Journal des anthropologues
Association française des anthropologues

138-139 | 2014
Santé globale - pratiques locales

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Electronic version
URL: http://journals.openedition.org/jda/4416
DOI: 10.4000/jda.4416
ISSN: 2114-2203

Publisher
Association française des anthropologues

Printed version
Date of publication: 15 October 2014
Number of pages: 65-87
ISSN: 1156-0428

Electronic reference
Gaia Cottino, « Obesity "epidemic" in the Kingdom of Tonga », *Journal des anthropologues* [Online], 138-139 | 2014, Online since 15 October 2016, connection on 20 April 2019. URL : http://journals.openedition.org/jda/4416 ; DOI : 10.4000/jda.4416

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OBESITY « EPIDEMIC » IN THE KINGDOM OF TONGA
Critical notes on the « right » body size

Gaia COTTINO*

In 2004 the AOA (American Obesity Association) pushed for including obesity in the CDC (Centres for Disease Control) diseases agenda, with the result that today obesity has the status of disease (Gard & Wright, 2005).

The crusade against *globesity* (Gilman, 2008) began in 2005 replacing the one against tobacco, right after the Medicare decision, communicated in 2004 by the American Health and Human Services Secretary, to « abandon a long health policy in which obesity was not considered a disease » (*ibid.* : 15). From this moment on, professionals in the health field have talked about its dangerousness employing a specific military language. Such language has created a monster which needs to be destroyed because otherwise it will destroy us: Regena Benjamin, former US Surgeon General, described it as « a greater threat than weapons of mass destruction » (*ibid.*) and Philip James, former director of the Obesity Task Force-UN office, created *ad hoc* after the inclusion of obesity in the

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CDC disease list talked about an « unprecedented obesity pandemic threatening the species survival » (*ibid.*).

Furthermore, as Sander Gilman points out, the overweight and obese condition has acquired a moral connotation as well: « many believe that fat people cannot fulfil their civic and military duty and become a drain on the state. The obese, from at least the mid-19th century on, were seen as a danger to themselves as well as to the others » (*ibid.* : 4) because « healthy citizens are better citizens: closer to God and able better to function in the modern world » (*ibid.*).

The paladin of this « war » against obesity is the WHO, together with specific offices as the OTF, publishing a number of action plans to overcome the obesity epidemic.

As Gilman writes, what is fascinating is « the power of using the term "epidemic" in the context of obesity as a means of characterizing obesity as a "disease" » (*ibid.* : 18). However, as the author points out, obesity is not itself a disease, but a phenomenological category which reflects the visible manifestation of bodily size, which in turn can have multiple causes. « No one », continues the author « dies from obesity. One dies from pathologies which may result from extreme overweight. Obesity may be a tertiary cause of morbidity or mortality: it may lead to diabetes, which may lead to vascular disease » (*ibid.*). Such oversimplification of the causal links between obesity and the various pathologies is the result of what Gilman defines as the collective desire to treat obesity as if it was caused by an infection.

Though, science is never *super partes*, is never an eye from above looking at phenomena from a disinterested outsider's perspective. On the contrary, science, as a way of interpreting reality, is always involved in the context. Therefore its role has political, economic and ethical implications. And medical science is no exception to it.

As Paolo Vineis, epidemiologist, and Roberto Satolli, medical doctor, have recently pointed out, thresholds such as cholesterol, glycaemia and also those separating healthy weight from

overweight, have been constantly lowered during the past thirty years. So, now, people worldwide « become » sick and diabetic way earlier than in the past and are medically treated in accordance with the pharmaceutical companies' economic strategies. The process that Vineis and Satolli underline, addresses the responsibility for a world becoming sicker earlier as that of a biomedical science which builds, categorizes and names certain phenomena or physical conditions, based on the illusion that the world can be dichotomized as either sick or healthy. Though, « where boundaries between sick and healthy are set depends on the biomedical paradigms in a specific historical moment » (2009 : 58). In this view of medical science as inexact and composed of many *fuzzyness* zones (*ibid.*), both external and internal factors of different origin influence the states of sickness, wellbeing and risk.

What is the role of anthropological analysis in this connection?

Thomas Csordas points out that anthropology's aim is definitely not that of proving biomedicine wrong, but instead that of situating it in the wider perspective of cultural and historical change: « Biomedicine is an instrument to manage the human beings' physical and emotional fragility, but also a cultural system deeply interrelated with social, economical and political contexts, which sometimes may help to hide the suffering causes » (2003 : 12).

In such contemporary globalized contexts, Western alarm concerning body weight has indeed reached faraway areas. According to the 2002 WHO Pacific Community Secretariat Report on Obesity, entitled *Too big to ignore*, the most worrying area of the world is Oceania, where the highest rates of body mass indexes are located, gaining such news headlines as « Pacific Islanders are the world fattest » (Feinmann, 2007), or « eating themselves to death » (*Island Business Magazine*, 2009). The world's six fattest countries are, therefore, in order: Nauru, American Samoa, Western Samoa, Cook Islands, Tonga, French Polynesia, Confederation of Micronesia and Niue. Though, the dramatization of these populations' body size fits poorly into the picture we have inherited

from the various 17th century explorers (Schouten, Le Maire, La Perouse, Cook, Vason, Mariner, etc.). When reading their diaries it clearly emerges a physical stoutness of the Pacific populations, described as being big, tall and muscular. Yet today, these stout bodies, once a matter of admiring amazement, are considered ill, with the result that big sizes have been medicalized.

Let me now further this claim through two related topics: the mainstream measurements of body size, and Polynesian different ideals of the preferred body size and beauty.

Standard measurements

The Kingdom of Tonga, a large archipelago of 100 000 people in the South Pacific is, according to the above mentioned WHO 2000 Report, the fifth country worldwide with the highest percentage of obese people. More specifically, the Tongan population registers an obesity percentage of 90% among females and of 84% among males (WHO, 2002).

Because of these high percentages I was prepared to find in Tonga a quite « critical » situation. Instead, I found an environment of big people – big built, tall and muscular – only few of which were visibly obese. Where did this obesity epidemic come from? Which were the parameters used to measure it?

My first criticism concerns the mainstream measurements used to universally calculate the body mass. Obesity is in fact worldwide measured through a simple Index, called the Body Mass Index (BMI). According to WHO the BMI is defined as the weight in kg divided by the squared height (kg/m2). Though, this Index does not take into consideration the proportions of body fat and lean muscle, bone density, fat distribution and bulkiness, which are distinctive elements to be taken into consideration when measuring a body, whether it is European or Polynesian[1].

[1] A committee of specialists appointed by WHO has recently raised the obesity threshold for the Pacific Islanders from 30 kg/m^2 to 32 kg/m^2, in order to recognize that Polynesian populations are generally big built.

As to Tonga, few quantitative researches on the obesity issue have been carried out in the past 30 years – all of them employing the standard BMI Index. Tonga in fact lacks an updated, and culturally appropriate, survey on the weight of its population, the available data are either the result of samples too small to be representative, or don't take in consideration the very special historical time and geographical areas in which they were carried out[2].

For example, one quantitative study (Mavoa & McCabe, 2008) combined a considerable amount of data, collected between 1973 and 1998, concluding that the increment of males' and females' BMI has been consistent, but again the data compared indistinctively uneven numbers of women and men, and didn't distinguish between rural and urban areas. A more recent sample survey on the Tongan populations' BMI confutes Mavoa and McCabe's results, thanks to a methodology that doesn't leave any space to critiques but can't be generalized, the sample being too small. The survey, conducted by a Japanese team, measured several times, between 1977 and 2001, the BMI of Tongans living in two areas, one rural and one urban. The results revealed that the BMI « hasn't significantly changed neither in men nor on women in the urban area of Kolofo'ou » but that « it has significantly increased in the rural areas' men (from 28kg/m² in 1977 to 31 kg/m² in 2001) whereas the increase in the rural areas' women isn't statistically significant » (Murayama *and al.*, 2010 : 365). Although such data can't be considered universal, they question the obesity epidemic alarm, underlying instead that the rural areas are subject to life style change, debunking the myth of a healthy country life and an urban life corrupted by modernity.

An expression of the island modernity, even if full of references to a glorious warrior past, is the rugby game. The

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Nevertheless, such revised index forgets again to take in consideration the elements mentioned above.

[2] The increment of the population's BMI registered in the late Eighties, for example, is easily attributable to the widespread diffusion of the rugby game.

percentage of young boys playing rugby is indeed very high: « Rugby is the second religion here in Tonga », I've been told in more than one occasion. In the *Obesity in the Asia-Pacific Region* WHO document (2000 : 17) we read: « Athletes have a high BMI, due to the weight of the muscles more than fat, for this reason they will have an index which indicates overweight even if they aren't fat ». Thus, it is no surprise to read in the introductive notes of the last *Tonga National Nutritional Survey*, that « it was difficult to take skin fold measurements in particular in men, for whom the good muscle development made impossible the measurement, for this reason such data have been excluded from the analysis » (1986 : 16).

While local health workers are quite sceptical about the BMI, standing at a cross road between biomedical parameters and social rules, the common population reacts to such index with even more scepticism:

> I always look at that BMI thing and I think is impossible to lose that much weight, I would disappear. They say my ideal weight should be 87 kg, and I go « My God have you ever seen me at 90? ». Everybody asked me what was wrong with me!!
>
> The BMI doesn't make sense with me and all the Pacific Island populations, I'm big because I played rugby all my life and now I'm obese according to them.

Before analyzing the power relationship occurring between global and local health policies, more Tongan ethnography needs to be provided in order to investigate the gap between what is locally considered the « right body » (Gould, 2005) and what is set by WHO as the « optimal size ».

Abundance: food and body size

Between 2008 and 2009 I carried out an ethnographic fieldwork in the Kingdom of Tonga, in particular in the southern region of Tongatapu. The research aimed to investigate body weight, from a cultural and social perspective. Therefore the main focus of my research has been the local body size and beauty ideals, in a context that historically acknowledges big body sizes, as a wide anthropological literature records (Cassidy, 1991; Pollock & De

Garine, 1995; Mahina, 1999; Kavapalu, 1995). The initial research question concerned the social and cultural factors influencing the Tongan « obesity epidemic », but soon the question became « is there really an obesity epidemic? ».

According to my observation big people aren't stigmatized− to have « meat around the bones » means « that your family took good care of you » – but skinny people are often picked on, because « to be skinny means to be poor and not to have enough food ». In the past, the chiefs, who embodied the political and economic power, high social status and strength, had bigger body sizes than the rest of the population, and their size became the beauty ideal. Today we witness, on the one side, the resilience of such ideal body size – it is not a surprise then, to hear compliments as « you grew fat! You look chiefly! » – and, on the other side, thanks to a better access to resources, a widespread acquisition of a big body size. If such big size is still today evident in high status people such as nobles, the royal family and priests, « who need to have a belly to show their *mana* », bigness seems to have gone beyond the socio-economic status. Thus, what seems to have happened, more than an epidemic of obesity, is a democratization of big body sizes (Cottino, 2013).

Tonga is not an isolated island, despite what many can think. It is instead inserted into short, medium and long distance relationships, and therefore western and Asian beauty and body size models flow within the Kingdom. Three times the number of the residents' live abroad and for this reason the Tongan emigration has obtained the diaspora status. Therefore, relatives visiting from overseas and overseas trips to visit relatives, together with media and the local beauty pageant Miss Heilala, which is consistently sponsored by the Tongan diaspora, contributes to bringing into the island new ideal body sizes; and for this reason what we witness today is a very articulated and complex « bodyscape ».

Indeed, beauty definitions are quite different among the generations, but interestingly enough they all recognize and describe the « Tongan body » in the same way. The *sinofakatonga* (the body at the Tongan way) is described as big – « big legs, big back and big

thighs » – and is considered to be the perfect body to dance « traditional » Tongan dances, such as the *tau'olunga*, but not the ideal body across generations. In fact, what is called as *sinolelei* (the beautiful body) represents a more personal taste and if for older generations (grandmothers and mothers) it corresponds to the *sinofakatonga*, for the younger ones it correspond to slimmer body sizes. Therefore, beauty ideals differentiate generations: if teenagers prefer slim bodies sizes, incarnated by music divas such as Beyoncé and JLo, the older generations, including their mothers, favour big sizes[3].

I personally don't sense in such preferences an adjustment to the « right body size » set by WHO, even if numerous are the programs enacted to slim down the population under the WHO guidelines. Instead, I believe, in the first place, that such new models and ideal body sizes are just the consequence of an obvious non-isolation of the island and, secondly, that the pre-marital body status is a short period of life in which women, more than in any other stage of life, are more in command of their bodies: they are part of a bigger family body but not yet the generating body. Such passage happens when women get married and become mothers and tend to build up weight, showing their social position[4] through it. Indeed, whoever keeps her teenage slim weight more than through spinsterhood is considered selfish, as a woman told me:

> I know a girl, very beautiful, who is already married and had kids and didn't gain weight. I think she did well in maintaining her weight, but my mom thinks that it shows how selfish she is, she cares more for herself than for her kids [and another woman underlined the normality of gaining weight after marrying]: I think is natural to gain weight after you get married [..]. It's not like the *palangi* (white people) who keep themselves, here is a cultural thing.

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[3] Age isn't the unique element influencing body size ideals: rank, economic income and occupation play a very important role as well.

[4] Helen Morton describes the stage in life following the birth as three months of segregation in which the women is fed and taken care of, after which women are, according to the Tongan eye, at the highest peak of beauty « pale, smooth and chubby » (1996 : 49).

What these interview fragments describe here is the embodiment process that takes place once the girl's status changes becoming a generating body, and therefore getting closer to the *sinofakatonga* ideal.

Furthermore, women are considered more powerful – richer of *mana* – than men: « A woman has to carry around a certain weight because it shows a whole world ». This view, and its implications for social ranking, are well summarized in the following interview fragment:

> Women in my culture are heavier than men because they have a higher status, for example in the family, even if the brother inherits the land, the sister will always be superior to the brother, so whatever she asks the brother will give it to her.

Not to incur into the depiction of an *obesogenic milieu*, which I believe not being occurring since abundance is different from fatness, I will here shortly mention one last important element: in Tonga, as in the West, excess weight is not valued and is considered inappropriate. Though, the distinction between a fat body and a big one, and the threshold between the two is relative to the context:

> We don't acknowledge obese people. I think there is some confusion between fat and physical abundance, which confuses the contemporary Tongan institutions [has affirmed an interviewee. Fat has indeed multiple facets, as another person underlined, since]: You can be fat and obese, fat and slender, fat and slim, it depends.

During fieldwork, those addressed as being too big were, not surprisingly, relatives living overseas. When visiting the mother island they indeed carried around very big bodies, bigger than they could get on an island diet, in order to symbolically show their success. But very often such excess weight was overlapping the threshold separating a beautiful rich, powerful and healthy body from a fat one. In other terms, they weren't embodying their social weight any longer.

Margaret Lock in this regards, has coined the term « local biology » (1993), meaning that both culture and biology mutually constitute each single and personal bodily experience. By using such expression she invites us to avoid considering the body as universal, equal at any latitude, because it is biologically composed by the

same parts, and also to avoid culturalizing everything and everybody residing elsewhere but in the West. As Cheryl Ritenbaugh underlines, the body talks back (1991): the cultural and personal efforts in manipulating the body are part of the dialogue between culture and biology. Therefore biology can't be understood separately from culture, neither cultural answers to illness can be understood without considering how biology shapes and contains individuals' subjective experiences and cultural interpretations. In Tonga, physical abundance, proportions and stature are the main characteristics of a beautiful body and obesity has nothing to share with them.

Abundance in the Tongan cultural context is valued both when embodied and when exposed. Indeed, as Pollock points out, carrying around a big body is like exposing a big pile of root crops: their abundance shows the power of a family (Pollock, 1992, 1995).

Food is central to Tongan life since it creates and strengthens social relationships, internal and external to the extended family. All rituals related to food – giving, exposing and offering – not only create ties and reciprocities but also indicate the social status of the people involved in such « transactions ». Big feasts called *kaipola*, (table of food) in which a great quantity of food is offered – much more than what you expect the people to consume, since « here in Tonga it's all about quantity » and « it's a shame to remain without food » – are often organized in Tonga for a number of different reasons (i.e. weddings, funerals, church conferences, etc.) and are part of regular Tongan life. Such connection between food and social structure, as Mahina points out, is expressed by the term *kainga* – the extended family, unit or ensemble of bodies, of production (food), reproduction (health) and political importance – which has in its root the verb *kai* (to eat) and is literally translatable as « the place to eat » (1999 : 282).

The daily consumed food differs from the ceremonial one not only in terms of quality, because every single staple occupies a place in a complex hierarchy which distinguishes which food is « good to eat » in each situation, but also of quantity. The local diet is based

on one big meal a day, leaving the rest of the day to empty the stomach[5].

Food, eating habits and patterns in Tonga changed in time thanks to the introduction of new staples, the relinquishment of others and their hybridization. Pigs for example, a staple just recently introduced in Tonga (late 18th century), are today the ceremonial food par excellence, and fish, which used to be the primary source of proteins, is today considered poor food and therefore seldom eaten. Moreover the habit of eating deep ocean fish fat before meals to satisfy the appetite changed into the consumption of imported meat fat, such as the kiwi lamb flaps[6] that « give in the throat the sense of satisfaction », with obvious different consequences on health.

Root crops are still eaten on a regular basis in Tonga, particularly during the Sunday *'umu*[7], though, imported food is everywhere in Tonga: sold by the very widespread shops (*falekoloa*) owned by Chinese immigrants, it is consumed on a regular basis, in particular by children.

The choice to consume imported processed goods is the result of many factors: first of all of the desire to diversify the diet, secondly of the parents' habit to consume such staples, thirdly of a competitive price, and finally of a large accessibility, since they are sold even in the most remote areas of the Kingdom. Unlike other Pacific Islands states, Tonga is not dependent on foreign food. The land is unalienable and allows each family to cultivate its own land and live out of it most of the year. Elsewhere, land shortage and

[5] If such a practice is related to when food arrived in waves and the practice of eating big quantities of food and emptying the stomach was current is not for me to say. Though, such alternation is currently undergoing a severe biomedical critique which indicates the three-meals-a-day regime as a universal standard of health.

[6] Lamb flaps are the gristly ends of the ribs trimmed away when the butcher cuts racks and rib chops. Kiwi is the New Zealanders' nickname.

[7] It is a ground oven in which food, wrapped in leaves or foil, is cooked for hours until it is soft.

political agreements have encouraged the substitution of traditional staples with imported ones, such as root crops with rice, creating food dependence with obvious consequences on health. Imported food in Tonga creates conflicting, ambivalent attitudes, depending on which values are prioritized. In principle, imported food is not preferred to « Tongan food » – which by the way is itself hybridized – however, since it is cheap, it is highly consumed; moreover, it is also very much valued because of its origin (and for this reason becomes also gift food). Indeed, the staples at the highest level of the hierarchy are those staples which, apart from their nutritional value, have a social value, because when exchanged or offered they strengthen social relationships.

Such consumption of imported food, frozen meat or junk food, is a concern because data record an increment of diabetes and cardiovascular diseases among the population (Colagiuri, 2000 ; Lower, 2005). The problem seems to lay, among the various causes, in the consumption patterns: until the food eaten was fresh island food, abundance in meals didn't constitute a risk for health, but today part of such food has been substituted with processed food, which instead needs to be eaten in small portions not to endanger health. Such awareness is not yet widespread, or, where it is, inevitably clashes with the local eating practices or, in some cases, with the belief that only God has the power to heal and end people's lives. The population's health problems seem to be much more related to their diet than to the – yet to be proven – overweight or obesity condition.

Local health *vs* global health

Although in Tonga God is perceived as having the power to heal through the healing ministers of the charismatic and Evangelical churches – « Let me eat what I want, at the end [it] is God who decides when is time to go » – the public health institutions, following WHO guidelines based on biomedical science, are entrusted with the population's health. Often treating the same diseases, even though with different approaches, both hospitals and

churches face the same supra-individual dimensions of illnesses and diseases, and not surprisingly the second appear more connected to the local cultural context: « These curers seem to be taking over the role played by ancient Tongan priests […]. If in the past it was often necessary to cut the fingers off or sacrifice a human in order to appease the wrath of the ancient gods and to obtain forgiveness and therefore health, with the Christian God only sincere repentance and faith are said to be required » (Bloomfield, 2002 : 41).

As many interviewee pointed out diseases are caused by relational disharmonies, internal and external to the family, namely with God and the ancestors' spirits, and wellbeing includes concepts such as generosity, respect of the family and social obligations, and the maintenance of good relationships not only with the living world but also with the spirits. As Bloomfield reports, good health in Tonga is classified together with all the aspects of good luck: success, money, a good job, etc. And vice versa diseases are classified together with the undesired events of life such as bad luck, poverty, unemployment and domestic problems (2002).

Therefore, when the biomedical system translated the term health with the neologism *mo'uilelei* (living well) in order to carry out health promotion campaigns[8], it created a gap, a high degree of non pertinence to the context, with the result that many believe going to the hospital is fatal.

The relationship biomedicine establishes with local health definitions is null since biomedicine itself is the product of a specific cultural context. Such gap is evident precisely in the biomedical standpoint on fatness. As Young Leslie underlines, the single health model endemic to the biomedical education fails in including other cultural perspectives (2002).

I have already pointed out the biomedical power to name and define certain bodily conditions and the historical dynamism of

[8] According to Leslie the term *mo'uilelei* was coined in 1959 by Churchward, who edited a English-Tongan dictionary (2002 : 298).

pathologies[9]. Therefore what might be worth considering is that obesity too represents a new pathology which, in the West, masks a social problem, and out a western setting is a new modality of controlling populations and States.

Indeed, *globesity* constitutes a new concept: on the one side it describes the diffusion of the obesity phenomenon on a global scale and, on the other, it introduces the concept of global health. To say it in other words, there are supranational ties and interconnections both in the diseases' diffusion (HIV, SARS, etc.) and in the health policies.

Mike Nichter defines global health as a « biopolitical agenda that involves the politics of an unnatural distribution of diseases and health care resources, as well as the politics of transnational governance related to the control of emerging diseases and threats to global bio security and health as human right » (2008 : 151). Therefore, if the global health concept is the expression of a supranational political network, the *globesity* expression does not, as the Pan American Health Association underlines, « accuse the single individuals, but globalization and development, where poverty is an exacerbating factor » (Gilman *op. cit.* : 64). WHO itself explains obesity as caused by « profound shifts of societies and behaviours during the last decades […] economic growth, modernization, urbanization, globalization, diet rich in complex carbohydrates, fat and sugars and the automatic transportation » (2000).

So, if the causes for *globesity* are supra individual and global − hiding social poverty in the West and political control mechanisms in the third world − why does biomedicine insist on individual responsibility, as the right strategy in order to fight obesity? In such a scenario culture also becomes a barrier. As C. Nishida from WHO writes: « To inform people of the risks don't affect their eating behaviours if we don't contrast also the socio-cultural,

[9] We can all certainly recall that melancholia was a pathology up to the 19th century, and people suffering from it were internalized into asylums.

environmental, psychological and economical barriers » (WHO, 2010 : 18).

Biomedicine sees two ways out of such pandemics: first of all, by transposing structural inequalities and cultural practices into individual responsibility and behaviour changes, and therefore insisting on the predominance of the head/mind over the body; secondly, it promotes a return to the healthy eating practices of an Edenic past. Nutrition projects corroborate the idea of a past tuned with nature which shaped slim and healthy bodies, and therefore the solution to obesity lays in a return to a state of nature, well fitting their indigenous status, « but only as long as the strict guidelines of civilization as to health, cleanliness, adequate labelling, workers' rights, and fair-trade foods are not compromised » (Gilman, *op. cit.* : 174).

As a result, the population finds itself squeezed between global and local powers with the effects well exemplified in these two fragments:

> When you grow up your parents tell you to eat to become big and strong, but when you are an adult health institutions tell you to lose weight. Is confusing; I grew up eating certain things and now these people come and tell me that I have to start eating what my ancestors used to eat! Do you think that if someone comes and tells me to stop eating meat fat I'll actually stop?

Those who experience the highest degree of non pertinence are the local health employees who embody the encounter between the biomedical system and the local cultural practices, hybridizing the first. In my ethnography I dedicated particular attention to the nurses, since they are, in my opinion, very interesting social actors who live through the contradictions of their professional and social positions. A meaningful example is their facilitating role with the patients' family members who bring food as a recovery gift. Even if it is prohibited to bring food inside the hospital, relatives still try to sneak some in – because is culturally appropriate to donate food to greet the patient recovery, since eating is a sign of health – and the nurses find themselves in the position of understanding such cultural practice but also having to respect the hospital rules. Solutions are

daily negotiated: so food might be let in, but only partly given to the patient. The rest is taken home to share with the family, with the result of opening another way for goods redistribution.

The wide healthy eating campaigns are another example of non pertinence. When Tonga was placed fifth worldwide for obesity, local health institutions – in synergy with International Health Agencies (WHO, OTF) and International Funding (AUZaid, NZaid, Japanese AID) – started numerous health promotion and prevention campaigns (Iaso/OTF, 2000)[10].

One campaign is worth mentioning: the Weight Loss Competition. Launched within work settings and aimed to educate people to healthy lifestyles and to the importance of slimming down, these competitions represent one of the many cases of western strategy, elaborated elsewhere. Health projects mean money flowing in the Kingdom, where it is extremely needed, so, whether the campaign is effective or not, those projects are accepted. The doctors' comments on the competitions reveal how ineffective they are:

> The problem is that if you want to diet seriously, for health, you shouldn't lose more 1 kg per week, if you lose 5 instead there's something wrong, in fact many didn't know how to diet. And no one joined the competition to be healthy or lose weight, but to win the money!

[10] Pacific Islands' health has been central to the international and institutional debate since 1995 (Swinburn, 2005), when the health policy framework New Horizons in Health and the Yanuca Island Declaration were signed and discussed with the health ministers of the Western Pacific countries. Since then, the two inspired diverse projects under the general theme Healthy Islands (see WHO 1995, 2002a, 2000b, 2000c). Though, the healthy Island concept has suffered some ambiguity since it was too general to fit each peculiar single context. It also underlined the role individuals had in changing their lives forgetting to address individuals as collectivities, as inter-personal selves. And finally it took for granted a definition of health (healthy eating, healthy living, healthy towns), disclosing a paternalistic approach according to which « communities can learn about themselves and act accordingly » (Gauden *and al.*, 2000 : 172).

People indeed would participate to win the money, buy a lot of food, have a *kaipola* and redistribute the resources back to the community and extended family, consequently gaining all the weight back. As already underlined, it is a matter of fact that in Tonga the social weight of the family is expressed in terms of body size, therefore weight loss is a sign of poverty or disease (Besnier, 2011).

Lastly, the investigation highlighted the necessity of an integration of policies, which, as they stand, are creating a schizophrenic scenario. On the one hand, the local health policy is based on global guidelines and standards, making a big effort in changing the population's diet, and, on the other hand, the trade and food policies are oriented towards a rapid development along the lines of the western model, prioritizing trade agreements with China, Australia and New Zealand, in other words the importation of processed food. In this regards the mutton flaps – called *sipi* in Tongan – importation is a quite interesting example. Already banned in Samoa and Fiji, because of its dangerous effects on people's health, *sipi* is still legal in Tonga and became in the past thirty years part of the diet: « There is no Sunday without *sipi* » people affirm, and huge amounts of it are eaten weekly. The policy of the Kingdom doesn't take in consideration the effects of the *sipi* on the population's health and sees it as a tie to New Zealand, its main exporter. According to many health workers, the fear of banning it in Tonga might be to jeopardize the economic and market relationship with New Zealand which is a quite important AID funder.

In conclusion, both global and local forces (political, cultural, economical) sum up, clash and overlap, making it difficult to find the crux of the matter. Nevertheless, by standardizing and ignoring social and cultural specificities, international health standards and policies, have a strong impact on contexts (Poltorack, 2010). Even if such biomedical messages haven't strongly impacted the population yet, probably due to a strong cultural centrality of food and a social dimension of body weight, shouldn't they be a concern for the future? As Anne Becker has clearly shown for the Fijian context, media messages of optimal body sizes and new body size ideals

have distanced young Fijian girls from a traditional body and are therefore responsible for having induced them to develop eating disorders. The Nuku'alofa hospital's dietician displayed her concerns for bad eating habits of young generations, who can't decide what to eat at home, so rather prefer to starve themselves, with the risk of developing eating disorders. But such a concern hasn't yet, as far as I know, become part of a public health debate.

Conclusions

In Tonga, many local cultural practices enhance abundance, but whether Tonga is in the middle of an obesity epidemic is highly disputable, both because of the Eurocentered criteria adopted and the lack of representative samples. The social and cultural practices around food, body and health are useful not only to describe the context, but also to open a discussion precisely on the parameters on which the West has built an epidemic. As Paul Farmer underlines, the identification of power regimes and biopolitics should always be contextualized (2006). If the identification of bodily difference happens in contexts where bodies are different from a European standard and therefore removed from their agency, to recognize a bodily difference, or a local biology, might be useful to reorganize the basis of the biomedical standardized indexes and global health planning.

Although such epidemic is not strongly perceived locally, there is confusion among the population due to the concomitance of messages conveyed by the local policies: on the one side, biomedical messages inviting the population to lose weight and eat healthy, and on the other side a wide accessibility to junk and processed tinned food, imported in big quantities, thanks to trade agreements with the first world.

Such confusion is exacerbated by those policies' deafness about the cultural aspects characterizing the body weight and the eating practices. In the name of a general concept of health, WHO sets universal guidelines to promote and fund projects aimed to fight the obesity pandemic, with the only result of strengthening its own

leading position within the global economy. I therefore agree with Young Leslie when she writes: « the biomedical categories, and the gender stereotypes in the health promotion messages, are not congruent with village practices or principles for being well. It is important for health promoters to recognize that because these are *not* the ways in which health, mothering, childhood, food and eating are constructed in the everyday practices codified as tradition [..] they must themselves begin to conceptualize "health" and "health transition" differently, if they are to be successful in their goals » (2002 : 300).

How important is it to keep in mind that a diabetic mother will put in front of her personal health the wellbeing of the family whose general health represents a harmony and equilibrium of relationships in the eyes of the community? Or to keep in mind that a body size carries a whole world and can't be seen in western aesthetic terms?

I therefore believe in the necessity to integrate the « local biology » with material conditions, social relations, socio-economical and structural factors predisposing, directly or indirectly, the populations to certain pathologies. I also agree with Nichter when he invites us to monitor carefully the social representation leading global health policies and projects, the yardstick used to evaluate the success of public health projects and the impact of both development dollars and global policies on the single territories.

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Summary

In a worldwide obesity pandemic, where a growing number of people all over the world are classified as obese, the fight against obesity has become an international priority. Large funds, numbers of projects and international guidelines for global policies are reaching as far as the South Pacific. This area indeed seems to concentrate the world's fattest and an obesity epidemic has been declared. Relying on her own fieldwork in the Kingdom of Tonga, the author questions this epidemic by criticizing the mainstream measurements employed to calculate the body weight – the BMI – which standardize one optimal size. She then positions the « war against obesity » in a wider global health frame, where global policies transpose global operating concepts to local contexts and shows that Tongan cultural

practices related to food consumption and exposition, beauty and body size ideals, health and social stratification and the local of a « right body » poorly fit them. Moreover, squeezed between international health directives, local economy and trade policies, Tonga sees an increment of the diabetes and cardio-vascular diseases' rates, addressed as the consequence of a yet to be proven obesity epidemic.

Key-words: obesity, food, global health policies, Tonga.

Résumé

L'épidémie d'obésité au Royaume de Tonga : notes critiques sur la « bonne » taille du corps

Avec le développement d'une pandémie mondiale d'obésité, où un nombre croissant d'individus est classé comme obèse, le combat contre l'obésité est devenu une priorité. Des financements importants, de nombreux projets et des recommandations pour une stratégie globale atteignent des régions aussi éloignées que le Pacifique Sud. Sur la base d'un terrain ethnographique au Tonga, cet article émet quelques doutes sur la réalité de cette épidémie. Premièrement, il critique la mesure de référence employée pour l'index de masse corporelle (IMC) qui définit la taille idéale. Il situe ensuite la « guerre contre l'obésité » dans le cadre plus large de la santé globale, où des politiques globales transposent des concepts à prétention globale dans des contextes locaux, et montre combien les pratiques culturelles locales relatives à la consommation de nourriture, aux idéaux de la beauté et de la taille du corps, à la santé et à la stratification sociale leur correspondent mal. En outre tiraillée entre les directives internationales de santé, l'économie locale, les politiques du commerce, le Royaume de Tonga souffre une augmentation des taux du diabète et des maladies cardio-vasculaires, considérés comme des conséquences d'une épidémie d'obésité dont la réalité reste à démontrer.

Mots-clefs: obésité, nourriture, politiques de santé globale, Tonga.

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