

Translational competency

On the role of culture in obesity interventions

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Abstract

This article introduces the notion of ‘translational competency’, a skill of attending to different understandings of health and how these are negotiated between medical settings and everyday life. This skill is especially important for the design of obesity-prevention policies and programs, given the diverse values surrounding both healthy eating and desirable weight. Through its focus on communicative interactions, translational competency entails a refusal to treat cultural differences regarding diet or body size as a problem. Rather, it encourages engagement with the relational contexts out of which health problems develop and transform, taking culture to be a process of negotiation and adaptation. In this article I present an example of the utility of the skill of translational competency taken from research on obesity in Guatemala. I then illustrate how translational competency might be used in the design of obesity interventions.

Keywords

cultural competency, culture, health policy, obesity, translational medicine

Translational competency: On the role of culture in obesity interventions

In 2017, the newspaper *The Guardian* published an article titled ‘Amsterdam’s Solution to the Obesity Crisis’ (Boseley 2017), which outlined how city policy makers were ‘leading the world in ending the obesity epidemic’ by treating obesity as a social – rather than an individual – problem. ‘Amsterdam’s solution’ has been widely heralded in the public health community as a success because of its numbers. Reported rates of obesity between 2012 and 2015 dropped 15 percent, with the largest decline seen among people in the lowest socioeconomic groups. The policy has also been celebrated by many parents as well: with two children in Amsterdam’s public elementary schools, I have observed many parents applaud the policy’s promotion of drinking tap water over soft drinks and its discouragement of corporate food sponsorship of school meals and events. Given how parents – and particularly mothers (Storeng and Béhague 2016) – are held responsible for their children’s growth, I am among those who appreciate efforts to place eating within an ecology of relations that extend beyond parenting decisions to address environmental and institutional influences – such as school meals and schedules – on children’s lives.

But if the framing of obesity as a social problem might initially seem to be a reason for celebration, the way the *Guardian* article used the concept of culture gave me pause. As an obesity researcher and an anthropologist, I am concerned that the newspaper’s description of how ‘culture’ influences obesity is rooted in an outdated and potentially harmful understanding of culture. Along with other anthropologists who caution that obesity prevention campaigns too often perpetuate harmful stigma (Brewis 2010; McCullough and Hardin 2013), I worry that the ‘solution’ proposed by this article might be fueling another kind of health-related problem. In the discussion that follows, I focus less on the details of Amsterdam’s anti-obesity program and more on how obesity is routinely framed as a cultural problem, as often seen in public discussions of obesity interventions. (For another example, see the *New York Times*’s series on global obesity titled ‘Planet Fat’,¹ which explores the causes of obesity in Brazil, Ghana, and Senegal, among other countries.) One lesson I have learned while ethnographically studying obesity in Latin America is that treating differences in body size and dietary preferences as problems of culture can lead to inadequate care, both in medicine and in public health.

To demonstrate how the misuse of ‘culture’ can exacerbate the challenges posed by metabolic illness, I summarize the *Guardian* piece’s main messages. I then outline an

¹ <https://www.nytimes.com/series/obesity-epidemic>

anthropological understanding of culture to make an argument for a set of skills I am calling ‘translational competency’. Finally, I present an example of the utility of translational competency from my research in Guatemala and illustrate how this skill might be incorporated into the broader design of obesity interventions.

From cultural competency to translational competency

The *Guardian* article opens with a problem: Amsterdam has the highest rates of obesity in the Netherlands, with a ‘fifth of its children overweight and at risk of future health problems’ (Boseley 2017). It then turns its focus to a neighborhood at the edge of Amsterdam where reported obesity rates are especially high. The author describes how Surinamese immigrants moved into the neighborhood following Suriname’s independence in 1975. In the 1960s, architects had designed experimental cycling paths through the neighborhood, but today these go underutilized. By way of explanation, the author ignores the eleven kilometers of distance between the neighborhood and Amsterdam’s city center, explaining instead: ‘Cycling was not part of their culture’ (Boseley 2017).

This is but one example the article offers of immigrants – people from outside the Netherlands, from ‘other’ cultures – whose undesirable behavior is presumed to contribute to their overweight status and their poor health. The article quotes a city health worker who speaks of an adolescent suffering from overweight, depression, and low self-esteem, whose mother, also from Suriname, may have practiced black magic and voodoo. The implication is that this practice – and not the stigma against people who practice it – has influenced the girl’s afflictions. It also mentions Egyptian health volunteers teaching their children to cook muffins made of egg, oatmeal, and vegetables instead of the food they had grown up with. The author quotes a parent attending a healthy eating class as saying that families ‘wanted to eat healthy food – they just did not know how’. Readers should presumably support the encouragement to exchange traditional recipes for ‘healthier’ ones, because many of these kids appear, to the author, to be ‘very overweight’. The overarching message is that these bodies are unhealthy because some cultures are ignorant about the right way to eat.

For some time, anthropologists have cautioned against this use of culture in medicine and public health. That anthropologists would speak against using culture as an explanatory framework may be surprising since anthropologists tend to be interested in cultural variation. Indeed, anthropologists were among early proponents of ‘cultural competency’, an educational agenda taken up by medical schools in the 1990s that encouraged health professionals to learn about non-Western health care practices. Cultural competency emerged as a challenge to the tendency of twentieth-century medicine to ignore cultural variation by treating all patients as if they fit the same (typically Western) mold.

Almost immediately, however, anthropologists found that the cultural competency framework did not have the desired effects. Taylor (2003a), who carried out an anthropological study of medical school education, notes that although concern for cultural competency initially aimed to foster an openness to difference, in practice it often perpetuated rigid stereotypes. The claim that Surinamese people do not bike is an apt example; I have many friends in Amsterdam whose families came from Suriname in the 1970s who bike everywhere. Kleinman and Benson (2006) similarly critique the idea of cultural competency, pointing out that the so-called cultural expertise of health professionals merely reduced ethnicities to simple slogans. Those studying the unfolding of cultural competency voiced a warning: treating culture as if it is static and easily captured in soundbites often furthers stigma and racial bias, perpetuating the very inequalities that attention to cultural difference was meant to redress.

In response to these shortcomings, Metzl and Hansen (2014) have championed the importance of ‘structural competency’. As they explain, the aim of structural competency is to train health professionals to consider how illnesses emerge out of inequities in institutions, markets, and health care delivery systems. By pointing out that health disparities are structured along lines of race, class, gender, and ethnicity, they hope to shift health professionals’ attention away from individual or cultural preferences and onto the structures – and infrastructures – that shape access to health care and other resources that facilitate healthy living.

Structural competency is a promising framework, but in the case of obesity it may not be quite enough: in addition to asking health workers to consider how structural inequities might be making some people obese, it is also critical to ask how – and for whom – body weight becomes a problem in the first place. Approaching health as a question and not an outcome is particularly important when it comes to obesity care because what counts as ‘healthy eating’ varies so widely from person to person and place to place (Napier et al. 2017). The notion of translational competency adds to structural competency an insistence upon querying aspirations for health and recognizing that not everyone will have the same objective when seeking care. In this way, gaining translational competence involves joining concern for cultural difference with concern for structural inequity, and understanding how medical structures, which are tied to histories of violence, colonialization, and dispossession, will value some cultures over others.

It is important that cultural difference, here, not be equated to ethnic difference. Cultural variation also lies within cultures of scientific expertise, where, in the case of obesity, there is no consensus that fatness is unhealthy. In fact, while the *Guardian* article implies that being ‘over’ weight is necessarily bad, scientific research negates this in several ways. For example,

research shows that people who are overweight are often healthy, even within the common medical frame of health, as defined as life expectancy (Flegal et al. 2013). It also shows that people may define a healthy life in ways that do not involve life expectancy (Meneley 2007; Kulick and Meneley 2005; Hardin 2015). Especially troubling is that even when weight loss is desirable, research challenges the common wisdom that monitoring what one eats or weighs will achieve this goal (Bacon and Aphramor 2011; Sanabria 2015). Instead, it seems that one of the most harmful things an individual can do to lose weight is to try to lose weight (Rothblum and Solovay 2009).

In response to the continued moralization of weight loss, seen uncritically as ‘good’, anthropologists have cautioned health workers that among the structures that might be considered when evaluating and caring for obesity are structures of exclusion that perpetuate the idea that large bodies are undesirable (Anderson-Fye and Brewis 2017; Yates-Doerr 2015). The concern is that the promotion of a thin aesthetic as a standard of ‘health’ operates as a classic technique of normalization, where a dominant demographic group positions its own norms as universally good, thereby reproducing its dominance among those that will not, or cannot, comply to these standards. The complexity that emerges is that the very promotion of ‘good health’ may perpetuate inequity and its consequences of poor health; and yet, this is not necessarily so – after all, the promotion of good health can also mitigate inequity.

Translational competency seeks to address this complexity by holding open the question of what health is and who has it, asking how health emerges and transforms in practice (Yates-Doerr 2014, 2017; see also Napier et al. 2014). A premise of translational competency is that, because interactions are dynamic, it is simply not possible to communicate without transforming meanings. To be competent in translation is to maintain awareness of the necessary equivocation that happens in interactions, where people speak using terms that will not mean the same thing between speakers, and which do not, in fact, have fixed meanings at all. The skill entailed in translational competency is the skill of attending to the contingencies in communicative interactions, asking how goods such as ‘health’ or ‘care’ are established as goods, and how these goods change as they move back and forth between clinical interactions and everyday life.

At the heart of translational competency is the anthropological concept of culture, in which demography is contextualized through attention to history, economics, language, and lived experience. Indeed, anthropologists have shown cultures to be multifaceted and constantly changing as people deploy the resources in their surroundings in creative, surprising ways (Taylor 2003b). As Napier and colleagues (2017) explain, humans use culture to make meaning, but because culture is also organized by the diverse, shifting parameters within which decisions and actions unfold, humans also use culture to make meanings transform.

Translational competency becomes important because it encourages attention to how structures, which may seek to reproduce their form, interface with the realities of everyday life, which defy stable reproduction. It asks that health policies, guidelines, and advice, as well as research into their efficacy, be always resituated to respond to particular cultural contexts. Where many policies offer general guidelines, translational competency turns attention toward the question of how these guidelines can be continuously adapted as they are taken up in everyday life.

Fatness is healthy

In the Guatemalan highlands I lived with people struggling with metabolic illnesses (cardiovascular disease, diabetes, hypertension, and so on) while also studying the design and deployment of regional obesity-prevention programs. During this time, people commonly told me: '*ser gordo es ser sano*', or, 'to be fat is to be healthy'. I heard this from people I lived with when they spoke joyfully of wanting to eat good food. The phrase was also used in a different context by educators, who offered it as an example of people's ignorance about the dangers of fatty foods and as evidence of the need to intervene to change cultural practices related to cooking, eating, and feeding. Believing that a cultural preference to be obese was contributing to obesity, educators frequently told me: 'They do not know the true meaning of being fat', referencing a 'they' comprised of women, poor people, and indigenous communities who saw fatness neither as a risk factor for metabolic illnesses nor as an illness in and of itself.

As I started to pay closer attention to the expression '*ser gordo es ser sano*' as it was used in the everyday context of preparing food and eating, I noticed that many of the same people who celebrated fatness also lamented the consequences of obesity in their communities. During my sixteen months of fieldwork, I heard many people speak of fatness as desirable but not a single person spoke of wanting to be obese. How could it be that fatness was healthy when obesity was not?

In tracing how people spoke of healthy eating both in and outside of spaces of medical expertise, I saw that patients and educators were often not after the same 'health' goal. Both patients and educators tended to regard obesity ('*obesidad*') as an undesirable medical problem correlated to imbalance, weak vision, exhaustion, and anxiety. Meanwhile, for patients, fatness ('*gordura*') pertained to having abundant good food, to eating slowly with kin instead of hurriedly at work, and, perhaps most importantly, to finding joy and pleasure in meals. Fatness might have been evident in a large body size but it could not be captured in appearance; to evaluate the condition of fatness you did not measure someone, you got to know them, a process that had no finite end. It was not only possible to want to be fat

without wanting to be obese, but very often fatness (a condition of health) was held to be the opposite of obesity (a condition of illness). I came to understand that the phrase ‘to be fat is to be healthy’ was not evidence of cultural ignorance about the dangers of metabolic illness. That educators took it to be so was rather a sign of the educators’ ignorance of – or perhaps, willful indifference to (Sanabria 2015) – how people valued health and eating in their lives. Awareness of this equivocation led me to suggest that policy makers and health educators should talk less about bodies and weight and spend more time attending to the conditions producing anxiety in people’s lives.

The point of my discussion of fatness and obesity has not been that the Spanish word *gordura* means, definitively, abundance and pleasure (in many cases it did not), but that sometimes, in particular contexts, it can mean abundance and pleasure. This is where the skill of translational competency, which treats communication as an interactive practice, becomes valuable. Just as we would be remiss to locate meanings in words and not in the social contexts of their use, so would we be remiss to situate a desire to be fat as an attribute of a specific ethnicity or nationality. Associating fatness with pleasure was not a Guatemalan belief; the educators I referenced here, who were Guatemalan, did not make this association. Moreover, even within the category ‘Guatemalan educator’ there was notable variation since other Guatemalan educators not yet mentioned here organized their clinical practices around the idea that fatness was good, encouraging people to eat in a fulfilling way (Yates-Doerr 2015). For an added point of variation, the notion that fatness is pleasurable is neither characteristically nor uniquely Guatemalan. Colleagues of mine who have studied eating practices in the Netherlands have found that some Dutch dieticians, responding to an overwhelming failure of attempts to diet, will also encourage their patients to forego attempts at weight loss and acquire health by appreciating food’s pleasures (Vogel and Mol 2014).

The question of how culture is made and remade – and who benefits and suffers in this process – is the starting point for much anthropological research. Competency in translation, when it is achieved, requires a sensitivity to knowledge production practices, one that entails slowing communication down so as to challenge assumed wisdom and common sense. The observation that concern for how values stabilize and transform can likewise become an important starting point in the work of caring for health. Practicing translational competency means following the effects of translation in the particular contexts in which they come to matter.

Translational competency in obesity policy

The field of translational medicine has tended to ask how expert knowledge can be moved from ‘bench to bedside’, referencing the laboratory bench as the site where knowledge is produced and the clinical bedside as the site where it is operationalized. In the case of obesity care, where the goods of healthy living and eating are not stable, a better strategy would be to attend to the translational work that takes place between and across professional and everyday negotiations. When it comes to ‘eating well’ there may be several goods at play – pleasure, fitness, abundance, satiety, commensality, togetherness, independence, tradition, innovation, and so on – that will never be better than the others in absolute terms, but which emerge as priorities depending on what else is happening in the cultural contexts of concern. One cannot know these contexts at a distance; knowing them, much like knowing a person, is an always-unfinished process that requires engagement with social negotiations and commitment to staying with these negotiations as they transform over time.

As Hortense Powdermaker (1960) explained decades ago in a keynote address to the New York Academy of Medicine, an anthropological approach to ‘the problem of obesity’ recognizes that the problem of obesity is, in part, that there is no singular problem. This observation challenges the prevailing models of translational medicine, since rather than assume there is a stable problem that expert knowledge can fix, much of the skill required for obesity care lies in an ability to care for the intersecting problems that emerge from diverse cultural contexts of clinics, cities, kitchens, mealtime tables, families, persons, and bodies. A policy maker in Guatemala recently told me that he would like to develop models for health intervention that do not depend on the notion of bench-to-bedside translation, but which are capable of responding to the varied needs that emerge at ‘the bedside’ – or in the kitchen, as the case may be (Yates-Doerr and Carney 2016). To complement his ambition, I have offered here the framework of translational competency, which encourages attending to how ideas cohere into ideals while also attending to how these ideals transition as they travel between and across different sites. This is an approach that takes culture as an adaptive, recursive process. In doing so, it asks how cultures of expertise can themselves be designed to respond to the inevitable transformations that policies will undergo as they move in and out of the communities they affect. This point is underscored by Corinne Hawkes, director of the Centre for Food Policy at City University in London, also quoted in the *Guardian* article, who stresses the importance of adapting obesity policies to people’s everyday realities (Boseley 2017).

Whereas much obesity science has been organized around the inquiry into people’s behavior, an effect of taking translation as an interactive process is to turn the inquiry toward the practices of making policy. This may be especially important when addressing obesity given

that many involved in the field have found that when it comes to controlling one's weight, there is little that the individual (or the parent) can really do. A reason why I have appreciated interventions focused on installing water fountains or addressing school or workday schedules in a way that considers the importance of sleep is precisely that these efforts turn the focus away from the behavior of individuals and toward the 'behavior' of institutions. Yet perhaps more important would be a move to address the cultures of exclusion that assume that large bodies are undesirable by shifting the public agenda away from body weight entirely.

The *Guardian* article describes a young, fat boy who has hidden in a bathroom stall at school to eat candy, implying that serving carrot sticks at school would solve his problems. Tragically, the article fails to unpack the stigmas against fat bodies that are stabilized in the narrative that what a person eats will be reflected in their weight. Also overlooked is the opportunity to emphasize that when it comes to 'improving' obesity, improving the stigma that surrounds it by learning to cherish the vitality of abundance may be one of the most important places to start. In line with a common trope of talking about obesity, the *Guardian* article treats cultural difference as a problem. 'Culture' keeps people from using bike paths, not exercising enough, and eating fattening foods. Translational competency pushes for a radically different understanding of culture. By attending to the shifting contexts in which values come to matter, it emphasizes that cultures are not detached entities but are practiced in varying and transforming ways. Though we are not all the same, neither can our differences be understood in simplistic binaries of us/them. Cultures might instead be understood as meeting points between different and shifting kinds of differences (Ahmed 1998). These may entail language, geographic origin, socioeconomic privilege, ethnic or gender identification, skin color, professional expertise, religious activities, or kinship patterns; but cultures may also be organized in other ways (a love of music and dance; an interest in home gardening; the burden – or privilege – of cooking; a longing to be with friends or to have time to one's self; and so on). Indeed, a goal of translational competency is precisely to not know at the outset what people value, but rather to be committed to an ongoing process of learning about how values are prioritized and how these priorities transform over time.

Understanding culture as produced in interactions, instead of as a fixed attribute of distinct others, can change the way policy makers engage with difference. In the case of obesity care, differences would no longer be seen as an impediment to be overcome but a vital resource to be listened to when caring for health. This is an approach that may help policy makers grapple with the devastating ways that predatory corporations destabilize healthy food economies without further stigmatizing the bodies of those involved. Regardless of what the headlines say, eating fried chicken or playing video games on a smartphone do not exemplify cultural ignorance or confusion. We likewise cannot know from a photograph or a scale if

one is sick or well. The designation of health is as variable as it is powerful. The challenge before us lies in learning how to adapt policy to the contexts of culture in ways that will facilitate living and eating well in whatever terms of health come to matter in people's lives.

About the author

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