

Gender, Health Inequality, and Hidden Healers in Rural Fiji ¹

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Abstract

This study of gendered patterns of illness, anxiety and depression in rural Lau, Fiji presents data on indicators of anxious and depressed affect among ethnic Fijians in a small island, analyzes the social production of psychogenic distress, and explores issues of inequality and feminine agency in indigenous healing practices. Based on ethnographic and survey data from pre-coup Fiji, the article argues that status (rank) and gender interacted with social, cultural, economic, and political forces to produce distinctive, gendered patterns of both depressive and anxious affect among rural native Fijians, often in somatized forms. Profound social inequities of gender and social status interact with economic marginality and poverty, harsh environmental constraints, high incidence of tropical cyclones, and social change accompanying development to produce community patterns of illness. However, women's largely unexamined dual roles as fishers and as healers also reflected women's agency in a highly constrained social environment.

The intersections of gender, class, and illness in Fiji have been little studied. This article offers a critical cultural analysis of gender, social rank, and health and well being among Lauan Fijians, based on extended ethnographic research on household health and indigenous healing systems and survey data on biopsychiatric symptoms of anxiety and depression in pre-coup Fiji. A marked pattern of community-specific health differences by gender and status/rank was found in this study, raising

¹ An earlier version of this paper was presented at a session on 'Signs of Stress: Culture, Person, and Gender in Illness and Distress' at the Meetings of the American Anthropological Association, Chicago, 20-24 November 1991.

pointed questions about the contrasts between the everyday calm and gracious interactions of pre-coup rural Fijian village life and the covert tensions, conflict, and stress that underlie this. In this study symptoms of anxiety and depression and their expression in cultural 'idioms of distress' (Nichter, 1981; see also Parsons, 1984) are interpreted as diagnostic of individuals' and groups' social locations and positions and the stresses and strains that accompany them, including adaptations to social change. The role of gender and status in emotional illness and distress is of central concern to the study. In addition, the work of Fijian healers, primarily women, in treating everyday individual and community symptoms of distress is also examined.²

The study of gender in the Pacific, particularly Melanesia, has attracted a great deal of interest from anthropologists (for example, Gregor and Tuzin, 2001; Lepowsky, 1993; Lewis, 1998; Linnekin, 1990; Lockwood, 1995; Strathern, 1972, 2001; Weiner, 1976). Healing and care in the Pacific, too, has had growing attention, with work on healing practices (Parsons, 1985; MacPherson and MacPherson, 1990), and childbirth and midwifery (Lukere and Jolly, 2002), among others. The health status of Pacific Islanders has been variably measured and reported. Summary data aggregated to the national level are available on life expectancy, infant mortality, infectious and chronic diseases, aging, and health care services and their utilization (see Lewis, 1998). Population wide health status of women by other indicators is more difficult to assess, and what data exists on morbidity patterns are often not disaggregated by sex (Lewis, 1998: 648). Notably, Lewis' (1998) overview on the intersection of gender and health in the Pacific notes that data were insufficient to include gender and mental health other than data on domestic violence and suicide. She notes as well that in addition to merging data by sex, these data aggregated by country mask the relatively poorer health of outer island residents, such as those represented in this study. Critical analyses of health and its social production are distinctly lacking, although recent work may help to remedy that (for example, Lukere and Jolly, in press).

The intersection of health and gender in Fiji has received surprisingly little attention to date, particularly that specific to ethnic Fijian

² Although more than two decades have passed since this field research was completed, there has been astonishingly little work on gender and mental health in Fiji in the intervening years (with the notable exception of Leckie, 2004b). There, however, have been numerous changes in Fiji's urban centres in the past twenty-five years (for example, see Becker, 2004 concerning changes in eating disorders among young women in Fiji in the past ten years).

women and men. Leckie (2002) and George (2004) have provided recent analyses of the politics of gender and social movements/advocacy groups in Fiji. Lukere (2002a, 2002b), and Lukere and Jolly (2002) have provided the most detailed analyses to date of colonial surveillance and control of women's bodies, indigenous midwifery, maternal and infant health, and emerging infectious diseases. Regarding mental health more specifically, Leckie (2004a) is studying the history of mental illness in Fiji and has published on this concerning Indo-Fijian women (2004b). Becker (1995) examined obesity and body image in indigenous Fiji from a clinical biopsychiatric perspective and has developed a more recent analysis of emergent eating disorders (Becker, 2004; Becker et al, 2002). Adinkrah (1999) has studied sex differences in rates of domestic homicide in Fiji; Aghanwa (2004) has looked at gender and attempted suicide based on hospitalization date; and Aucoin (1990) has examined the incidence of reported domestic violence among ethnic Fijians. More specifically concerning anxiety and depression, Becker (1998) and Becker and Lee (2002) have also presented evidence on postpartum depression among ethnic Fijians in Western Fiji, indicating that indigenous social support processes may work to attenuate postnatal illness. Spiegel (1983) reported the absence of depression in Fiji, based on his visit as a tourist to a village on Viti Levu. Herr (1981) reported on the prevalence of nightmare experiences among rural ethnic Fijians as evidence of anxiety.

This study is about, to borrow from Emily Martin (1987), the women and men in the bodies, sick and well, in rural Fiji. It is also about the community of care in Fiji that is involved and embodied in both illness and healing. Bodily complaints in many social and cultural contexts in the Pacific and around the globe metaphorically have been shown to express personal and interpersonal distress. Existential experiences of worry, frustration and demoralization are often expressed, collectively or individually, in what medical anthropologists have called cultural 'idioms of distress' (Nichter, 1981). Such cultural idioms can be defined as 'shared, culturally distributed sets of symbols, behaviours, language, or meanings that may be used by people to express, explain, and/or transform their distress and suffering' (Hollan, 2004: 63). This paper examines gender-based expression of distress and its social reception in Lau, Fiji.

Anxiety and depression are more prevalent worldwide among women than men (Weissman et al, 1993); in clinical studies they frequently coexist (Barbee, 1998). Numerous aetiological explanations have been offered in various literatures for women's greater experience of depression. Stress models of anxiety and depression aetiology, originating

with Selye (1956) almost fifty years ago, still provide the most comprehensive explanation for depression and anxiety cross-culturally. Refinements include cognitive theories like Seligman's (1995) learned helplessness model of depression, stressful life events models that show depression among women often to be associated with acute or long term exposure to stressful life events (Brown et al, 1994), and the realization that stressors' effects are greatly mediated by the personal (and cultural) meaning systems through which sense is made of a threat, danger, or risk, with loss response associated with depressive symptomatology. Role stress is one explanation for women's great morbidity. In particular the lack of power and control available to women in 'traditional' gender roles has been singled out along with greater experience of loss, as the most salient explanations of women's depression in 'traditional' contexts, for instance, those under classic conditions of patriarchal subordination (Finkler, 1985). Social support is an explicit part of the life stress models in two ways: lack of social support, defined as people to turn to for help in times of need, is particularly predictive of depression among women (Brown and Harris, 1989); and single mothers with few economic resources have double the risk of married mothers, in part because of their dependence for support on other similarly stretched single mothers who are poor (Brown and Moran, 1997). Poverty and class, as well as race and ethnicity, are implicated in many of these studies as key factors as well. The precise interrelations among these factors are far from clear, however. This article aims to go beyond the debates on the politics of the maternal subject, which have often been limited to discussion of the role of the mother (cf Leckie, 2002: 161; Jolly, 2002), and ask how gendered and hierarchical social class-based processes are embodied in illness and distress (and health) among ethnic Fijians.

Background

The study upon which this paper is based took place over a two-year period (in 1979-80) on a small, isolated Pacific Island in the Lau Group of Fiji.³ The two published studies adducing evidence on the mental

³ My research participants in Vulaga preferred that I not obscure their identities or location. I am following their wishes here. I believe this desire to have their stories told is a reflection, in part, of their social, political, and geophysical location. This study is based on dissertation field research conducted in Southern Lau in 1979 and 1980. The work was supported by an individual pre-doctoral National Research Service Award from the National Institute of Mental Health to the author. I thank the people of Vulaga, particularly the women, for their hospi-

health status of Fijians at the time of the study consisted of one regional survey (Murphy, 1978; Murphy and Narayan, 1979), based on hospitalization records at the one in-patient mental health facility in Fiji, and the published findings of one expatriate psychiatrist who asserted the absence of depression in the culture, based on his brief sojourn in Viti Levu as a tourist (Speigel, 1983). Both these studies assessed very low (or nonexistent) rates of affective and anxiety disorders among ethnic Fijians.

Reports from the neighbouring Pacific Island nation of Tonga also had asserted strikingly low population figures for mental disorders of all kinds (but see Parsons, 1984). Ethnographic reports focused on psychosocial development (for example, Howard, 1979; Levy, 1978) frequently typified the day-to-day interpersonal style of Pacific Islanders as one of 'blunted' affect, which was argued to derive from the repression of hostile feelings necessitated by the social and economic demands of face-to-face living on small islands. Others (for example, Kleinman and Good, 1985; Lutz, 1998) have argued with considerable persuasiveness that depression as manifest in the United States [and as defined by the master biopsychiatry classification text, the Diagnostic and Statistical Manual, DSM IV (1994)], does not correspond to a culturally or linguistically meaningful constellation of symptoms, disorder, or illness in many Pacific cultures and, indeed, that emotions themselves and their identification are culturally contingent.

This study focused primarily on existential malaise or demoralization (Young, 1988), with an emphasis on the social (and political) origins of distress and illness, and this intentionally broad focus eventuated in a study of Lauan Fijian experiences of anxiety and depression, fear and loss, pain and worry, both from an ethnographic perspective and from a biomedical (though not truly epidemiological) one. The level of analysis was on anxiety and depression symptom clusters, following Abbot and Klein (1979), regarding anxiety and depression as culture- and gender-specific symptom clusters, although the relationship between symptom clusters and disorders was also explored. The attention to the bodily experiences of anxious and depressed emotion was informed by the work on somatization by Kleinman and Good (1985).

tality, countless kindnesses, and their unwavering patience with the stranger in their midst, particularly in the early months of the research when language and cultural barriers were the greatest. The Ministry of Fisheries provided vital instrumental assistance as part of their rural Fiji fisheries development program. At the University of the South Pacific, Bruce and Claudia Knapman, and Randy Thaman provided invaluable assistance and friendship.

The Study

The participants in this study were all the residents of the small southern Lau island of Vulaga⁴ (389 persons), who lived in three ranked villages. The island was entirely populated by ethnic Fijians. Vulaga in particular and southern Lau in general are notable for their isolation and remoteness from the economic, political, and cultural centre of Fiji, although they were the centre of power in the nineteenth century. While Lau, and eastern Fiji more generally, was ‘. . . the site of most of what happened of significance in Fiji [in the past century], today it has become entirely ‘periphery’’ (Brookfield, 1977: 11).

In this article I discuss the two larger villages of Muanacake and Muanaira which are located about a kilometre apart from one another on a beach facing the island’s extensive barrier reef.⁵ The villages were separated physically from each other by dense coconut plantation and socially by their differences in hereditary rank and associated distribution of personal, natural, and supernatural resources.⁶ Muanacake (literally and figuratively, ‘high side’ or chiefly village) had a population of 169⁷, 83 females and 86 males, with 44 per cent of its population living in extended families, and 56 per cent in independent nuclear families. The second village, Muanaira (‘low side’), had a population of 135, very asymmetrically distributed with 48 males and 77 females; only 30 per cent of the population was living in extended families and 70 per cent in independent nuclear families. These differences in population distribution and household organization are both pertinent to the findings below, so let me recap by saying that Muanacake, the larger, chiefly village, had a fairly equal distribution of the sexes and had a higher percentage of extended family households, while Muanaira was smaller, had a relative surplus of females, and had a lower percentage of extended family households.

⁴ I am following indigenous preferred naming, rather than the colonial codified form of Fulaga.

⁵ A third village of Naividamu was studied but is excluded from this discussion because it was even smaller and more recently established, had been inundated in tidal surge from a tropical cyclone and very disrupted. It was also more distant from my location in Muanacake and hence less frequently observed informally.

⁶ The small population size limits the epidemiological significance of the findings, but islands in Fiji represent distinct and significant social, economic, political, and cultural bounds. The exclusion of small populations, or the aggregation of their data into larger geopolitical units, masks important local behaviour patterns and practices. Pacific studies have yet to fully reconcile this problem.

⁷ In 1980, when I conducted this census.

These population patterns were of many decades' duration.

Vulagans have the distinction of occupying what has been called a 'famine' island (Thompson, 1940). It is composed of raised limestone and covered with dense tropical hardwood forest, with little arable soil and no surface fresh water sources; communal rainwater catchment was somewhat haphazardly depended upon for drinking, cooking, bathing, and laundry water. Men cultivated coconut, cassava, sweet potatoes and yams, and raised pigs; women cultivated pandanus and were the predominant fishers. Copra, produced mostly by men; mats, produced exclusively by women, and carved items, produced exclusively by men, were the primary sources of the very limited cash income Vulagans could generate.⁸ When available, kava (*yaqona*) was consumed on a daily basis by adult men; in contrast to western Fiji, women were excluded from the kava drinking group. Patrilocal residence was still the norm in 1980, and women were restricted in mobility, work, access to food, cash, and other resources, and reproduction.

In the larger Lau and Fiji frame, Vulaga was regarded as low ranking and poor (Hocart, 1929); it is the most marginal island economically and socially in the Lau group, which is itself on the periphery in Fiji (Brookfield et al, 1977). In the past, Vulaga's dense hardwoods made the island a particularly strategic locale for the construction of large double hulled canoes used in inter-island and inter-territorial warfare in the nineteenth century by Fijian and Tongan chiefs (Derrick, 1950).

Women's lives in Vulaga

Vulaga, like much of Fijian society, particularly in Lau with its strong historical Tongan influence and cultural interchange, can, like Tonga, be typified as a 'kinship society', one with a communal mode of production (Gailey, 1987). It was and is a highly stratified society, one in which ranking competes with gender and age as the most significant source of social differentiation, although gender relations in 1980 were unquestionably characterized by the subordination of women and an almost complete division of labour by gender. As in both Melanesia and Polynesia (cf Weiner, 1992; Gailey, 1987), however, women in this Lauan society do have bases of power in the form of women's wealth, in this case primarily fine mats and intricately decorated *masi*, but also including less valued objects like fans, brooms, and scented coconut oil that

⁸ Dried fish and *bêche de mer* were also being erratically produced by villagers in response to rural fisheries development efforts of the Fisheries Ministry.

are nonetheless vital in communal exchange. The *Soqosoqo Vakamarama* (a national women's organization; cf Leckie, 2002) also provided women a context in which they wielded authority, but women's participation in funerary ritual (where they were the leading ritual authorities) and ceremonial exchange was a much more significant domain for exerting authority. Even in these settings, however, male authority dominated.

An additional and thus far unrecognized form of women's wealth in Vulaga is the widespread ownership of specialized healing knowledge, knowledge that is used in the communal care of ailing women, men, and children. In Vulaga medicine (*wai*) was owned by healers (*vuniwai vakaviti*) and knowledge about it closely guarded; 'ownership' included both the knowledge of which plants to use, when and how to collect them, how to make medicine from them, when and how to apply them; it also included the moral right to that knowledge and expertise and the power (*mana*) acquired through legitimate ownership and skill. Ownership was passed down (*vuluvulu*'d) in *mataqali* lines that complicate any systematic understanding of kinship or in unpredictable ways across *mataqali* and gender lines (for example, from a *vuniwai* to a sick person she has healed with it). Health (*bulataka*), which inscribes the spiritual health with a minimization of somatized and subjective symptoms of anxiety and depression, is always inherently an active communal production rather than an individual state or product, and as such it both reflects and refracts communally bestowed care in a process of which gender differentiation is an intrinsic aspect.

In Vulaga, village life, meaning those activities that go on in the public view within the confines of the village itself during the middle of the day, often proceeded at a very slow tempo, the pace dictated particularly by the necessity of caring for young children in a dangerous environment (for instance, by the sea). Adolescent and elderly females, women with small nursing children, and pre-school age children were all that remained in the households. These adults and quasi-adults engaged in caring for pre-school age children, taking midday meals to children in school, doing laundry, caring for the sick, weaving mats, and preparing food for the rest of the household. The temporal pace was languid, but the production was relentless, and 'idle' did not describe women's days (or nights) in Vulaga.⁹

⁹ Sahlins described women's lives on the island of Moala as idle: 'in households with many women and girls, members of the fair sex do seem to spend an extraordinary amount of time in idle, sometimes vicious, gossip' (1968: 121). Moala is about 100 nautical miles to the west of Vulaga and is a much larger,

Vulaga women in Muanaicake where I lived were engaged daily (except Sunday) in crucial food getting, particularly communal fishing activities. They were the best informed members of the community about local marine resources and their exploitation, and, when not fishing, they worked in relative isolation in patrilineal and patrilocal households from early morning often until late into the night in endless chores of child caretaking, elder care, household management, collecting firewood, food preparation and serving, cultivation, harvesting, and preparation of pandanus for mat making, weaving mats, and healing consultations and care. Work in the village was often tedious and physically taxing; fishing was universally viewed as dangerous, risky, and tiring. Small children were never allowed to participate in fishing, so each household urgently needed at least two able-bodied adult women, one to go fishing and the other to remain in the village and take care of children and household.

Men, other than the civil servant teachers and minister, laboured daily on weekdays in communal *mataqali* (patri-clan) groups at root crop (mostly cassava) cultivation and carving activities but also drank kava and told *talanoa* together at leisure for many hours daily.¹⁰

Methods

In this study, two convergent lines of inquiry were conducted. The first was a systematic study of illness and health in every household on the island over about six months, as self- and other-recognized, classified, diagnosed, and treated within the community. This study was preceded and accompanied by the quasi-ethno scientific elicitation of indigenous illness categories.¹¹ The study entailed weekly visits to all households and interviews of all available family members (adults and adolescents) about their own illnesses, those of other family members, and about any instances of seeking care from healers. Additionally, as an overlapping

more fertile, populous and politically powerful island. And yet even with this qualification, Sahlins' description is unconvincing.

¹⁰ Sahlins' depiction seems arguably like that of a contented patron in an impeccably-run restaurant who can delude himself into thinking that the timely and non-intrusive appearance and disappearance of his food is an effortless and leisurely cultural product.

¹¹ 'Quasi-' because on the ground I found the implication of prohibited witchcraft beliefs and practices in illness and healing activities precluded simple, direct questioning of villagers about these very sensitive topics (see Cook, 1974 for a similar account). Thus, the classification system I describe is far more emergent.

measure, I visited, observed, and interviewed participants of all known consultations with healers of which I was aware or became aware during the household visits.

In the other linked study, I administered a modified version of the Health Opinion Survey (HOS)/Beck Depression Inventory (BDI) (after Abbott and Klein, 1979) in Lau dialect Fijian to all adult residents. The symptom checklist-like questions were a number of health- and illness-related questions and were self reports with a three-point scale for response. They were translated and back-translated into Fijian and then English, first at the University of the South Pacific in Suva, and then again in the village. The instrument focuses on the physiological and behavioural manifestations of anxiety and depression (for example, palpitations as an anxiety symptom) rather than emotional/mood symptoms. I administered the HOS/BDI in Lauan dialect Fijian to all individuals nearly a year after my arrival in the village in the context of private, extended interviews about personal health histories, the ownership and knowledge of Fijian medicines, recent and past consultations with local healers, experiences with the public health care delivery system in the country both locally and in more central parts of Fiji, self perceptions about body size, shape, and weight, dream and nightmare experiences, and, for women, additional questions about their menstrual, birthing, and menopausal experiences. I had a young female assistant with partial secondary school education present to assist in translation if needed. My own training in the administration of more complex assessment tools¹² which depend in part on clinical judgment rather than self report also was utilized to supplement assessment of behavioural, cognitive, and affective status of individuals. These judgments were incorporated in general field notes of the interviews.

The key findings I wish to present here focus on gender and status differentiations in the self- and other-reported depression and anxiety as measured by the HOS and the relation of these findings to ethnographic and ethno semantic data on Lauan Fijian perceptions of and treatments for dysphoria and anxiety, as well as the relative positioning of such symptoms, syndromes, or disorders within the constellations of Fijian-identified illnesses.

Spencer's (1941) study was the only prior comprehensive published

¹² Prior to conducting fieldwork, I trained at the University of California at Los Angeles's Neuropsychiatric Institute in the Psychiatry Department of the School of Medicine in the administration of the Present State Examination (PSE), and other clinical psychiatric intake and assessment measures in use in the late 1970s.

account of Fijian medicine (*wai vakaviti*) and healing, and her account differed in key ways from these findings. Parsons' (1984) study of Tongan classification of sickness and healing also provides a useful frame of reference, especially as descendants of Tongan carving clans are residents of Vulaga who were incorporated as high ranking members (Tonga conquered Lau in the nineteenth century) and thus imported some Tongan medicine and classification. The resultant system in Vulaga is doubtless hybrid in many respects and reactive to Wesleyan Methodist attempts to contain and suppress it. One manifestation of the latter was the lack of overtly practicing *dauvagunu* (witchdoctors, almost always male) on Vulaga and a high prevalence of women *vuniwai* of varying power, skill and reputation.

Illnesses (*baca*) in Vulagan lexicon were divided into *bacataka* (sickness, as a contrast with health (*bulataka*)). *Baca levu* (great sickness; major chronic illness). *Baca vakaviti* (Fijian illness) was distinguished from *baca papalagi* (European illness) such as diabetes (*baca ni suka*), or anaemia (*lailai a dra*). Simple *baca* are the kind of self-limited illnesses of mild symptoms and short duration, including many skin infections, boils, fevers, diarrhoea, and menstrual disturbances. They may be reclassified if symptoms become more severe or chronicity results. Other diseases are either classed as types of bodily disease (de facto *baca ni yago*, although this term is not used, which may have acute but highly localized bodily symptoms) or *baca ni yalo* or sicknesses of the *yalo* (soul or spirit), which are all potentially life threatening and supernatural in aetiology. These are ghost illnesses (*curumi tevoro*), *draudrau* or *drau ni kau* (sorcery-caused illnesses), or soul loss (*cavu yalo*). Space does not permit an elaboration here, but in general, anxiety symptoms tend to be somatized as *baca ni yago*, bodily disease with localized pains and upsets. Such symptoms as tension, inability to relax, headache, stomach aches, palpitations, sweating, breathlessness, are all readily understood and accepted as such *baca*. Treatment is readily available from *vuniwai*, and help seeking is encouraged. There is not necessarily any wider social implication of these illnesses in either attribution of blame or moral responsibility to get treatment for the sick person. On the other hand, depression symptoms such as dysphoric affect and mood, insomnia, early morning waking, motor retardation and especially social withdrawal, tend to be identified as *baca ni yalo* with symptoms of harmful *tevoro* contact of some kind, are seen as requiring immediate intervention, and arouse the care and concern of the extended family or even the *mataqali*. Any withdrawal of the person from full work and social participation, except

within the clearly defined period for mourning, is disvalued and necessarily involves others.

In Muanaicake, of thirty six adult women, twenty five were owners of one or more *wai*, and seven more are younger women whose mothers or other close relatives, women or sometimes men, were active *vuniwai* who had not yet *vuluvulu*'d their *wai* to their daughters. Younger women who are more actively involved in child bearing and child rearing were discouraged from practicing medicine because of the risks it would pose to their children's health. Noted *vuniwai* are all older, some with no children, unmarried, divorced or widowed. Of thirty-five men, seven owned *wai vakayavusa* and three more just did the massage (*bobo*) part of a *wai*. In Muanaira, twenty of thirty-five women owned *wai*; four of twenty adult men owned *wai* and another two just did *bobo*. For the island as a whole, 53 per cent of adult women are *vuniwai*, while only 17.6 per cent of men fill this role. *A i uku* (medicines) are numerous and complex, and there are many more everyday herbal remedies people use that were not considered *wai*; this represents a highly elaborated part of the cultural knowledge system and one which women dominate in knowledge, reputation, and skill. Healing is considered dangerous, it is without pay or compensation, although sometimes modest gifts are given to a healer, and healing rituals, which minimally last for four nights' duration, can consume significant portions of a successful healer's time.

Anxiety, Depression, and Illness

In Muanaicake, where I lived and knew people most intimately on an everyday basis (and hence where these data have the greatest congruence with other kinds of understandings), women scored significantly higher than men on both anxiety and depression composites from the HOS/BDI. These findings were entirely consistent with my ethnographic data; Muanaicake women were observed to manifest distress with both anxious and dysphoric aspects far more than men in the village. Similarly, for the indigenous illness and help-seeking data in the chiefly village, with observed and self-reported illnesses so minor they did not even get classed as *bacataka*, there was no significant difference between females and males, while in the other three main classes of disorders women had significantly more instances of each per week than did the men in the village. As well, significantly more women than men sought assistance from local healers for somatic *baca ni yago* complaints, while directionally more women than men consulted village *vuniwai* about supernaturally caused illness.

In somewhat astonishing contrast, but also consistent with the ethnographic observations, the smaller, lower ranked adjacent village, Muanaira, displayed an almost entirely different picture of mental and somatic health and illness, no matter what measures were used to assess them. This context provides a fascinating one for the discussion of the intersection of gender, stress, and illness in Fijian society.

More specifically, in Muanaira *men* scored significantly higher than *women* on the HOS on a composite of somatic items ($t(53) = 2.06$, $p < .05$) and they scored directionally higher than women on all composites of anxiety and depression (highly significant by sign test, $p < .001$). Another way to look at these data is that women in Muanaicake scored significantly higher than women in Muanaira on all 7 composites ($p < .005$, by t-test), while men in the two villages did not differ significantly from one another (although men in Muanaira scored directionally higher than those in Muanaicake on 5/7 composites, ns by sign test). These data converge interestingly with those from the weekly monitoring of indigenously-defined illnesses, where men in Muanaira experienced significantly more instances of very minor, and more instances of serious supernatural illness per week over the six-month period than did women in the village, while there was no significant difference between men and women in the other two more moderate classes of illness. Muanaira had twenty-four *vuniwai*, twenty female and four male, who were consulted by men and women with approximately equal frequency.

First, I need to address the issue of whether the findings are significant (by which I mean meaningful). 'Village' or 'town' are standard demographic units used in ethnographic and epidemiological studies. These findings are disturbing unless one dismisses them. While one might not choose the HOS as an assessment tool, the findings seem so consistent with both my observations and the other empirical data collected on illness that their face validity is fairly high. Second, the differences reported above are statistically significant, not just trends or directional differences. Third, it is not easy to dismiss the findings as transitory given that the weekly household data were collected over a substantial period of time and corroborate the survey data. For clarification, the level of disorder present is comparable to DSM-IV clinical disorders such as dysthymia, generalized anxiety disorder, and adjustment disorder. Thus, chronic mild disorders were common in this Fijian population as measured and assessed in biopsychiatric terms. Finally, even if you disputed the disorders' clinical validity, there is little question about the differences in response patterns by gender.

The explanations I draw for these reported differences are multifaceted. To clarify, I am specifically talking about gender differences, rather than sex differences, in the patterning of disorders. These data particularly highlight the gender relational aspect of community-wide patterns of mental health and illness. This paper addresses only the issues of gender role stress and social support; it aims to address the gender and village interaction in the apparent production of significant levels of distress and illness in a rural Fiji context.

Women's roles in the two villages are very different because of status differences, ritual exchange responsibilities that accompany these, and household organization and production. It is important to note that there were no significant economic differences accompanying the status differences. Women in both villages are the main producers of the only abundant food in the site, marine food, in a society that greatly values food abundance and in a context of local food scarcity, and yet their crucial role in production is systematically under recognized. Like fishers everywhere, women in Vulaga dealt with the stresses of unpredictable catch and physical risk. Unlike Muanaicake, Muanaira had a surplus of women throughout the past century; household organization was based on nucleated households of men with their spouses and other unattached women. Such household arrangement minimizes the gendered work load on individual women by assuring the availability of able-bodied adult women from each household for fishing activities daily without compromising child caretaking and other household labours. By the same token, male-produced root crops, already in short supply, need to be provided for all the members of these nucleated households, in this case for a large number of women who do not participate in their production.

Unlike the Trobrianders Weiner analyzed (1992), where women's wealth has its own intrinsic and non-transferable value in exchange, Vulaga women's wealth had come to be exchangeable for men's wealth, in part because of the commodification of the craft industry in Fiji. Thus, as an adjunct to tourism, work that would have been men's work in the past was devolving onto women. Women have become increasingly burdened with production of domestic food and mats, cash for cash production, and mats essential for use in intervillage and interisland exchange and church contributions. These effects were much more evident in the chiefly village, where chiefly male authority seemed to wield more power over women and where chiefly obligations to lead in exchange and to *lomani* visitors demanded that more goods be produced.

My analysis, then, is that the obligations of men's higher rank in Muanaicake devolved on the women there with an oppressive work load,

social isolation in often hostile patrilineal extended family households, and increased ritual, moral, and social responsibility in the island-wide and interisland community. In Muanaira, the men's lower rank was an intrinsic attribute they cannot transfer to the women - they express their situation in an idiom of witchcraft which carries with it high risks; risks which were manifest during the period of this research. The social organization in Muanaira into nucleated households with extra adult women also seems to have created a context of far less strain for women, but increased stress for men, possibly because food preparation by food component is totally gender-typed, and women-produced food is more abundant than that produced by men. These patterns, of course, are more visible in this context of chronic food scarcity.

The male body and female body in Lau are very much social bodies and present and experience refracted images of communal care and well-being, because of the communal nature of the construction of self (cf Strathern, 1972) - being well-fed, for example, reflects participation in a series of kin relationships that invoke images of plentiful food production and generous food sharing. So, too, being healthy reflects both communal care and good will; ill health on the other hand indicts the community of care - the care of the patrilineal family, extended family, patri-clan, and village. Anxiety and depression, both subjective and somatized, are responded to with physical somatic care (massage and pressing/moulding), herbal medicinal treatment, and ritual observance that serves to express and assert caring and to attempt realignment of the sick person within the kin group. Anxiety symptoms and disorders in general are tolerated and cared for as relatively minor bodily complaints, except for acute panic symptoms. Depression, particularly with any vegetative symptoms such as motor retardation, social withdrawal, and loss of appetite, is always regarded as a serious supernatural illness, and immediate intervention with care and treatment, administered mostly by women healers, is always pursued. Associated with this rapid intervention, very little major depressive disorder as clinically defined (for example, by DSM-III-R or DSM-IV) was seen, although there was much chronic milder depression/dysthymia.

Women were suffering in the constraints of village life and its duties, particularly women in the ranking village. They also owned and deployed practices that ritually realigned the sick person, demonstrated social support in a context exacerbated by patrilocal residence (for instance, where married women were primarily living in their mother-in-laws' households and their husbands' *mataqali* essentially owned their chil-

dren), provided physical and psychic relief without allowing resort to a sick role. Women frequently answered, when asked what they had done to take care of themselves when ill, 'if I stop working, I die'.

Healing power unquestionably provides agency for women, particularly for those who are disvalued within the community in other respects (for example, barren women, who are called '*maumau tapioke*'—food waster—in their husbands' *mataqali*), and women take risks with the supernatural to gain power and respect. However, I would also caution against the romanticization of women's agency (cf Leckie, 2002). Lock and Kaufert, in their discussion of 'pragmatic women' as women negotiating competing issues of agency and constraint within the contexts of their pragmatic, everyday lives, argue that in a global political climate of marginalization, '...the possibilities for resistance or critical reflection in situations of extreme isolation where structural violence is at its most constraining ... are minimal (Lock and Kaufert, 1998: 24). In such contexts, they add, post-modern analysis '...which plays with the idea of multiplicity, with the possibilities for individual remaking of the world... seems flagrantly irresponsible' (1998: 24). Thus, Latina farmworkers in the USA are, indeed, so structurally constrained that their 'choices' are most often grounded in the pragmatic exigencies of survival (Harthorn, 2003). Vulagan women are similarly constrained, but this study shows that some are more constrained than others, and for men, low status rank may be accompanied by acute embodiment of stress as well.

Is the proliferation of women healers in this context to be seen as a form of female resistance, conscious or not, to an oppressive system of subordination that undervalues the work of women, overtaxes female labour, restricts access to education and even to the food that women produce, and puts on parade male control and leisure, or is it simply the case that 'traditional women's role' as reproducer and nurturer in this context involves the nurturing of the entire community? Lewis notes the contradiction inherent in recent emphasis on women's economic value, which also may increase the 'burdens on and responsibilities of women as the primary producers of health for their families and their societies' (Lewis, 1998: 642). This added burden on women of the social project of creating and maintaining 'the healthy family' (and, in this case, the healthy community) is one seen not just in the Pacific region but throughout the North as well as the South as global vertical economic integration is accompanied by increased individual responsibility for maintaining health and reducing health risk (Oaks and Harthorn, 2003).

These findings are not anomalous. Researchers examining the intersections of gender, health and equity across the globe, examining mortal-

ity, morbidity, health care, and clinical health research, conclude that 'gender biases are important and pervasive stratifiers of health outcomes for women and men' (Östlin, George and Sen, 2003: 150). Such inequalities in health and well-being are also accelerating, particularly in relation to 'macro-determinants' (Bambas and Casas, 2003; Farmer, 2003; Wilkinson, 1996), although the gender specificity of these processes has been missing in almost all analyses. While the broad contours of health and equity are undeniably important in understanding women's and men's struggles and their embodiment in ill health, they aggregate many important differences that only fine-grained local research can illuminate.

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