are not how she sees the way to do family life. 'Ana considers she understands the meanings within her culture much less and her family's values less than her Tonga-raised sisters. Without parents or other elders in A/NZ she is aware of her 'freedom'. For Faleola, she has chosen with her husband to consider her nuclear family's needs above that of family and church elders, at the cost of being criticised by extended family.

Conclusion

In this chapter I shared a range of explanations and experiences of medical and family encounters demonstrating ranked behaviour according to status being shown: expectation placed on the relationship between patients and their medical practitioners; and two accounts around the *mehikitanga*/father's sister. Siosifa taught me about the reverence held for her and the importance of upholding one's standing, that Tongans are always looking for a reason as to why something has happened and *fahu* is the most significant tapu to uphold. 'Ana's story of her *mehikitanga* (though she never used this term) expressed conflict and feelings of her aunty's disapproval of her, and of her own non-acceptance of her aunt's presumption to enact her authority physically. Collective hierarchical expectations towards monetary and gifting priorities were particularly brought out by female participants that Tongan people act according to the expectations placed upon them by those of higher status. However, this is not always followed as shown by



non-participation and non-conformity decisions by some participants. Whether making adjustment to their level of obligatory giving or not, participants seem often pre-occupied with competing responsibilities of contemporary Auckland life and retaining their cultural values.

Universally, humans might not incline to attend preventative health actions if feeling well but as Bloomfield states, social health is always more important to Tongans: 'It's about what others will think' (p. 127), which were precisely Siosifa's words to me. For Tongans, preventative or risk management healthcare appears both pragmatically and culturally to lack priority because reputations rest on upholding duties of respect to higher others. This simply figures higher in the Tongan community mind.



6. Risk, Responsibility and Pathologised Existences

Introduction

Tongan epistemology as described in Chapter Four, conflicts in several important ways with the ideal of the autonomous subject celebrated by neoliberal democracies like A/NZ, where the individual is encouraged to manage his or her own health. However, this is not to say that my participants only employed knowledge of their traditional society/culture. On the contrary, they each generally embraced biomedicine. This was particularly the case for Reverend Simone, who emphasised his family's attentiveness to testing for risk; for him *noa*/harmony is achieved holistically and embracing newer biological technologies is compatible with the honouring of relationships in Tongan culture and one's faith in God. However, other participants related to me how Tongans' engagement with health care services is negatively affected or determined by spiritual belief, by culturally specific ideas about causality, and potentially by more pressing priorities which, although often financial, are considered to be Tongan and culturally derived.

In the previous two chapters I used *talanoa* material to sketch some cultural perceptions of how the Tongan world is known and demonstrated the significance of collective and authoritative hierarchy. In this chapter, I develop the theme of NZ Pacific/Tongan populations as people located within a neoliberal democracy which places assumptions and expectations of personal responsibility around personal health risk and its management upon populations who have other spiritually and culturally-derived conceptions of wellbeing and risk. How one perceives health risk particularly impacts one's choice to use or not use public health services such as genetic testing and predictive medicine.

Undertaking this research caused me to question semantic issues around my own frequent use of the word 'risk' in interviews as well as the word 'genetic', both so common in this discourse. What my fieldwork indicated to me was that people were using differing knowledge paradigms regarding the determination and prioritisation of risk in daily life. This is important to understand because it impacts on how Pacific people then engage with public health services, and is exacerbated by the semantic entanglement of ideas about genetic biology with ideas about metabolic disorders.



Although my research project *talanoa* intended to elicit dialogue around attitudes to testing for increased risk of genetic conditions, only one participant was connected with any genetic health service. Participants inevitably chose to discuss their perceptions of ‘genetic predispositions’ as indicating diabetes⁶³ and obesity. Conversation flowed freely and sometimes fatalistically on these issues as participants described an existing general perception that Tongans are, and believe themselves to be, unhealthy people. Listening to participants talk about family tendencies to cancers and metabolic diseases, I discerned a conflation of the lifestyle causes of disorders and the genes they carry. In Chapter Four, I shared M’s account of the local Tongan mother with two multiple-disabled children from birth (including syndactyly/webbed digits). To M, these congenital disorders were punishment for wrongdoing rather than physiological anomalies. Of course this situation might not be genetic, but when I asked her about hereditary genetic conditions she chose to tell me about her father and other relatives eating the wrong kinds of food to excess and neglecting their doctors’ instructions. Whilst I accept that my own words and their delivery impacted how questions were interpreted, my efforts to rephrase didn’t seem to draw each of our understandings of genetic inheritance any closer together. Clearly, my *talanoa* partners were more comfortable talking about, and probably more concerned with, the biomedical discourse around metabolic illness and diet.

I had purposely avoided the pre-natal discourse presuming that a prenatal genetics topic would raise moral reasoning/new eugenics/genetic engineering/genetic citizenship discourses, well covered by others (i.e. Franklin and Lock (2003); Lippman (1991); Rabinow and Rose (2006); Rapp (2000); and in A/NZ: Fitzgerald, Legge and Park (2015); Park (2009) etc). Instead, I introduced my topic as about hypothetically considering testing for increased genetic risk at stages of life other than prenatal. During my fieldwork I realised that in using a genetic cancer predisposition as an example⁶⁴ for seeking genetic testing I was unintentionally opening participants’ schemata towards diseases with multifactorial genetic mutations, such as some cancers, cardiac disease and obesity. My use of the term ‘genetics’ did not raise congenital conditions or adult onset genetic diseases for my participants other than at the hospital with the Navigators, and with one other participant employed close to the public health arena. The remaining participants didn’t bring up congenital conditions or disabilities⁶⁵ and I am not certain whether this was: (a) due to the sensitivity of the topic, (b) because my research question suggested to them the topic of

⁶³ See Lock and Nguyen 2010:354 outlining ‘racial’ ideologies in Type 2 diabetes causation

⁶⁴ Sometimes I asked if they had heard about Angelina Jolie’s breast cancer story in my lead in.

⁶⁵ Other than M’s account of children with congenital disabilities which I have already described.



metabolic disorders, or (c) (probably most likely), because I let them direct the conversation, and they simply directed the conversation toward topics with which they were familiar.

Whichever is correct became less relevant as I realised, listening to Tongan viewpoints, that in a hierarchical and collective culture such as theirs, managing personal health risk in *Pālangi* terms would probably not be accorded high priority, particularly for those who consider themselves culturally-focussed (although Reverend Simione did inform me of the importance, to him, of testing when living with an increased risk of disease). Rather, Tongan cultural ideology would see a person's place and position in the world as pre-determined, oriented to the needs and demands of others, and structured by norms of *'ofa* (which includes an importance of hospitality and sharing food). The cultural importance of providing hospitality in meal form was mentioned frequently. As Siosifa emphasised in the previous chapter, 'It's about the other'. In this chapter, I juxtapose observations of Tongan self-perception against a biopolitical discourse emphasising the notion of risk, in order to situate NZ's public health policies which, whilst premised for the 'common good', promote personal autonomy and self-responsibility, alongside a Tongan worldview. By describing these positions, the disjunction between Tongan culture and state health policy becomes easier to discern.

Commoner Status-bearers in a Neoliberal Democracy

All Pacific people who have migrated to A/NZ share the similarity that they have come from small islands to a larger, wealthier country, a liberal society where socioeconomic status and race tend to matter more than rank and community membership. However, in the case of Tonga, people are also coming from a kingdom⁶⁶ in which the distinction between nobles and commoners is key to social structure. Noble/*'eiki* and commoner/*tua* relations are closely entwined within contemporary Tongan cultural ideology in which upholding these relationships, or not, is part of the complexity of Tongan life in diaspora. Vaka describes the transition of societal political structure as akin to 'letting go of one's original knowledge' (2014, p. 56). Taking up citizenship in a liberal democracy is 'complex and challenging as it requires more than just giving up one and adopting another idea' (p. 56).

⁶⁶ Strictly speaking, New Zealand and Tonga are both "unitary parliamentary constitutional monarchies" (according to Wikipedia). Tonga was a British Protectorate between 1900 and 1970. Democratic reforms in 2010 resulted in creation of a parliament with political parties, elections and the first commoner prime minister, 'Akilisi Pohiva. As this thesis is completed, August 2107, media report the Tongan king's dissolution of this parliament.



Unaccustomed to individual self-management and personal autonomy, and based in Tongan epistemology, participants speak of stratification from a position of somewhat lowly and modest self-perception as well as a collective one.

As described in the previous chapter, participants spoke of the high respect and regard placed on persons of higher status, particularly medical professionals and pastors. Those who had lived and worked in Tonga described an environment whereby Tongan hospital staff exhibit their status, and treat their patients disparagingly, manifesting contemporary Tongan noble/commoner status. The complexity of a person's *mana* and their *tapu*, as arising originally from chiefly rule followed by monarchical rule, derives from an ancient sense of anxiety about chiefly immanence (Gell, 1995; Mills, 2016; McGrath, 2003, p. 34).⁶⁷ Tongan spirituality and values originated within a non-physical, non-material, pantheistic-like world of sacred chiefdoms and their commoners, states Gell. Thus *tapu* is both the required regard for the nobler person and about the vulnerability of their perceiver if they are low in rank. Unless a Tongan person possesses and also adopts the epistemology of education in health science, biomedical knowledge can be a problem area over which Tongans hesitate, as to them it may verge on the sacred, the spiritual, and the domain of a higher order of person.

Thus social location, the ideology of noble/commoner, runs diametrically opposite to understandings of status in settler society where Pākehā New Zealanders have historically prided themselves on their egalitarian values, (even if this is today disputed. See Kelsey, 2015 etc). However, as Hau'ofa pointed out, subordination of Pacific people by European colonisation paralleled and re-emphasised this pre-existent social ranking, reinforcing in Pacific people a sense of smallness as a state of mind (2008, pp. 3, 4, 7).

Tongans can find it challenging to consider how to relate and interact with medical people, whom they perceive to be of higher status. Also, due to an underlying expectation of being ruled over rather than self-ruling, self-help practices in healthcare add a further dimension of unfamiliarity; even more so when risk, risk identification, management, and reduction are required. As well, this is a population whose spirituality may already create hesitancy or scepticism about biomedicine and attest strongly to God's ordination of their lives in

⁶⁷ Gell claims this is the reason for the rapidity of Christian conversion in 19th century to accept a transcendent God. Their chiefs were too *pō*/sacred so people wanted them to leave when they died, to the point of their loss not being mourned. The Christian God also promised the common people souls and everlasting life which Addo considers is a most valuable salvation, worth plenty of gift giving to maintain fair exchange (p.171).



socio-spiritual sense of community. Highlighting the embeddedness of individualistic practices such as self-surveillance and other risk measures in societies like A/NZ, this chapter draws attention to the lack of familiarity or cultural relevance of risk and self-health care for Pacific/Tongan people.

Sketching Relevant Western Epistemological Adoptions

The limitations of biomedicine when seen as a secular physical healing system are well known to Tongan people and in Chapter Four I note the paradox of biomedicine being 'Christian' to a Tongan mind as an established element of plurality in Tongan culture (Besnier, 2011, p. 5). Chapter Four also notes their lack of confidence in biomedicine generally.⁶⁸ It is interesting to consider this outlook against Byron Good's view 'that medicine plays a very soteriological function in modern societies, characterised as they are by materialistic individualism' (1994, p. 86). The idea that medicine delivering humans from suffering can be likened to a form of redemption is also strongly implicated in Foucault's *The Birth of the Clinic* (1973); the concept is that over the last century or so medical 'health' replaced spiritual 'salvation' for millions of modern westerners as secularisation gained footing. (See also Finkler, 2000, p. 175). The rise of health as a major value of modern western society accompanied the 'dethroning of salvation', (Beck-Gernsheim (2000, p. 2) cites Rohde, 1974) which I take as pertinent for my subject population who, being dominantly Christian, defer to concepts of salvation and eternal life.

Risk as replacement for what once was assigned to providence is a further 'radical epistemological transformation' within secularised 'contemporary society', states Lock (2012, pp. 135, 6) and potentially insignificant in Tongan ontology. Assessing the rise of the 'risk society', Giddens (1999, p. 10) and Lock (2012, p. 136) cite Ewald's (1991) claims that western society's modern governance practices created a new 'world without God, a laicised world where 'society' becomes the general arbiter answerable for the causes of our destiny' (p. 208). Another stance on the evolution of risk philosophy is taken by Mary Douglas (1990), that risk replaced sin⁶⁹ but with an aura of neutrality as chance became danger. She suggests risk is now able to be used as a 'forensic resource', whereby people can be held accountable and that, in Foucault's analysis of society, the next step in the conceptual progression of risk is that of self-surveillance (Lock 2012, p. 136); the action of

⁶⁸ Colin Tukuitonga, 'Pacific Island health', Te Ara - the Encyclopedia of New Zealand, <http://www.TeAra.govt.nz/en/pacific-island-health> accessed July 15, 2017.

⁶⁹ Although she clarifies it doesn't equate to sin.



testing for risk is valued as a form of early illness prevention. Thus, as Good summarised, medicine as predictive medicine is enacted in an increasingly biological, and thus narrow, view of the human person, germinated from fertile soil of the 'modern' (p. 87) where other non-physical aspects of being human are reduced or neglected (see also Mol, 2002).

Kavanagh and Broom (1998) argue it is important for medical and public health practitioners to define more carefully for their patients and public the types of 'risk' to which they refer when using the word. Kavanagh and Broom argue for the addition of 'embodied' or 'corporeal' risk to public health educators' vocabularies, which have tended to particularly focus on lifestyle risks (such as smoking) and also environmental risks (i.e. pollution). My participants' perceptions of health risk, including an awareness of Pacific predisposition, are recounted in the next section of this chapter. However, they tend to attest emphasis being placed on lifestyle and I discuss there the consequences.

Predictive genetic testing⁷⁰ language is laden with 'risk' talk; a significant proportion of McEwen's (2011) thesis on the effect on lives of women living with increased risk of breast and ovarian cancer is devoted to dealing with risk: identifying it, managing it, reducing it, living with it. When increased risk is determined with genetic information, averting onset of disease can then be managed by self-surveillance, prophylactic (disease-preventing) measures such as surgery and specific treatment pathways. Therefore, predictive genetic testing for those with a relevant family history exemplifies health maintenance as a personal responsibility in western societies. Rose states that the language of genetic risk enabled new perceptions and vocabulary with which to conduct one's life: the project of working on oneself, highlighting 'values of autonomy, self-actualization, prudence, responsibility, and choice' (p. 125).

A/NZ's political movement away from state interventionism to neoliberalising policies of individual choice and responsibility is particularly seen in the healthcare domain through health promotion campaigns and literature (McEwen (2011, pp. 48, 49) cites Kelsey 2000) and expectation of self- management of personal health risks which has manifested in

⁷⁰ Genetic tests are used to diagnose a wide range of conditions, some of them caused directly by a gene mutation (such as cystic fibrosis, Huntington disease and haemophilia); some by a chromosome change (include Down and other syndromes) and other types of mutation can lead to breast cancer, bowel cancer, melanoma and prostate cancer with family history indicating possible higher risk. Testing for mutations which might lead to certain diseases is known as predictive genetic testing. Such conditions can have both genetic and environmental factors involved. Paraphrased from <http://www.genetics.edu.au/publications-and-resources/facts-sheets/fact-sheet-5-genetic-conditions> accessed July 15, 2017.



increased attention to lifestyle. Signal and Ratima argue that A/NZ's neoliberalist commitment to individualism and the reign of the free market are antithetical to public health promotion because inequity is not addressed, as it would, they claim, in a social democratic system (2015, p. 291). Instead the state offloads responsibility on to numerous NGOs (Signal et al), a timely and neat fit with Māori aspirations of self-determination.

The Ministry of Health (MoH) upholds several models for understanding Māori⁷¹ and Pacific wellbeing and health, such as frameworks of Fonofale (Karl Pulotu-Endemann, 2009); and Fonua (Sione Tu'itahi, 2007), which adopt natural metaphors to express the importance of cultural principles such as the spiritual, collective and ecological as well as physical and mental (Tu'itahi and Lima, pp. 74, 75). However, I suggest that even these holistic models overlook or fail to assess the underlying origins of 'responsibility' and 'risk'⁷² embedded within western individualistic health assumptions against cultural implications or discomforts. 'Health promotion' is a good example of shifting responsibility:

Maori health promotion seeks to reorient health systems and services – first, towards cultural competence criteria, and second, towards health promotion criteria – in order to enhance quality and *to shift the emphasis from tertiary care to health promotion*, primary health care and disease prevention. (Italics added)
(Ratima, Durie & Hond, 2015, p. 55)

In this study, *talanoa* exemplify some Pacific people's perceptions towards risk revealing key cultural constructs (Finau 2000, p. 91) about notions of risk and response. As I show below, these notions of risk and responses appear to place people at a higher risk.

Risk as Raised in *Talanoa*

Participants spoke with ease about health issues they had experience with. The outing which M and I enjoyed at the botanical gardens resulted in a long transcript as we covered much and I tried to learn how her family had dealt with disease and how they might act to prevent a potentially genetic disease. It was not my intention in the *talanoa* to explore risk

⁷¹ For example, Rose Pere's *Te Wheke*/octopus with its head, eyes and tentacles upholding Māori principles of wellbeing including spirituality/wairuatanga and family including the role of ancestors; Mason Durie's *Te Whare Tapa Whā* / four equal cornerstones of the building which incorporate the whole spiritual person and family (1998)

⁷² For example, a MoH report on Health Loss in New Zealand (2016) defines itself assessing 'what proportion of health loss is attributable to known modifiable risk factors, and is therefore potentially preventable' <http://www.health.govt.nz/publication/health-loss-new-zealand-1990-2013>



as a topic, but obviously when I was trying to introduce notions around genetic disease, risk was a close association. Participants spoke of awareness about lifestyle choices which put them at higher risk for some diseases, as were they aware of pre-existing disposition to these 'Pālangi diseases' for which lifestyle and genes can play a part. As in western lay vernacular English, M speaks of genetic disease 'going in the blood' through generations/*toto*. Thus Tongan and western traditions share the concept of blood/*toto* for genetic transference, although no one mentioned the term *toto* in *talanoa*.

H: ... like a DNA test positive can show that you have a high chance of getting that cancer or maybe it's a heart condition or something. How would Tongan people feel about having the blood taken? And how would they feel about having that knowledge in their family? Would they like to know? Or would like rather leave it?

M: Yeah some want to know and some of them they would rather leave it. 'Cos they don't want to hear what's going on, what's happening to them.

H: You mentioned that there had been people dying in your family.

M: Yeah, my grandpa died from the cancer and my aunty too. So I don't know who's next for the cancer.

H: It might not be genetic of course, it might not be, it might just be chance. But it might not. So you could go and have a test and then find out maybe that you definitely don't have that gene and that you can't pass it on to your children. So sometimes it's a kind of (*exhales*) relief thing.

M: Yeah, if I go do that, go check if I got that. If the doctor said no, I don't get it. But one of my kids, they going to have because that thing is going in the blood. It's nonstop. But if my kids stay healthy then none of them gonna get it. But if they don't want to stay healthy one of my kids, they gonna have it because that thing's it's going in the blood.

At Langimalie, the GP and the nurse shared with me experiences of the struggle to have their patients think about the importance in risk and prevention.

G: One of my genetic cases is a young man who had inadvertently, ah, opportunistically was found to have a heart - I can't remember if it was arrhythmia or something -



H: OK

G: - on the ECG. He was quite young only about 18. So he ended up going off and being checked by the cardiologist and they said his family should be checked because it's the kind of thing where they can suddenly go into arrhythmia and die at quite a young age. It's quite serious. But I'm pretty sure from subsequent letters that the family haven't been that good at fronting up to genetics. Or they had to go and have an ECHO or something first. And I think the other thing is and this is common in all people, not just Tongan that - maybe it's a bit more in Tongan - that if you don't feel it you don't have to worry about it

F: Yeah, true

G: You know, like diabetes. You don't feel it. You've got to trust. And this is like when they don't come back, you just can't trust how you feel. 'Cos they sometimes say they stopped all their medicines and they say they feel better and I think yeah, they probably did, no more side effects. But then the sugar is high and with sugar you've got to go by the blood test, you can't go by how you feel. So with genetic counselling it's kind of a - I guess if it was a baby - like shall I have a child or not 'cos my first child was born with this terrible, terrible condition and died. Do I want another child like that? That's very much in your face. But if it's a matter of saying Grandma had bowel cancer and it looks like it's in the family well you know young person why should I think about that and I think the health literacy thing is not -

F: Absolutely

G: - it is not there as much with the Tongans!

H: Because?

F: Because it depends on their aging. But when they young they never think about it, bowel cancer, if your grandmother had that in the past, until they grew up and up to old age kind of thing and they might be thinking and some symptoms come up. And my grandma had that. But when they young they never think about it.

G: And they don't ask.

F: It's more like understanding of health contacts and thinking about what's going on the family. Yeah, that sort of understanding.



G contrasts the lack of health risk prioritisation with importance Tongans place on hospitality in eating together in the present now. She tells of attending her extended family's special meal just that weekend where she noted several diabetic Tongans overindulged on the fat of the roasted pig. The sharing of the pleasure of togetherness and bounty of the meal as a sociocultural activity was more important in that moment than diabetic moderation. She exclaims:

But the joy of the moment, particularly the meals, it gets me.

G & Faleola's description here of Tongan attitude to what they see as a Western fascination with knowing the medical cause of death also indicates different cultural emphases. In my earlier chapter, the raised status of the person after death was described. How Tongans die seems of less consequence than the new spiritual dynamic that their death ushers in. A medicalised view, by contrast, needs a cause of death because it focuses on the physical rather than other social aspects at play,⁷³ including the simple fact that 'humans are mortal beings and that death is merely part of the human condition (Finkler, p. 176).

G: ... often when you ask people: what did your mum or dad die of, they don't know. And they haven't expressed curiosity. I had one just recently and one of the parents had died relatively young and I said what did she die of? He said, I don't know. I said, well, it's worth finding out. And it's not always because they died in some remote village and they just put down heart attack because they can't think of anything else, you know. These might have died here or in Australia or somewhere! They don't seem to. It's not a big deal to know why!

H: Yeah

G: Death is a funny thing in Tonga you know. When my patients died, I think only once I was asked about a death certificate. This was whether they died in the hospital or in the village or where. And you know, I thought, if a person just shows up and dies, you know, it's a sudden death. Don't they want to know what medicines the person was on?

F: Cause of death

⁷³ I acknowledge that cause of death moves beyond the epistemological, death certificates are one of the regulatory requirements of modern states.



G: And if the family says, oh, they were going to heart clinic. I would just hear through the grapevine maybe ages later that a person has died. Ooh. I haven't been asked for a death certificate. I filled in very few death certificates in Tonga. And it's like it's not that important to put it down. So their statistics aren't very good

F: I think that sometimes they was ringing the hospital like if they die in the community or something and that the town officer will write a letter and put this person has died. But um they just depend on whatever notes that they get from the hospital and the death certificate will be written down without confirming what's the real reason.

G: I'm sure they try in the hospital because there's some good specialists, actually good specialists, in the hospital or people in charge of the departments. So they would think it through carefully. But all the deaths in the community it's just a bit of a guess and the town officer is not medical.

F: I know.

G: Sudden death – 'heart disease' or 'heart attack' (*laughter*)

H: OK. So that does for filling out the stats, but is it also about something related to people accepting their lot in life?

F: Mmm

H: Like 'God determined my years' and it was their time to die and they're not so worried about whether it was this disease?

F: They mostly say that.

G: I think they do say that. But there is still also a fighting thing sometimes. They'll do all sorts of things to delay the death, to treat it. But yeah, there is more acceptance I think.

Within other *talanoa* too, participants described not acting upon increased risk when there is family history even when they know they might benefit. Siosifa shares his situation, rightly noting that his reticence to reduce his risk of heart disease through his choice-making is not limited to Tongans, but universal (see Lock and Nguyen p. 28).



S: A classic example and I take my Dad's side. My father died of a heart attack. Went to sleep and just kept sleeping. It was same thing with his father. So it's highly like because it's in our genes that I've got to make sure I'm OK in terms of risk for heart attack and that sort of thing. So, because of what I know now, I don't have that same view of say a traditional Tongan person might have where they're just resigned to the fact they're going to die like that anyway. Yeah, they don't take any further. So if you have the foresight you can do something about it. Having said that I haven't done a lot about it but I know I should. I know there are things you can do like diet and exercise. And it also goes back to that: if it's going to happen it's going to happen. It's a very male thing, just the resistance to wanting to change what is obvious or inevitable in some ways. And that's not just confined to Tongans I think it's a male thing across the board.

H: I think you're right.

S: Yeah (*laughs*)

H: And all of us aspire to be self-disciplined about these things but it's hard.... So potentially you could go to your GP and say: Could you refer me to Genetic Health because I have a history of this cardio whatever, it might be something genetic and you might be able to have a surgical procedure.

S: You see I've never had that conversation with my GP. I've got a number of genetic predispositions that I know I'm probably very highly likely to get. But I don't have that conversation with my GP. I've kind of kept it from the GP. 'Cos I think the way it's done is that the GP is only worried about your health and not necessarily about you know ... I don't ever think my GP's ever asked me – has your father ever had dah dah dah?

'In whose consciousness does the disease/infraction arise?' (Das, 2017)

These participants' descriptions which skirt risk management of disease and self-surveillance suggest the non-priority of preventative actions for Tongan people who, we have seen, do not culturally value the idea of an autonomous self, and for whom neither biology, nor risk are particularly ontologically important concepts. This is significant in the clinical situation and also especially when one considers risk as the criterion through which



racially-profiled populations (Rose p. 171) are targeted subjects of long term public health campaigns. Both are applicable to the predicament that I discuss here. This is particularly the case in A/NZ where, with the aim of health equity and under the auspices of responsibility as both health practitioners and Treaty participants/partners, the state health system categorises some of its population by ethnicity. This conversation is too big to fully explore in this thesis but in drawing attention to disparities in notions of personal risk management (i.e around susceptibility to disease) as an example of individualistic lens versus hierarchical collective, I suggest that conflicting epistemological realities flaw the existing structure in A/NZ.

Agreeing with Finau that western medicine most commonly deals with “disease” whereas Tongan or traditional medicine treats “illness” as it occurs through disturbance of relationships with gods or supernatural beings (Poltorak, 2010, p. 3; Finau, 1994, pp. 53-56), I argue that for Tongans the concept of “risk of disease” is not part of a commonly-shared understanding of health. Rather, earlier modern western definitions of health in which medicine sought to restore harmony/health are conducive. But, particularly in recent decades, biomedical technology’s creation of the ‘at increased risk’ ‘pre-patient’ also risks pathologising people who are not yet ill (Rose p. 85; Lock, 2013, p.43; Konrad, 2005, p. 16) and does not correspond with a Pacific understanding. A Pacific state of health or wellbeing concurs with harmony, a positive state ‘where the subject and his body are one’ (Canguilhem 1991, p. 91). However, modernity has brought changes in concepts of health, of pathology, of scientific discourse historicity which ‘must begin with the infractions – only through error can nature be known’ and importantly that the error or diagnosis or potential for the error/risk is a notion owned by medical experts which separates a person from their body, (Das 2017, p. 9). In the view of a Pacific culture, this creates disharmony where none is apparent.

This thesis argues that NZ Pacific/Tongans struggle with ‘health risk’ messaging as the epistemology from which these messages are derived is culturally alien; so too is the idea of being tested for something they don’t have but which their DNA might show increased risk towards. At the same time, they are accustomed to risk messaging⁷⁴ which, from what

⁷⁴ Tongans are possibly the earliest population globally to receive health risks broadcast by radio. Queen Salote ordered this in 1918 when the Tongan islands were struck by an influenza epidemic after which radio continued to be used for health messaging and lectures on Tongan traditions (Young-Leslie 2004, p. 398)



I heard, they understand to be messages about how they need to eat less, exercise more, etc.

An issue that stood out for me in *talanoa* was how public health messages about Pacific Islander risk for “lifestyle” diseases like diabetes, heart disease, and obesity were what participants chose or most connoted to genetics, speaking of the need for healthier lifestyles. This is hardly surprising given the proliferation of messages focussed on metabolic/lifestyle diseases and given what their personal histories reveal about family members afflicted by these diseases. The conflation of cancer and obesity as diseases to which they, as Polynesians, are pre-disposed, has become so common that it would be challenging to disentangle ideas about testing for metabolic disease from, for example, testing for those cancers indicated through heritable mutation.

Consequences of Pathologising Health Messages

In addition to the challenge of thinking about others’ (non)conception of personal health risk and self-responsibility, I also note that these *talanoa* indicated conflated understandings of heredity and an expectation of unhealthiness and suggest this is an issue of concern for health educators and practitioners. Concerns about Pacific health risk communications were raised by Finau in 2000, who described ‘fuzzy logic’ that was clouded due to professionals being oblivious to implications of ways their messages can be taken up by receivers (p. 90).

At the gardens M continued to tell me about her family:

M: OK. If one of our family like for example if it’s our grandpa or grandma got cancer. That thing goes in the blood and if you try to me – if it’s going in the mum or the dad and going to the kids or the grandkids. Because in Tonga, to be honest, they can’t keep healthy. They can’t eat food healthy. They rather eat meat all the time. Tongan people they eat all the time. They always like to drink Gogi⁷⁵ and stuff like that. That’s the truth. Tongan people can’t keep healthy.

H: Even though they grow their gardens?

M: Yeah but it’s not. They cook together their food with the veggie but when they eat they leave the vegetable to the side and eat the meat. So

⁷⁵ A fruit drink marketed in Tonga and controversially claimed as providing health benefits



H: So the lifestyle choices are not healthy ones which is a problem that we've that is also a very much a western problem isn't it?

M: If you want to stop the cancer, they can stop it if they try to be healthy. But they rather eat unhealthy food

M and Siosifa express a sense of fatalism that they will die of cancer or heart disease, that messages about 'unhealthy' Tongan lifestyles have become a self-fulfilling prophecy. Siosifa casts doubt on the value of 'genetic testing' because his ethnicity opens him to many 'predispositions'.

S: In terms of the scope of your project around whether it would be useful for Tongans to have a test, would it be kind of useful to know. Ah, I'm not too sure. 'Cos there are a lot of genetic pre – what do you call it?

H: Predispositions

S: Predispositions that we tend to have as Polynesians. Obesity. The propensity to be overweight with all the associated things around you know - high blood pressure, diabetes

These excerpts indicate something of the challenges presented when raising a topic like genetic testing to Pacific people who have been targets of public health promotion messages about risk. The quotes illustrate how, due to the complexities of multifactorial genetics anyway, lifestyle choices and genetics are easily conflated. I was concerned at the negativity by which participants viewed their families/population's levels of health, (a pressing yet pessimistic need for people to live better, die less prematurely) and that they considered their genetics to significantly factor in this. These conversations raise the possibility of unintended negative consequences of health risk messages in public health policy promotion to Pacific people. The messages themselves I suggest can be risky when received by people burdened about diseases they've acquired since European contact and which are also now described as genetic and possibly inevitable.

Concluding with Responsibility of Leaderships, both Tongan and Political

In Chapter Four, I discussed expectations in Tongan society for leaders to take responsibility and I have mentioned Reverend Simione referring to pastors as leaders who ought to take



responsibility within their communities. That pastors as community leaders assume mediation, education and dissemination roles was mentioned by several participants as well as being noted in literature.⁷⁶ Participants suggested genetic health education would be best developed in conjunction with the churches and their pastors as they are seen to be the vehicles for responsibility of sharing new knowledge in Tongan communities. As the Tongan cultural group is hierarchical, dissemination of new knowledge is expected to be top-down and health messaging and medical services have been delivered through Pacific churches in A/NZ for many years.

What I have raised in this chapter is how personal health risk is an assumed concept by health promoters which is not necessarily also held by their targeted communities. This can cause health messages to be lost or have unintended consequences; be possibly conflated with other concepts; and also be pathologising to the intended population. The role of those who promote health material is grounded in health ethics and social responsibilities of care which I challenge as needing (re)examination. In striving to be accountable, the notion of social responsibility, evident in state foundational documents such as the Treaty of Waitangi and New Zealand Public Health and Disability Act 2000,⁷⁷ rapidly lose context, and thus meaning, in 'government speak' as this page on Pacific Health Responsibility lifted from the MoH website shows

Responsibility for Pacific health outcomes - All parts of the health and disability sector are responsible for improving Pacific health outcomes and reducing inequalities.

Solutions to improving the health of Pacific peoples will require mobilising all key stakeholders, including the Ministry of Health, district health boards (DHBs), the Pacific health sector, and the Pacific community to be responsible for coordinating and building effective interventions that are responsive to Pacific realities.

⁷⁶ In the diasporic context those ranked as such, especially pastors are accorded chiefly status wherein the church community has become a surrogate village and the pastor holds the highest status (Macpherson in <http://www.teara.govt.nz/en/pacific-churches-in-new-zealand/page-2>, accessed May 10, 2017)

⁷⁷ For example, Section 22: Objectives of DHBs 1 (g) to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services...
http://www.legislation.govt.nz/act/public/2000/0091/latest/DLM80807.html?search=sw_096be8ed813ee3b1_responsibility_25_se&p=1&sr=4, accessed July 7, 2017.



In recognition of the leadership role of the Ministry of Health, all business units and teams retain responsibility for Pacific health outcomes as part of their work programmes and operational activities.

DHBs similarly take responsibility for Pacific health outcomes. The District Strategic Plans and District Annual Plans of DHBs describe their plans for improving Pacific health and reducing inequalities⁷⁸

I ask, what does “responsive[ness] to Pacific realities” look like? Focussing effort and attention on ‘reducing inequalities’ rather than examining and comparing cultural and ontological disparities I suggest comes up short on responsibility to the ‘Pacific community’ and fails to address some real barriers about Pacific participation in public health services. Dialogues in this study indicate that Tongans and other Pacific people in a predominantly western culture in A/NZ presume *Pālangi* to be generally secular just like their biomedical science. They correlate this with an assumption that a biomedical practitioner would not recognise the place spiritual belief holds for them, or the place of God’s providence for risk. In the following chapter, I discuss how these might be considered together.

⁷⁸ <http://www.health.govt.nz/our-work/populations/pacific-health/responsibility-pacific-health-outcomes>, accessed May 15, 2017.



7. Finding Patterns in Weaving Strands of 'Ofa/Empathy

I have introduced a Tongan sense of being in the world. I have described and juxtaposed some Tongan self-perceptions and perceptions of relationship and engagement with health practitioners. I raised the negative burden borne under pathologising labels placed on Pacific people by public health promotion. All this, I suggest, is of interest to genetic health service practitioners, especially Tongan beliefs around causality. My question was: Are people able to respond – both Tongan/Pacific community and Genetic counsellor/medical practitioner? I answer: Likely not, unless one is labouring back and forth from the interstices (Bhabha, 1994) as some of my participants do. I recall the participant who had a vision for 'both and' who I mentioned at the end of Chapter Four, Siosifa's ideal situation of Pacific healthcare delivery that honoured and utilised the better features of both epistemologies, Western and Tongan/Pacific. How might these be shared to offer a 'both and' combination?

Empathy is a concept both paramount to genetic counselling and embedded in Tongan 'ofa which I take up here. In this chapter I propose a first step of sharing and learning one another's epistemologies (Pacific and Western) is to acknowledge and encourage empathetic approaches with the intention of also bringing benefit to Pacific communities (Smith, 2012).

Entangled Weaving and *Felavai*/Interweaving

As shown in the previous chapter, participants in this study revealed that sometimes unhelpful entanglements occur resulting in blended health information, for example, M conflating notions about genetic conditions and overeating. Several were negative about Pacific health outlooks. Nurse Faleola and the Reverend sighed during separate talanoa, at one point the Reverend saying

You know, God enabled them to think for themselves. And you know, we have to be the role model that God wants us to be and help them with what we are supposed to be leaders of, of people not only to know God, but how to take care of their families.



The Reverend bears the burden of his responsibility: he admits that Pacific leaders such as pastors need to better lead their people into health education. The Navigators team are similarly convinced, the *matua*/elder stating several times during our five person, spontaneous *talanoa* that NZ Pacific people need time to learn and embrace new knowledge systems. I realised afterward he didn't mention the implicit loss of cultural logic, their former knowledge, simply the time needed for acquiring the new. As the elder sat nobly clasping his *tokotoko*/stick, I intuited faintly his complicated burden of responsibility to his people and wished I had asked him more.

Participants' recognition of unwise entanglements echoed familiarly with other stories of Tongan adaptive strategies in traditional medicine (Bloomfield, p. 55). They told me about misuse and non-use of prescription medications by their relatives, traditional healers crushing unlabelled tablets into their concoctions, and unquantified dosages. The mixing of old and new in healing activity is sometimes 'dangerous' exclaimed Siosifa, adding that side effects from pharmaceuticals and over-medicated *Pālangi* can be just as bad. Dangerous entanglements need to be unwound. They should be kept apart, he said. Siosifa proposed the idea of balance by offering Pacific people choice of the best of both epistemologies, 'the good things' of two knowledge systems.

Fijian scholar Reverend Carroll, whose mother was a weaver, points out that sometimes a weaver needs to unravel their strands because there is a mistake or in order to make the finished fabric better, the pattern more harmonious (Carroll, 2006, p. 46). The craft of weaving, she writes, as well as being concerned with new designs, is about how patterns of the past inform the new patterns of the present. In creating new meanings informed by the past sometimes the weaving needs to be unravelled to make it better and it takes some practicing and awareness of not knowing everything about every pattern. She uses this metaphor to discuss theological practice in multicultural environments but I use it drawing on Ka'ili (2005) to preface a Tongan pattern style of *kupesī* to begin laying out a potential response, to acknowledge western and Tongan epistemologies, to look for strands in the knowledge patterns that can be helpful to consider wellness as a Pacific epistemological concept alongside western/*Pālangi* parlance of health risk management, specifically genetic health. Similarly, a reflection exists here whereby geneticists also see patterns about genomics being informed from older knowledge but making new patterns as new knowledge emerges. Interestingly, before I read Rev. Carroll, participant Rev. Simione, had recalled for me his mother explaining the principles of weaving to him. What he



remembered most particularly was the importance of the foundation row whereupon again I thought I heard his own burden of responsibility.

Weaving *kupesi* patterns

Other participants in this study didn't mention weaving metaphors for incorporating multi-epistemologies during *talanoa*, but I see some of them living this concept in their interstitial *vā*/space as they take responsibility upon themselves to embody concepts of *'ofa*. As I noted in Chapter Three, Pacific anthropologist Tevita Ka'ili applies the metaphor of the Tongan weaving style *kupesi* to envisage the incorporation of other epistemologies into science (2012). *Kupesi* emphasises evenness and symmetry through placement of repeated equitable geometric shapes called *amoamokofe*, *amoamo* being rubbing movement like the pulsing rhythm of Tongan massage. Symmetrical patterning signifies equivalent importance and balance. Tongan *felavei*/interweaving as *kupesi* patterns symmetrically intersecting is found in aesthetics of tattoo, lashing, and barkcloth making. I take up Ka'ili's *felavei* to draw parallels representing acknowledgement of western and Tongan epistemologies to create richer textured fabric of knowledge for all, with the incorporation of biological technologies upon traditional understandings of causality, multi-layered and beneficial. The *amoamokofe kupesi* illustrating these pages provides a visual expression to recognise and work with this, the central vein representing universalities of humanness and the running triangles above and below representing plural, valid epistemologies.⁷⁹ 'Contents' of the 'triangle' patterns: beliefs, histories, and practices form the rest of this chapter.

Belief

Rather than relegating 'belief' as something that ought to be replaced by science, a long held priority of public health generally (Good, p. 40), spiritual belief and faith can be positioned alongside biological explanations for heredity. This picture of woven harmony was drawn by the Reverend Simione who described to me 'both faith and the medical team working together' in harmony, telling me he offered to pray for an unknown surgeon in a New Zealand hospital corridor as he sat with a family and of this surgeon's willing acceptance of divine support as he set to perform his role. Good cites Lepowsky in PNG describing a similar combination of scientific-materialist and spiritual explanations for

⁷⁹ I acknowledge and thank artist and architect Semisi Potauaine for creating *amoamokofe* for this project.



illness, whereby people accepted the efficacy of penicillin but assigned ultimate credit for cures to supernatural powers (p. 40).

The separation of physical health and spirituality is a recent western norm not necessarily held by a majority of people even in the West. Furthermore, belief is recognised as important in the genetic counselling setting (Featherstone et al, 2006). Their ethnographic study in the UK spanning five years, working out of a genetics clinic at a teaching hospital, employs a symmetrical approach to value all beliefs, 'all forms of knowledge' (p. 19) which people have towards inheritance. Their 'symmetry' theory places recognition of validity of their client families' 'lay' alongside 'professional' knowledges in equal symmetry although they admit uncertainty as to how this might be conceptualised (p. 20).

The genetic counsellors who participated in my study consider that, in general, New Zealand clients tend to separate health and spirituality, more so than perhaps in others locations they have practised such as Britain and the USA. They welcomed working with families with a more holistic outlook in the counselling situation, expressing that they find it helpful if clients share their beliefs or faith about genetic concerns. In a Tongan context this might be both a Christian belief set of some kind⁸⁰ and it might also involve the reality of the ancestors' presence for them. Siosifa's *talanoa* expressed the power of those ahead upon those who come after. People are bound to each other both past and future in the community of their shared heritage. Siosifa's statement that you are more powerful after you die can be likened to the role one's genes play in our descendants' lives. This concept can be important across cultures, be they Western, Pacific or other indigenous peoples. In what Finkler (2000) has called 'the medicalization of kinship' she states that people are brought together because of their biological kinship, that a 'family history tree recapitulates the kinship history for people whose kinship memories may lack depth' (pp. 186, 187), such as western/*Pālangi* families in settler societies. For Pacific people genomics has potential to reinforce and celebrate bonds in *kainga*. Possibly this can be a new level of family discovery which through genetic etiological explanation allows someone to be united with their ancestors, their existence and their deeds.

Historically Adaptive People

In Pacific epistemology '*ofa*/generosity/ love/empathy is a resource that is shared and which requires serious responsibility (Thaman, 1988). Towards practising an empathetic

⁸⁰ Some more defined under Old Testament teaching (i.e punishment for sin) and other Christian belief sets not at all like that



utilisation of resources I point out that Tongans are already an adaptive people. Despite the ideal notion of the fixed traditional Tongan collective culture, Tongan history shows a people who are familiar with and recognised for their creativity in enfolding and adapting ways of ruling, believing and learning. This applies as much to medical explanations and remedies as to political structures and religious orientations. As noted earlier Besnier states Tongans aim to retain their culture through a preservation of the dignity of Tongan decorum and values (Besnier 2011, pp. 29, 240) as if these were static entities, whilst the Tongan nation changes rapidly in the face of globalisation. Similarly, Poltorak, (2010) calls Tongan healing methods 'fluid, cultural-fashioning of cure' which are creatively evolving, neither fixed cultural 'systems', nor old. Traditional ethnomedical systems have always evolved (Macpherson and Macpherson, 1990) through being pragmatic and flexible (Lock & Nguyen, p. 63). This is why they continue to thrive, state Lock and Nguyen (ibid). No culture is 'hermetically sealed' to provide 'fully constituted and coherent cosmologies within which illness is experienced, diagnosis made, and therapies are sought', states Das, primarily because they have all become deeply entangled with biomedicine one way or another (2015, p. 29). I suggest the possibility of adapting to biological explanations (as in genetics) can be likened to previous sociocultural adaptive strategies.

Modern Tongan history is replete with examples of creative incorporations and entanglements: constituting a Westminster style Monarchy; enfolding Christianity into itself by transference of gods (Bloomfield p. 36) whilst retaining the belief in powers of other spiritual forces (ancestors); to the higher education offered at Futa Helu's 'Atenisi Institute in Nukualofa, founded upon ideals from classical Greek philosophy.⁸¹ Cowling has noted that a western Christian, whose monotheistic belief cannot also revere other gods or powers for supplication, perceives conflict in observing Tongans appealing to the Christian God whilst simultaneously calling upon other spirits (perhaps of ancestors) to intervene. However, her Tongan participants perceive the combination as normal (1996, p. 73). An example in this study of similar combination was 'Ana's confusing experience, having never lived or spent extended time in Tonga, tending her dying mother whilst healers performed their 'hoo-hah on her' and multiple Christian pastors also arrived to perform their ministrations (Chapter Four). For participant Reverend Simione the power combination is

⁸¹ Also intriguing is the reinterpretation story that Napoleon Bonaparte was of Tongan origin, his mother coming to Tonga on a ship from America as mythologised in Kolonga, Tongatapu and retold in Fiji (Rowlands, 2016, p. 1, Appendix A: Fison, 1904) offered in applying Entanglement Theory (Thomas) as adaptation rather than hybridity (p. 6, 7).



spiritual (God) and physical (medical physician) working together in harmony. His Christian belief with his cultural perspective embraces physical science in universalising harmony.

Medicine, in whatever culture, is no different in that it incorporates methods that demonstrate efficacy, claim Lock and Nguyen (p. 63). Island life has historically necessitated resourcefulness, of improvising due to isolation and lack of better resources. In spite of the distrust and fears by which some Tongans associate biomedicine and its practitioners, as I have already raised, most scholars of Tongan approaches to healing have described biomedicine as seen by Tongans through a nautical metaphor: it is just one of many *vaka*/boats, vehicles for God's healing power (Bloomfield, p. 53, 92). This is perhaps an unsurprising progression amidst tradition where Tongans have always sought help from a range of healers and consequently used diverse remedies (Poltorak, 2010, p. 8; McGrath 1999, p. 491).

'Ofa/Empathy

Throughout this field study and the reading that accompanied it I looked out for connections of concepts shared by both genetic counselling and Pacific ontology and its healing methods. First I noted that empathy is a major concept not only to counselling but to Pacific ontology (Lepowsky, 2011, p. 57; Lohmann, 2011, p. 112). I have also already mentioned empathy in *talanoa* as an intentional form of intersubjective experience as argued by Farelly and Nabobo-Baba (p. 320). Empathy as a human ability to mirror another whilst retaining one's own identity or 'approximating the subjective experience of another from a quasi-first person perspective' (Lohmann, p. 112 cites Hollan and Throop, 2008) is further detailed in Pacific-derived detail in *The Anthropology of Empathy: Experiencing the Lives of Others in Pacific Societies* (Hollan and Throop, Edrs, 2011). They particularly draw on bioethicist and MD Jodi Halpern (2001) to define empathy within a complex set of emotional and cognitive concepts which has at its core that through empathy 'we gain a first-person perspective on another's thoughts and feelings' acknowledging that the degree to which this can be attained remains controversial within psychology and philosophy.

Whilst no Pacific languages have a singular word for empathy, it is intrinsic to the core cultural virtue of Tongan '*ofa*'/love-compassion-concern-pity'. Empathy is Besnier's selected gloss of the word '*ofa*', which with its contrasting emotion, *mā*/shame, he states can be both contradictory and complementary according to the situation, his example being a Tongan pawnshop (p. 122). '*Ofa* (*alofa* Samoan/*aroha* Māori) has varying



implications and meanings between contexts yet never means a third-person detached insight, state Hollan and Throop (2011, pp. 2, 3, 10). *'Ofa/alofa* also defines giving and generosity, especially in Tongan and Samoan culture (Mageo 2011, p. 77, cites Milner, 1979).

Empathy, as a core precept of genetic counselling practice, is challenged by the dilemma of how to enact this empathetic responsibility and intention in duties of care when the client belongs to another culture. Drawing from Sarah Ahmed's contributions on facing up to difference (2000, p. 144), Canadian social work researchers Jefferys and Nelson (2011) took Ahmed's question, 'What are the conditions of possibility for us meeting here and now?' to social workers in their communities to conceptualise issues around ethical encounters with 'an/Other'; how and what might that look like in the 'practice of care' (p. 248). Their conclusions list further ensuing questions regarding how much does one need to know of another's worldview, why a client might not want to encounter a (state-employed) professional, how important is it to examine one's own biases and preferences and to what degree, culminating in a challenging set of starting points for their profession to grapple with.

To enter into an empathetic encounter with Pacific people is entering the space between/*vā*.⁸² I suggest that to be able to enter into this space a practitioner must have made it their responsibility to respectfully discover something of the worldview that their client probably possesses including how the client might perceive them, (remembering the importance of hierarchical social order to Pacific epistemologies and the importance of making a personal connection). When an explanatory gulf separates the client and the practitioner's worlds, this is far from straight forward. In an Australian context, Guthrie and Walter (2013, p. 241) admit that their 'knowing' of an Australian indigenous person is more likely a name on a patient list than a real person. This is less the case in A/NZ where Pacific people visibly share in the embodiment of New Zealand's national identity as sporting heroes and more assimilation exists across employment and geographical residence than what these writers of the Australian context call 'residing in different realms'. None the less 'knowing about' someone's culture generally is not 'knowing' someone in the sense of entering into empathy and Guthrie and Walter caution health

⁸² A helpful graphical form:
<http://www.cmnzl.co.nz/assets/sm/7499/61/NZAOTpresentationwithoutvideos.pdf> accessed May 25, 2017.



professionals about the need to understand one's own social positioning, that one's own realm of assumptions is not necessary another's (p. 242).

Acknowledging that the ability to know someone is a contested concept in the Pacific world I add Lohmann's (2011, p. 113) conclusion that empathy for all humans whatever culture is an imprecise estimate of another's inner state but that somehow it enables the ongoing transfer of cultural information sustaining recognisable traditions of societies generation upon generation. My personal experience in this study has been to sense empathy as 'heart-togetherness' (p. 103) readily in my face to face encounters with Tongan people and participants. However, when I attempted initial contacts by phone, there was often hesitation and caution, if indeed I achieved the communication. This was not so much a language barrier but a cultural one, whereby 'ofa /empathy could not be initiated without a proper face to face encounter.

The spoken word and *tauhi vaha'a*

Making successful contact with Pacific people challenges Northern Hub GHSNZ⁸³ as they service a region which contains the world's largest Pacific populated city, Auckland/Tāmaki-makau-rau. This was exemplified with my own research project: to telephone a stranger of whom it was not known if they spoke English, and once they were on the line to attempt an explanation for one's interruption of their day. Some Tongan participants stressed using culturally appropriate modes of contact, face to face and ideally with a person of *mana* who is able to make a family connection, or, at least understand the critical importance of that first encounter. A letter or a phone call is not viewed as a suitable means to first raise something as sensitive as a genetic topic with Pacific families. This is easier said than done within the resource restraints of public health delivery. The genetic counselling team utilise available cultural liaison resources to discuss potential cultural issues and additionally the Tautai Fakataha Navigator Team, who service both Waitemata and Auckland District Health Boards in A/NZ, are another on-site cultural resource who were interested in being more involved with mediated introductions.⁸⁴ But my intent here is not to point out problems or offer solutions. Rather, what I think is positive and useful to note is existent *kupesi* symmetry in the importance of the spoken word to both Tongans and genetic counselling.

⁸³ Participant interviews and email correspondence November 2016

⁸⁴ Their service is to hospital inpatients <https://www.healthpoint.co.nz/public/other/auckland-dhb-pacific-health/>



Tongans who are familiar with the traditional healer encounter seek someone to whom they expect to listen for advice of what best to do, someone who understands the burden on them and how to deal with it (Poltorak 2013, p. 277), who offers prayer or prepares a concoction to be drunk. Poltorak (2010) explains Tongan traditional medicine is largely a spoken service specific to the person seeking care who, upon finding a suitable type of healer, also gives weight to the relationship that exists and further develops between them. Healers who possess high levels of explanatory skill are highly regarded; in the Pacific to make a speech is a socially constitutive act (Poltorak, 2010, p. 9, cites Malinowski (1937) and Firth (1975)). The comparison that Tongans make here with medical doctors is that traditional healers speak *with* their patients in ways which they understand implying that medical doctors don't. Poltorak goes so far as to state '[p]eople in general have more faith in people's response to requests for help than in the diagnostic categories used to define the sickness' (ibid). Thus faith in the healer person and the words they offer exemplifies *tauhi vaha'a* (maintaining harmony by nurturing the space between those in the lineage – oneself, one's kin and kin-like others) at the healing encounter (p. 10). It is about relationships, firstly the biological ones – *mehikitanga*, parents, grandparents – and looking out for them.

Looking after one's relations is a loaded statement for Pacific people as culturally they would infer also the inclusion of ancestors, those gone before. This I see as compatible with the working practices of genetic counsellors whose communication medium with clients is also speech (interspersed with a few diagrams) through which they support their clients, informing them about implications of their biological relationships, including ancestors. Maintaining harmony in the genetic lineage is a concept well understood by those who examine genetic sequences. And like traditional healers, genetic counsellors don't perform internal physical examinations or conduct sample collections. Realisation of this might reduce apprehension for Pacific people if learning about genetic counselling: more the role of guide and supporter which would be a more culturally familiar one.

Universality appears in *amoamokofe*

Some *kupesi amoamokofe* shapes are identical which I use to represent some universal human tendencies regardless of cultural grouping. Curse has been a way for human societies generally to explain what genes cause before scientific explanations were available, thus is not exclusive to Pacific and indigenous cultures. Ancestors are in the story, they do influence the future. Genetic counsellors are accustomed to working with



families who have named their genetic condition a curse, regardless of cultural background, and with new technology can now give it a new name.

I suggest too in facing or not facing living with genetic risk these, to be less culturally-derived, that people universally might not want to know what is likely ahead of them when they are presently well, not prioritising something that isn't immediate. Dr G spoke to this in *talanoa*, and Siosifa mentioned not acting to manage medical care of his own predispositions. When genetic testing clients do acquire new information, some tend to only absorb selected aspects of it or add it on to pre-existing (lay) ideas about heredity (Müller, 2009; Porz, 2009), thus it is seen to 'supplement rather than replace' previously held knowledge about heredity and health, states Lock (p. 140). Some people ignore or challenge the results (Lock and Nguyen, p. 311).⁸⁵ What is less common here is varying reasoning why people choose not to know if or to what degree their genes pose higher risk. In affluent and Western societies this is considered to be based upon stigmatisation fears, for example, obtaining insurance, employment, and maybe a spouse (Finkler, 2000, p. 181; Rose, 2007, p. 107; Lock and Nguyen, p. 311; Müller, p. 34).

In my study these types of fears were not raised at all. Stigma for Pacific people would be socially felt as moral judgement. However, 'Ana, potentially a higher risk presymptomatic candidate, was intending to be tested for BRCA/breast cancer gene. I do not know if she went ahead. Her next step was gathering her family pedigree and this, she told me, was where she was stuck. She felt awkward about attempting communication with family members to gather the information required. Family communication is complex in any culture. Although, these *talanoa* do not follow a family's experience through communicating genetic testing information, genetic counselling professionals are already well aware of the variety of possibilities in how clients choose to use and disseminate information or not. They realise that families choose to or not to communicate with one another about their particular genetic risks also transcends cultural, economic, religious,

⁸⁵ The rapid development of biotechnologies from the late twentieth century caused social science discourse to predict them to have major impact on modern life, including that people would rush to taking up new versions of genetic testing, such as for susceptibility, (for example, Gibbons & Novas (2008); Rose's 'life as project' (2007); Rabinow's biosociality (1996)). Although the number of genetic tests available continues to increase, their impact has not yet altered western society as social scientists predicted. Medical anthropology discourse tends to describe this as 'resistance' to genetic testing. For example, according to Lock, 'only between 15 and 20 percent of adults designated at risk for a genetic disease, or for carrying a fetus believed to be at risk for a genetic disease, have been willing thus far to undergo genetic testing, a finding that has held for over ten years (these numbers vary from country to country and differ according to the disease in question.' (Lock, 2012, p. 138).



ethnic possibilities, demonstrates variety and universality in how human families operate generally.

Conclusion

The reality of double epistemologies as shown from research *talanoa* and discussed here might seem challenging yet they also provide opportunity to discover beneficial similarities within the variety. I used visual metaphor here to locate similarities and symmetry which might be further developed as empathetic encounters into *vā*. In multicultural A/NZ positivity towards weaving strands of knowledge can make for richer understandings of the variety and complexity found within humankind. Also I have shown that some patterns are very much the same: tendencies for human universality in not wanting to know what might be ahead, and of families not using or sharing information available to them.



8. Conclusion

This study set out to gather NZ Tongans' perceptions of managing increased genetic risk by engaging with Tongan participants through their culturally familiar research frame of *talanoa*. Due to time limitations of this project only one participant was connected with genetic health services. Informal, usually one on one, *talanoa* took place with participants of various life situations amongst whom I found connection in their views towards healthcare engagement, genetic predisposition, and other issues they face being Tongan in contemporary A/NZ.

Talanoa discourse directed my thesis argument to challenge expectations placed on Pacific people to participate in the A/NZ public health system, a secular/physical health care service which for many Tongan/Pacific people neglects important aspects of non-physical humanness; a system also marked by assumptions of self-autonomous responsibility upon a population formerly unaccustomed to liberal democracy. Using the concept of responsibility as 'respons-ability' I asked whether Tongans and healthcare practitioners who serve them can fully respond to each other when they sometimes operate from differing ontological realities marked with different social priorities, such as collective obligations of respect and generosity, over personal health management.

Taking up Pacific epistemological discourse I established *tā* and *vā* concepts of reality of Tongan culture which attends to a holistic, socially stratified and spiritual worldview. Participants expressed themselves and offered stories and explanations which demonstrated reverence held for persons and beings of higher rank through ontological precepts of *mana* and *tapu*. This concurred with scholarship which describes Pacific views of biomedicine as lacking the wholeness of healing such as that provided by Tongan folk healers and pastors through prayer; and that Tongan people have a strong, well repeated sense of knowing why things happen, particularly of illness and congenital anomaly as due to breach of *vā* /relationship infraction. Some participants raised stories exemplifying this cause and effect aetiology; truth creation by moral justification to explain congenital abnormalities and conditions.

I discussed the major role which Tongan kinship plays, particularly as regards elevated status and *tapu* power, and how this can impact on Tongans' interactions with medical



practitioners, who are highly revered, and also other family members who hold special status and power, using the example of the father's sister/*mehikitanga*. The operation of rank both within the family group and the community, the respect accorded to those of rank, and the importance of the collective over the individual can impact on Tongan people choosing not to prioritise personal health management, particularly in a situation when spiritual agents might also be involved. Thus a referral to genetic counselling might be seen to threaten social/familial harmony unless engagement of senior family members was gained. Practice of obligatory giving is also dominant in the societal order and some female participants spoke of the burden and dilemmas of familial obligations around collective expectations and hierarchical responsibilities, some expressing agency to reduce their cultural giving.

Participants expressed themselves through differing knowledge paradigms regarding the concepts of health risk, its determination and prioritisation in daily life, and connotations held around genetic predisposition. *Talanoa* indicated views of pathologised identities as categorised objects of health messaging. This I argued points to potential unintended consequences of A/NZ public health policy sectioning populations by ethnicity to target them with selective health-raising messages such as diet and exercise choices. This is important to understand because it impacts on how Pacific people then engage with public-, and possibly particularly genetic-, health services, exacerbated by the semantic entanglement of ideas about genetic biology with ideas about metabolic disorders, even though these can, of course, be connected.

Some participants showed that they work across two worlds of knowledge: multiple ontological and epistemological realities with which they are familiar. At this particular point in time amidst cultural fluidity they desire to be both responsible Tongans and responsible New Zealanders when, depending on the particular location, work or home and church, they can possess two or more distinct ways they know things to be true. I intuited a sense that sometimes this serious labour from the interstices is a burden of duty they bear; nurturing *vā* by old and new ways in a new land. One participant saw no conflict between paradigms, that all healing: physical, mental and spiritual, is about bringing wholeness; another strongly encouraged plurality, of Tongan and biomedical methods both being practiced (but selectively in the case of some Tongan practices). Others raised health literacy hindering their people because in their daily work duties they observe conflicts of misunderstood or unknown epistemologies when some Tongan/Pacific patients do not



respond or are fearful about appointments or simple medical procedures such as injections. Several spoke of awareness for Tongans and other Pacific people of *fakamā* around conditions of heredity, of breach of *vā* aetiology and corresponding curse as reasons for some conditions. For some, upholding their Tongan *vā* and *tā* accords high priority especially around *tapu*, areas of sensitivity which involve others and have potential for supernatural involvement. They expressed complexities working with spiritually-principled realities in a western and secular biomedical care service.

This thesis experiments with the politics of research using methodology more typically used within 'indigenous research' by engaging *talanoa* and using Tongan theoretical concepts. Owning neither Tongan knowledge nor knowledge about genetics and its counselling I wrote from a place outside, at a particular moment in time, a gap somewhere in between them adopting the Tongan concept of *vā*, *tauhi vā*, to develop a sense of relatedness. By learning something of both fields simultaneously, I discerned possibilities for further *talanoa* to discover places of commonality and of thinking about genetics with Pacific epistemology.

Noting previous historical adaptive strategies of diversity in Tongan healing practices I suggested the incorporation of biological explanations (such as genetics) might be seen as a further *vaka*/vehicle to God-acknowledging healing. I also stated that even within secular health systems, such as biomedical genetics, 'lay' knowledge has long been recognised and genetic counsellors work with and acknowledge people's spiritual and lay beliefs in the clinical situation. I raised similarities between Tongan knowledge and genetic counselling practice which can perhaps be utilised for empathetic encounter honouring of both epistemologies taking as a metaphor Tongan weaving pattern, *kupesi amoamokofe*, identified by its balance and symmetry. Although sometimes needing some unravelling to learn to weave a new design, the balanced pattern of *amoamokofe* triangles can metaphorically acknowledge the place and role of non-biological beliefs alongside medical genetics for Tongan people.

With *kupesi amoamokofe* I emphasised the importance of empathy both within Tonga/Pacific concepts of *'ofa* and as a precept of genetic counselling. I argued that to enter into empathetic space a practitioner must respectfully discover something of the worldview that their client probably possesses including how the client might perceive them. I noted the symmetry between the importance of the spoken word to both counselling and Tongan healing encounters, that genetic counsellors can uphold traditional



Tongan principals by the nature of their empathic conversation with clients once they have gained their trust. Using my own field experiences, I cautioned reliance on phone calls for introductory communications as lacking cultural suitability for initiating relationships with Tongan people, noting the important role an intermediary plays in Pacific introductions. I finished by noting that human tendencies are often universal: of not wanting to know what might be ahead, and of families not using or sharing information available to them; that reticence towards unknown medical situations are not necessarily cultural but universal.

As time wasn't available for me to research experiences with genetic health services specifically, I used this more expanded data about health care engagement for NZ Tongans to challenge politics of responsibility in A/NZ contemporary healthcare. The Treaty of Waitangi provides a state tool for *vā*, for relationships which recognise one another's differences. Through the Treaty Māori have set A/NZ apart from other similar societies to have a strong sense of responsibility in striving to be bicultural, enabling lawmakers to address hurts and disparities, to aspire to what becoming multicultural looks like, including the implementation of health policies intended to address disparities among certain ethnicities. However, this thesis concludes that good intentioned responsibility can risk sustaining chasms if neither public health providers nor sections of the population are well placed to respond due to lack of comprehension of each other's worlds and knowledge systems.

Genetically derived conditions and anomalies are a sensitive topic for Pacific people thus it is important that any impetus for further research or any potential bio-genetic education is led by the Auckland Tongan community themselves rather than be a recommendation of this study. However, without my elicitation, participants in this study and other Tongans who spoke to me suggested genetic biology and information about genetic health services ought to be introduced and discussed among Tongan people. They suggested the church community and leadership as being the normal site where this would occur for Tongan people. This *talanoa* was brief and preliminary. With a more realistic time span and input of some resources, initiation of *vā* between the Tongan community and genetic health care practitioners could *fofola e falà ka alea e kāinga*/roll out the mat for further community dialogue and knowledge exchange. To echo Havea (2010, p. 180), *talanoa* is a vehicle for recognising diversity and connectedness, of recognising different voices and valuing them. And, I add, *talanoa* can be an environment of empathetic encounter to develop responsibility.



Glossary

This glossary has been created from others' translations and glossaries, specifically: Herda, Terrell and Gunson (2001), Thaman (1988), and Vaka (2014).

| | |
|--------------------------------|--|
| <i>'anga faka-Tonga</i> | Tongan ways, culture |
| <i>'anga lelei</i> | appropriate, good behaviour |
| <i>'anga faka'eieiki</i> | behaving with dignity |
| <i>'āvanga</i> | spirit-caused diseases/mental illness psychotic |
| <i>'eiki</i> | elder , socially superior; high-ranking person, chief |
| <i>'ofa</i> | love, generosity, empathy, kindness |
| <i>'ofa fe'unga</i> | to demonstrate appropriate compassion |
| <i>'ulunga'anga faka-Tonga</i> | real Tongan traditions, way of life |
| <i>ako</i> | learning, formal education |
| <i>amoamokofe</i> | style of even patterning in tapa and other art forms, <i>amoamo</i> literally is the pulsing movement of rubbing, massage |
| <i>fa'ē</i> | mother, her sisters |
| <i>fahu</i> | brother-sister relationship; the man's sister's child; the power of <i>mehikitanga</i> to make certain decisions |
| <i>faito'o</i> | to treat or cure, process of healing |
| <i>faka'apa'apa</i> | respect as showing and returning it to someone carrying more <i>mana</i> and <i>tapu</i> ; <i>'apa'apa</i> is to do with being at the side position in a protective stance (Taumoefolau, 1991) |
| <i>fakatapu</i> | salutation, acknowledgement to elders and those of higher rank when giving a speech |
| <i>fale</i> | house or household |
| <i>famili</i> | family |
| <i>fakafonua</i> | traditions |



| | |
|---------------------------------------|--|
| <i>fakamā</i> | shame |
| <i>faka- talanoa</i> | first talanoa or informal talanoa |
| <i>fānau</i> | family |
| <i>fātongia</i> | duties and obligation in Tongan society |
| <i>felavei</i> | interweaving pattern |
| <i>fekau’aki</i> | connection |
| <i>fofola e falà ka alea e kāinga</i> | roll out the mat for further community dialogue |
| <i>fono</i> | village, family meeting |
| <i>fonua</i> | homeland, place of origin |
| <i>kāinga</i> | kin group |
| <i>kakala</i> | fragrant flower garland and its making |
| <i>koloa</i> | women’s gift of ceremonial <i>tapa</i> mats/barkcloth, traditional ceremonial exchange, treasure |
| <i>kuonga mu’a</i> | time past, – literally time ahead |
| <i>kupesi</i> | decorative repeated patterning, traditionally on <i>tapa</i> cloth |
| <i>laumālie</i> | spiritual |
| <i>loto</i> | heart, soul, will, depths |
| <i>lotu</i> | prayer, worship, religion |
| <i>mahaki faka- tēvolo</i> | spirit-related illness (literally devil-caused), mental distress |
| <i>mahaki faka-Tonga</i> | Tongan sickness (as apart from western sickness) |
| <i>mala</i> | curse |
| <i>mālō e lelei</i> | greeting, hello |
| <i>mana</i> | superiority and power, a mystical quality of extraordinary or supernatural ability to make things happen |
| <i>mateuteu</i> | to be prepared, ready |
| <i>matua</i> | parents, elders, seniors |
| <i>mehikitanga</i> | father’s senior sister/aunty – highest and most privileged position, <i>fahu</i> |
| <i>monu</i> | blessing, good luck |



| | |
|--------------------------|---|
| <i>mo'ui lelei</i> | wellbeing |
| <i>noa</i> | free, harmony |
| <i>nopele</i> | titled nobility |
| <i>Pālangi/Papālangi</i> | European, westerner |
| <i>poto 'ianga</i> | wisdom, with skill and competency |
| <i>puipuitu'a</i> | family background, genealogy |
| <i>puke faka tevolo</i> | to be possessed, mentally distressed |
| <i>pule</i> | authority, position of authority |
| <i>tā</i> | time, rhythm, beat |
| <i>talangofua</i> | obedience as in to a higher rank or God |
| <i>talanoa</i> | to talk in open, frank conversation |
| <i>tamai</i> | father |
| <i>tapu</i> | forbidden, sacred as in certain relationships between family, royalty, nobility and also with practitioners |
| <i>tauhi vaha'a</i> | sustaining and nurturing relationship |
| <i>tevolo</i> | transliteration of 'devil', spirit |
| <i>toto</i> | blood (including heredity, genes) |
| <i>tu'a</i> | socially inferior, common person, relative ranking lower than you, outside |
| <i>tu'i</i> | royalty |
| <i>tupu'anga</i> | ancestors |
| <i>vā</i> | relatedness, relationship, space |
| <i>vaka</i> | boat, vehicle |



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Appendice



Date: 01 September 2016

Dear Heather Mann

Re: Ethics Notification - NOR 16/36 - Ethnographic Research Project for Master of Arts in Social Anthropology

Thank you for the above application that was considered by the Massey University Human Ethics Committee: Human Ethics Northern Committee at their meeting held on Thursday, 1 September, 2016.

On behalf of the Committee I am pleased to advise you that the ethics of your application are approved.

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Brian Finch
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

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