Medicine of the past in the present

A study of medical knowledge and practice in a Solomon Islands village.

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Front page picture: The clinic in Kia after renovations in 2008

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Orthography

The language of the area in which research for this thesis has been conducted is called Zabana. As is common in Solomon Islands (a nation with more than 80 distinct languages), a name like “Zabana” refers to a language, its speakers, and the area in which it is spoken. Zabana, thus, is the local language of Zabana area, located on the north-western end of the island of Isabel.

For this brief description of orthography I have used the Zabana dictionary by Drummond Ama and Matthew Fitzsimons (1985), as well as anthropological monographs concerning other languages of Solomon Islands.

The vowels in Zabana are

a, e, i, o, u

/a/ as in the first a of “banana”, /e/ as in “egg”, /i/ as in “eat”, /o/ as in “open” and /u/ which is pronounced similar to the Norwegian “o” (cf. White 1991: xvi)

The consonants in Zabana are:

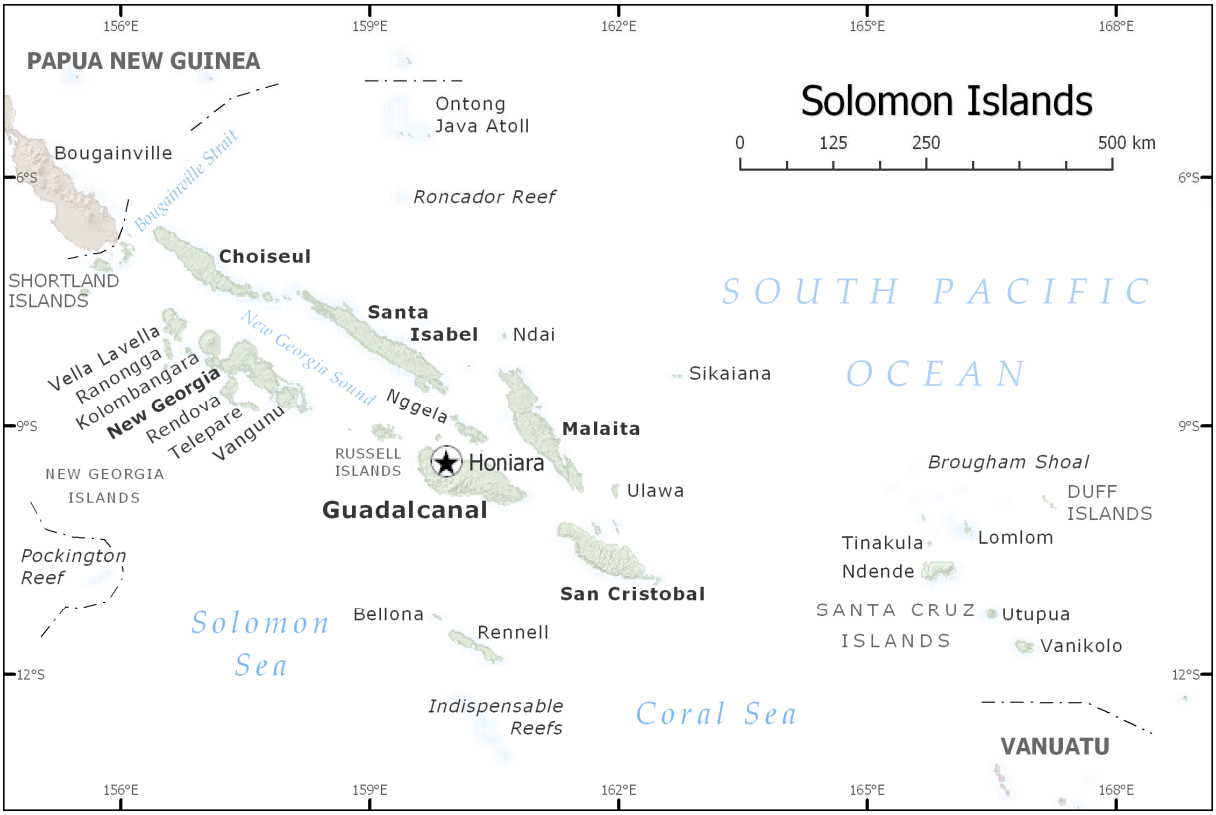
b, d, f, g, gh, h, k, l, m, n, ng, p, r, s, t, v, w, z

The consonants are pronounced fairly similar to English although there are some differences, the most notable being

gh - which is a velar affricate, common in Melanesian languages and sometimes referred to as a Melanesian “soft g” (Hviding 1996:xxix)

ng - which is is a velar nasal, pronounced as in English “singer”

Map of Solomon Islands



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Introduction

Kia village, Solomon Islands, 07.05.2008

It is late in the morning on a very warm day in the end of May and the small leaf house, built as a temporary clinic until work on the main clinic is finished, is full of people. There are both young and old, all waiting for their turn to see the nurse sitting behind a sheet hung from the ceiling, which functions as a door. There is a woman with the nurse at the moment. She tells the nurse what is bothering her. She has strong pains in her back and in the stomach. The lady explains that usually she uses *kastom* medicine[1] for this problem, but now it does not work anymore. The nurse nods, asks a few more questions and gives her something for the pain. The clinic is out of most medicines again. The nurse excuses himself and says that painkillers is all he can give her this time. The nurse does not seem surprised by the woman's use of *kastom* medicine. He does not condemn it, but instead asks what *kastom* medicine she has tried. I ask the woman whether she always uses *kastom* medicine first when she gets sick or if she would sometimes come straight to the clinic. She explains that the petrol she needs in order to get to the clinic is very expensive and therefore she would always try *kastom* medicine first. I asked her a hypothetical question; "If petrol was very cheap, would she then have gone to the clinic first?" She pauses before she answers. "No", she replies, she would still have tried *kastom* medicine first.

Outside there is a young family, a mother, a father and a daughter. The daughter is there to receive a vaccination injection and she is crying. After the little girl is done, the father quietly asks if the nurse at the same time could have a look at his wife's hand. Her hand is swollen to nearly 3 times it size. She can not close her hand and she is clearly in a lot of pain. She explains that she cut her hand while working in the garden seven days earlier. She had tried *kastom* medicine but it had not worked. She had not come sooner because they live far away and their daughter had an appointment for her vaccination this day so she had waited to go with her.

[1] *Kastom* medicine is the name for the local medicines and healing practises of the Zabana people, a term that will be defined later in this chapter.

> The nurse starts treating her, he gives her a local anaesthetic and cuts open the swollen and infected abscess that covers her hand. He turns to me and says, half to me and half to her, that some of the tissue on her hand has already started dying and that she should have come in earlier. After he has cleaned her hand and wrapped it in a bandage he explains that she needs to take antibiotics. However, he continues, the clinic is all out of antibiotic pills. They only have injections so she must come back every day for the next 5 days. She becomes quiet, not wanting to disagree with the nurse, but her husband explains that it will be very difficult for them to come every day, because they live very far away. The other nurse on duty that day goes down to his house and returns with antibiotics pills from his personal medicine cabinet. They are the last he has. The husband and his wife thank him before they begin their long journey home.

This is a description from one of the many days I spent at the small clinic in Kia. This is where many of the questions important to my thesis were answered, but possibly where even more questions were formed. The clinic worked as a meeting point between nurses and patients, between science and religion, between two different bodies of medical practice and knowledge and as a point which linked events on the macro level with the micro level in the village. From the particular day of the above narrative a wide range of questions, important to my thesis can be asked. What is *kastom* medicine? How is the use of *kastom* medicine organized? How does *kastom* medicine interact with biomedicine? Why has the woman with the damaged hand not come to the clinic earlier? Why does the clinic not have medicines and what implications does the lack of medicines have? These are some of the questions I will address throughout this thesis.

Main focus

The general aim for this thesis is to explore knowledge and practice related to health in a rural Solomon Islands village. One of the first things that struck me after my arrival in the village was the frequent use of local medicines and healing practices, locally labelled as, "*kastom* medicine". I was fascinated by this partly because I have had a long standing interest in "indigenous medicine", but my fascination also stemmed from the frequent use of *kastom* medicine and its cohabitation with the biomedical medicines and healthcare options available in the village[2]. What seemed to me as two diametrically opposed bodies of knowledge and practice, here lived side by side and I immediately assumed that somewhere there would be

[2] Biomedicine is a term I will frequently use throughout this thesis, its definition will be provided later in this chapter.

tension at the meeting-points between the two approaches. The biomedical clinic in Kia seemed an obvious area for potentially difficult meetings between *kastom* medicine and biomedicine. However I was soon to find out that my initial assumptions were not accurate. As time went by I came to understand that although I initially perceived the two medical systems to exist in opposition to one another this was not necessarily the way in which people in the village experienced their relationship.

In this thesis I aim to give a deep and thorough understanding of health and illness in a Solomon Islands village and in this respect it is important not only to focus on healthcare on the local level. There is a magnitude of research concerning national and international policies and interventions but very little research in the Pacific that focuses on the local side of the interface between national policy and the infrastructure of rural health. I wish to contribute to comparative medical anthropology by giving an ethnographically grounded analysis of knowledge and practice concerning illness, health and healthcare in Island Melanesia.

A contribution to this field is the doctoral thesis by William Parks (1998) *Under the shade of a Talise tree, Understanding the household management of childhood illness in Marovo lagoon, Solomon Islands.* Parks looks at how mothers and other household care-givers recognize and explain illness. He investigates what kind of treatments they have available and their decision-making process concerning what treatment to choose. In recent times there have been several national and international attempts to reduce child mortality in Solomon Islands. Parks recognized that they have had some success but argues that in order to increase these programs' success rate, lay knowledge and practises need to be taken into account. Although Park's research sheds light on some important issues, I feel that his decision model approach to illness is too mechanical and does not sufficiently consider the wider, social, cultural and political economical context of rural health. I believe my thesis is an important contribution to the ethnographic research of Solomon Islands and that it is particularly interesting due to the unique location of my fieldwork; the village of Kia in Western Isabel, believed by many to be the largest village in Solomon Islands, and where no published anthropological research has previously been conducted.

In this thesis I will draw upon literature from the field of medical anthropology, from the sub-fields of both meaning-centred medical anthropology and critical medical anthropology. By employing theories from various fields within medical anthropology I hope to give an accurate view of health related knowledge and practice. Throughout the thesis I argue for the application of a holistic perspective, not only because this is one of the

cornerstones of anthropological research, but because, as will be shown, the Zabana people themselves have a holistic understanding of health.

I am particularly interested in the interaction between local and biomedical forms of knowledge and practise. My hypothesis is that these two interact and influence one another. I will pursue the interactions and examine them in different contexts, on the local level, in an historical perspective and on the macro level of political-economy.

Approaches in medical anthropology

Medical anthropology is a subfield of anthropology concerned with, but not restricted to what Lambert (1996:358) describes as "the social and cultural dimensions of health, ill health and medicine". The focus within anthropology towards health related issues is not a recent development, it dates back to the very origins of the discipline. In 1898, the Torres Straits Expedition set out and anthropologist and doctor, W.H.R Rivers argued that ideas and practices around health and healing found in preliterate societies constitute internally coherent structures about the causes of disease (Lambert 1996) However it was not until after WW11, in the 1950s, that medical anthropology was recognized as a distinct sub discipline of anthropology (Good 1994).

In the first textbook of medical anthropology ever published, Foster and Anderson (1978:2-3) defined medical anthropology as "A biocultural discipline concerned with both the biological and sociocultural aspects of human behaviour, and particularly the ways in which the two interacted throughout human history to influence health and disease." Defining the field of medical anthropology is a difficult task and in the attempt to illuminate the boundaries of such a wide ranging discipline one risks excluding important aspects. Baer et al. (2003:3) states that "Medical anthropology concerns itself with the many factors that contribute to disease or illness and with the ways that various human populations respond to disease or illness." Their statement shows the wide field of interest within medical anthropology and accordingly there are many theoretical reference points from which one can examine these issues. Brown (1998:1) suggests that as there are so many varieties in theoretical approaches, instead of referring to a single field of "medical anthropology" one should think of the discipline as a field of "medical anthropologies". Although the discipline is hard to define Foster and Anderson (1978) nevertheless point out some important elements of medical anthropology, describing it as a discipline which is deeply embedded in the natural sciences of

biology and medicine while at the same time existing within the field of the social science of anthropology. The dual nature of medical anthropology described by Foster and Anderson (1978), leads to one of the challenges medical anthropology faces to today; to find a way of integrating information from two distinct disciplines - natural and social science. This idea will be discussed further in chapter 2.

Today the field is often divided into a variety of different sub disciplines, which generally fall within the bounds of two or three different categories; the ecological or biocultural approach, the cultural (interpretive) or social approach and the approach of critical medical anthropology (Helman 2007, Brown 1998, Singer and Baer 2007). Medical ecology focuses on the notion of adaptation, whereby human populations have evolved and adapted to their ecological surroundings over time (Lambert 1996). Cultural interpretive anthropology on the other hand, is critical of the adaptative approach employed in medical ecology, in which humans react to diseases which are seen as part of nature and external to culture (Baer et al. 2003:36). This perspective argues for an approach where disease is understood as a part of culture, and claims that "humans can experience their external material world only through their cultural frames" (Singer & Baer 2007:32). Critical medical anthropology seeks to go beyond locally focused, ground level analyses by focusing also on the larger political and economic structures which take part in and shape how people deal with and understand health and illness.

In between the different theoretical perspectives much critique and interaction has occurred, and the fields exist in a constant state of development. It is possible to find scholars that are both firmly grounded within their specific sub field and those who do not perceive themselves to be limited to any one theoretical field and who freely combine the approaches they find useful. The field of health encompasses a wide variety of factors ranging from the individual experience of illness to global political trends and economical situations. I believe that in order to examine the healthcare situation in Kia, a theoretically holistic approach encompassing and recognizing all of these factors will be needed, and therefore I will combine theories from a variety of different anthropologists particularly from the cultural interpretive approach and from the approach of critical medical anthropology.

Critical medical anthropology is not the sole perspective of this thesis, nevertheless it has been an important and inspirational theoretical perspective to me and has helped shape this thesis. This perspective is the framework for chapter 4 of this thesis but it has also been an important factor in shaping my approach throughout the whole thesis. A common notion in critical medical anthropology is the idea that knowledge and practice concerning health are

not static but instead exist in a dynamic historical, social and political-economical context, and this is an idea which will feature prominently throughout this thesis and my focus on each of these different contexts will appear in the different chapters. Critical medical anthropology therefore offers an understanding of health which is inclusive of the contexts within which it evolved. Singer (1995:81) argues that critical medical anthropology seeks to understand issues of health, illness and treatment in terms of the interactions between different levels of society, "The national level of political and class structure, the institutional level of the healthcare system, the community level of popular and folk beliefs and actions, the micro level of illness experience, behaviour, and meaning, human physiology, and environmental factors." Thus, critical medical anthropology seeks a holistic understanding of health and healthcare that is inclusive of many different levels of explanation.

In chapter 4 my focus will be directly aimed at the political-economy of healthcare in Kia as I seek to establish some relation between processes on the local, national and global level. Grønhaug (1978) is an anthropologist who sets out to do just that. He has developed what can be referred to as "field theory" which seeks to develop a method to study social life within its macro-context. In order to do this he suggests studying a complex system in terms of its social fields. By fields he refers to "a relatively bounded interconnected system stretched out in socio-space" (1978:118). Furthermore Grønhaug limits each fields scale by referring to the number of actors involved and its expansion in time and space. In this way Grønhaug argues that it is possible to determine the scale of different social fields such as household, kinship or religion. Grønhaugs ethnographic material is from Herat, Northwest Afghanistan and as examples of various fields in Herat he uses locality, which is a Herat village, ecosystem and religion. Grønhaug states that by studying different social fields in Herat he is aiming to find "their organizational patterns, their level of scale and their interrelations with each other" (Grønhaug 1978:82). Grønhaugs field theory further implies that one studies events. Different events within different fields can then be related to each other and their interrelations can be postulated. Grønhaug argues that by employing this perspective one will be able to explore the interconnections between life on the local level and on the macro level of national and international economy and politics (Grønhaug 1978:104). By applying Grønhaugs field theory to my material from Kia I will seek to establish some relations between life on the village level with macro level events.

For critical medical anthropology however the context of political-economy should be dominant in an analysis (Singer 1986). My thesis exhibits a stronger focus on the local level in my analysis of health and healthcare in Kia, and by also applying theoretical perspectives

of anthropologists such as Arthur Kleinman, Byron J Good and Allan Young (who all make part of what I have previously referred to as cultural interpretive medical anthropology), I will give a detailed and locally embedded ethnographic description which I argue is necessary in the examination and understanding of any population's health and healthcare.

Much of the ethnographic research found within critical medical anthropology is conducted in areas involving much despair, injustice and oppression. Examples of this can be found in Farmers (1992, 1999) research from Haiti, Scheper-Hughes (1992) who has worked in Latin-America, and Singer (1998, 2007) who has worked with AIDS and drug abuse. Because of the politically volatile nature of the areas in which much of this research has been conducted, there is often an emphasis on macro level factors.

Life in the Melanesian village of Kia is in many ways different from the impoverished areas portrayed in the literature mentioned above. Although Solomon Islands is classified as a third world country and the health of its inhabitants is far from adequate, the desperate poverty experienced by many inhabitants in the areas mentioned above is not felt by the population of Solomon Islands. According to the WHO (2004:331) 79 % of the population of Solomon Islands live in rural areas, supporting themselves by subsistence farming and fishing. The country has a vital subsistence economy, and although there is an increased dependence on imported goods there are very few cases of people starving in rural areas. It is not until very recently that Solomon Island have experienced segments of its population living in poverty as large amounts of people have settled in the country's capital where both land needed in order to grow food and jobs needed in order to buy food, are scarce.

Due to the location of my fieldwork in the village of Kia, which still has a vital subsistence lifestyle, my research will have less emphasis than the above mentioned literature on overarching political and economical structures creating and upholding health related inequalities. However, in this thesis I emphasize the importance of exploring a population's understanding and needs in relation to health from a micro perspective, while placing these in a macro context where health is in no way is separate from history, politics or economy. By employing this perspective in my research in Kia, a setting not typical for previous research done within critical medical anthropology, I hope to extend the perspective's applicability and show the importance of considering political-economical factors in areas where this kind of research is lacking.

Approaching the terminology

In this section I will define my use of terms which will be central in my analysis throughout the thesis.

Medical pluralism

When examining issues related to health and illness in areas with two or more available healthcare alternatives the term "medical pluralism" is frequently used. Medical pluralism implies the co existence of two or more differing medical traditions in one place. Medical pluralism is extremely common throughout the world, and it would be difficult to find a society which relied exclusively on either traditional methods or the methods of biomedicine (McGrath 1999:484). Baer et al. (2003:11) suggests that many medical systems[3] tend to be plural rather than pluralistic where one medical system attempts to keep or gain dominance over others. One clear example of this can be derived from "national medical systems in the modern or post modern world" (Baer et al. 2003:11) where biomedicine tends to have a dominant position over other existing medical systems. In Kia however I found, that although biomedicine is incorporated and indeed an important part of healthcare, it is not necessarily dominant. Throughout this thesis I will argue that the medical system of Kia is indeed pluralistic rather that plural.

Kastom medicine and biomedicine

When studying health and illness with a comparative focus, certain terms need to be defined. In this thesis I study a complex body of knowledge and practices concerning health of Zabana people which will be labelled *kastom* medicine, compared to knowledge and practices derived from what I will refer to as biomedicine. By biomedicine I refer to medical theory and practices which are predominant in Euro-American societies (Hahn & Kleinman 1983:305). This category of medical knowledge and practises has received many names, allopathic

[3] The term "medical system" has been defined in many ways, I will use the definition by Faberga and Manning (1979) which states that "A medical system include the knowledge, practices, personnel and resources that structure and pattern the way healthcare is sought and treatment is received". However it is important to note that my use of the term medical system is an analytic rather than an empirical term.

medicine, scientific medicine, western medicine, modern medicine and cosmopolitan medicine to name but a few. I choose however, following Hahn and Kleinman (1983) and Brown (1998) to use the term biomedicine as it refers to what I see as the primary focus within this genre of medicine, a scientific and biologically oriented method of diagnosis and cure, while excluding non-rational factors such as religion. In this way biomedicine differs from *kastom* medicine in Zabana and what I see as their general understanding of the world which is holistic and lacking the stark dichotomy between medicine and religion.

Another term I will use when discussing medicine in the locality of the village is the term "clinic medicine". This is drawn from the ethnographic setting. When discussing medicine which was not from the local range of medicines the Zabana people would call it "meresen blong klinik" in Pijin, translated to English, "clinic medicine". This term corresponds to what I refer to as biomedicine.

I have chosen to use the term *kastom* medicine instead of other commonly used terms such as indigenous medicine, folk medicine, ethnomedicine and perhaps the most common, traditional medicine. I will not use the term traditional medicine when talking about the medicine of Zabana people as this evokes a notion of a system that is static and unchangeable which, as I later show, *kastom* medicine is not. The word "*kastom*" is a much discussed term within the field of anthropology and elsewhere.

Kastom can be used in many different ways and can be understood as a selective representation of the past for use in the present (Keesing 1989). It is a vague term and therefore it is very powerful as "it can mean (almost) all things to all people" (Keesing 1982). Keesing (1982) exemplifies this by stating that it can for example both be used to assert national unity or that it can be used to promote regional separation. *Kastom* is also frequently used as a political symbol. *Kastom* has for example been used by post-colonial Melanesian leaders as an idealization of the pre-colonial past in their appeal for national unity, and the term has been used as a symbol of "the Melanesian way" which separated Melanesians from other parts of the world, particularly Europe (Keesing 1982).

For ordinary people in Melanesian villages such as Kia, *kastom* is a concept used by them to invoke in a very general way the beliefs and practices seen by them to have been handed down by past generations. In the culturally very diverse Melanesian world, *kastom* becomes a way of identifying the distinctly local, or culturally specific, as exemplified by the very common pijin expression: "*kastom* blong mifala" (mifala being a pijin form of the peculiar 1st p. exclusive of Pacific languages).

In this thesis I will use the word "*kastom*" as it is used in everyday life as part of the vernacular language of Zabana. *Kastom* can mean a variety of things depending on the context in which it is being used. My main use of the term will be in relation to medicine. "*Kastom* medicine" is a term which will feature prominently throughout this thesis. This is the term used by Zabana people themselves when referring to medicines and treatments taught to the present generation by their parents including, herbal treatments, massage, bone setting, touch and black magic or rather the undoing of black magic. The term *kastom* medicine is also used by the Solomon Islands ministry of health in their publications (SINHSP 2006) where they state that "*kastom* medicine is still widely used in some provinces"

The word *kastom* is also used for referring to the real, true, or the right way of living or doing things by Zabana people. For example, a response to negative behaviour of people in Kia, is "That is not good, that is not our kastom". Also, items and practices stemming from the traditions of Zabana people could be labelled *kastom*, such as "*kastom* food" examples of which are puddings and taro as opposed to imported goods, or "*kastom umbrella*" - an umbrella made from various leaves found in the bush, the construction of which has been taught to the present generation by their ancestors.

Although I differentiate and recognize differences between biomedical medicine and *kastom* medicine I emphasize that there is not necessarily a clear boundary between the two. Both biomedicine and *kastom* medicine are fluid categories and in a state of constant change. This will be explored further throughout the thesis, in particular in chapter 3.

Disease and illness

Disease and illness are also terms I will use throughout my thesis and they require an accurate definition. At first glance, the two terms seem to be synonymous and are commonly used interchangeably. However, within medical anthropology, it is common to make a distinction between illness and disease. It is common within medical anthropology to use the term disease for the biomedical recognition of a maladaptation of biological processes in the body (Kleinman et al 1978:252) whereas the term illness is used to refer to the personal dimension of sickness and also to the ideas which correspond to a "folk healer's" definition of sickness.

Singer and Baer (2007:67) suggest a reconceptualization of the terms illness and disease, in which disease refers to the diagnosis of sickness made by any biomedical practitioner or another "professionalized" practitioner, such as a folk healer, while illness only refers to the patient's phenomenological experience of sickness. It has been suggested that

categories of disease can exist which are not possible to translate into the biomedical body of knowledge, but nevertheless are well known disease categories within the local population in question. In his study of villagers responses to illness in Roviana, Solomon Islands, Furusawa (2006) found that 5 medical conditions recognized by the local population did not have an equivalent within the biomedical realm. Similarly I found in Kia several well known conditions of which, neither the nurses in the village, nor myself, have been able to find a biomedical equivalent. Therefore I agree with Singer and Baer's definitions of the terms. However, as Singer and Baer (2007:67) also state, although the terms are used to refer to separate categories, the boundaries between the two are fluid because they are both culturally constructed "rooted in both biological and psychosocial processes"

The ethnographic research record

My research, although focusing on healthcare also contributes to the ethnography of Solomon Islands in general as there has been very little research conducted in this area of Solomon Islands and very few have conducted research in Kia before. There has been even less research conducted with a focus on health. However there are a few important works which I will use throughout this thesis.

In 1948 medical practitioner George Bogesi, wrote an extensive anthropological article from the area of Bugotu on the southern end of Isabel. Bogesi wrote about the history of Isabel, its clans, rituals, daily life, magic and religion and also about disease (Bogesi 1948). In 1950 Bogesi moved to the northern side of the island and began writing an ethnographic description of Kia and the surrounding area (Bogesi 1950). This material has never been published but is available through Bogesi's own fieldwork notes. Bogesi concentrated on history, social organisation, magic, religion, diseases and provided excellent information concerning life in Kia before and shortly after the arrival of missionaries. Bogesi's material provides a valuable addition to the accounts of the past that I received from my informants.

A more recent regional account of Kia was made by Baines and Tetehu in 1993. Their article was never completed or published, but still provides useful information. They sought to develop a better understanding of the healthcare requirements of the population of Kia, investigating how both traditional healthcare and modern healthcare are practised in the same region and how they work together to emphasize the aspects of traditional healthcare which remain present to this day.

Other anthropological research from the island of Isabel which will be of interest to me is material by Geoffrey White (1991). Although not concerned with health, his material provides useful information especially in regards to the introduction of Christianity in the region and its interactions with the local belief system. This material has helped me in exploring how knowledge and practice relating to health is related to history and religion in Kia.

There are in addition a few contributions to the study of healthcare, both biomedical and *kastom* healthcare, in Solomon Islands, which have been important to me. As already mentioned there is William Parks (1998) who examines the household management of childhood illness in Marovo lagoon. Takuro Furusawa's (2006) quantitative analysis which explores factors which are important in the treatment-seeking behaviour of people in a rural village in Roviana, Solomon Islands, has provided some interesting comparative material to my own. David MacLaren's (2006) doctoral thesis on culturally appropriate healthcare in Kwaio, Malaita is also an interesting comparative source as it explores the importance of religion, the traditional Kwaio religion and the Christian faith in the local populations choice of healthcare. The Kwaio population can either choose to seek treatment at the Adventist hospital or to stay away in order to stay true to Kwaio religion and way of life.

Ethnographic Context

Solomon Islands is an island nation located north-east of Australia and east of Papua New Guinea in the Pacific Ocean. Solomon Islands consists of nearly one thousand islands and in 2008 was estimated to have about 500 000 inhabitants (Solomon Islands National Statistics Office 2009) and more than 80 distinct languages. The country is divided into 9 provinces and a capital district. They are called Central, Choiseul, Guadalcanal, Isabel, Makira-Ulawa, Malaita, Rennell and Bellona, Temotu and Western provinces, and the capital city of Honiara located on the island of Guadalcanal. Together, these areas cover a land-mass of 28 000 square kilometres.

Archaeological excavations have shown that Northern Solomons has been inhabited since 28 000 BP, but little is known of the lives of people in the islands before the arrival of explorers in the region. The first foreigner to leave a written account of these islands was the Spanish explorer Alvaro de Mendana de Neira who arrived in Solomon Islands in 1568. Mendana arrived on the eastern shores on the island of Santa Isabel, today called Isabel,

which is the island on which I conducted my fieldwork. However the Spanish encounter does not seem to have made a great impact on the island and little is known of the area both before, but also shortly after its discovery (Bogesi 1948:209). After Mendana, the Spanish made several attempts to settle colonies on the island but were unsuccessful. In the following 200 years Solomon Islands received few visitors. There were however, a few Europeans that visited Solomon Islands during this time, but their reception was often hostile. As the Europeans sought to expand their colony with the islands an Anglo-German treaty was established in 1886, which stated that the northern Solomon Islands were under the German protectorate while the southern Solomon islands where under the British protectorate. However in 1893 Great Britain gained full control of the islands and remained in power until the country got its independence in 1978. Throughout the 19th century, Solomon Islands saw an influx of Europeans with the arrival of traders, whalers and missionaries. They brought new goods, new influences and a new religion. In addition they brought with them something which came to have a great impact on the local population - foreign diseases.

There are many reasons why the healthcare in rural Solomon Islands is the way it is today. In order to fully understand the present situation it is important to view healthcare in rural Solomon Islands in light of the important historical events that have taken place over the last 200 years. Here I will give an historical overview of the arrival of Europeans and other foreigners and their impact on health conditions in Solomon Islands. This will form an important backdrop for the topics discussed later throughout this thesis.

A historical overview of contact history and diseases in Solomon Islands

Prior to the arrival of Europeans, the population of Solomon Islands was, like any population, not disease free. There are diseases known to be endemic[4] to Solomon Islands, for example malaria, hookworm infestation and yaws. These are the most serious endemic diseases. They can be dangerous and even deadly, especially in children, but usually they did not prove fatal to adults. The impact of these diseases was often limited to weakening the population because they had developed some resistance to their native diseases. (Bennett 1987). The foreign diseases introduced in this period proved to be much more detrimental to the population and resulted in a rapid decrease of health in many areas, causing population numbers to drop rapidly. The most serious of the introduced diseases were tuberculosis, influenza, whooping

[4]Endemic refers to a disease which occurs continuously or with regular intervals in a population (Taber's cyclopedic medical dictionary 1997:634).

cough, bacillus dysentery, leprosy and veneral diseases (Bennett 1987). Cumpston (1923:1391) also mentions measles which killed large parts of the local population. In addition to the introduction of new diseases other factors related to the arrival of foreigners also played a role in the deterioration of local health.

Inter-tribal warfare was common in pre-European times. Although incessant raiding led to the depopulation of certain areas it had one important outcome – limiting the spread of diseases. The constant worry of assault from other tribes decreased the movement of people restricting them to their own tribal areas (Black 1956). Prior to the arrival of foreigners, the health of Solomon Islanders was protected in part by their isolation from the world and by each settlements relative isolation from other settlements (Maddocks 1975), limiting the spread of diseases from one settlement to the next. With the arrival of Europeans and a European Government, certain aspects of life in Solomon Islands changed. Headhunting was forbidden and the old patterns of inter tribal warfare were largely diminished. The mobility of people increased and therefore diseases could travel more easily between the tribes (Lambert 1928). Mobility was further increased when Europeans conscripted Solomon Islanders for plantation work from many different locations within the island group. Traders and trading ships hired Solomon Islanders as crew on their ships for travels both within Solomon Islands and also to foreign ports (Bennett 1987:39). Administrative personnel moved from place to place and children from different areas were gathered in central schools (Black 1956:138). In addition to this the Melanesian Mission and other mission groups did extensive mission work in a multitude of places in Solomon Islands. All of these factors created a constant flow of people and diseases moving from area to area.

An example of the consequences of the increased mobility is given by Cumpston (1923:1391) who recites what was said by the Rev W Durrad after an epidemic of pneumonia in Tikopia introduced by travelling missionaries.

> "It has to be confessed that the *Southern Cross*[5] is one of the chief agents in the distribution of the pneumonia germs. Among the many occasions I can recall of severe illness following the ship's visit no one stands out so prominently in my memory as an epidemic of pneumonia that raged on Ticopia, when I was put down there on one occasion, for a few weeks, while the *Southern Cross* cruised among the Solomons. What should have been one of the happiest of experiences was converted into the most tragic. The message of the gospel was stultified by the terrible sufferings of the people. Forty persons, most of them in the prime of life, and many of them fathers and mothers of large families, were struck down in death."

[5] The supply ship of the Melanesian mission

It was not only introduced diseases that became a problem as the mobility of people increased. Also the diseases endemic to the area became more problematic as the mobility of the local population increased. An example of this is malaria. Although much of the population already lived in malarious areas and had become resistant to the disease, increased mobility now put them at risk. A certain population could be immune to a certain strain of malaria, but if people moved to another area and were exposed to different strains of malaria, they would become ill and in some cases it would even lead to death (Black 1956:138). Relocation of people within relatively small areas was also a problem. There are several stories of whole villages being moved, particularly from areas in the mountains to areas more easily accessible by missionaries, traders and government, down in the coastal areas (Black 1956:139). Previously the population would have been protected, living in higher altitudes unsuitable for the malaria vector; the anopheles mosquito. Now they were settled in areas where the malaria vector lived and bred. People who previously were protected from contracting malaria were now exposed to the disease and with low levels of resistance it could have grave consequences.

Another reason for the decrease in health in Solomon Islands during this period was the modification of traditional practices. Traditional living patterns were disrupted and often people were moved into larger villages leading to hygiene and sanitation problems. In his article, Lambert (1928) discusses the introduction of tuberculosis and states that poorly ventilated houses and European clothing was a problem which increased the prevalence of the disease. “In the Melanesian Islands the natives will put on clothing which they do not usually remove until it rots away. They may go to bed with it wet with rain or sweat and never remove it” referring to clothing as “the worst curse of western civilization to them” (Lambert 1928:370).

Some stated that the depopulation of Melanesia had started already before the arrival of Europeans due to faults of their own such as “the heathen custom of polygamy” (Rivers 1922:87). However Rivers (1922) dismisses this notion. Instead he suggests that the decreasing population is due to what has been called “the psychological factor”. He states that the population was decreasing due to the Melanesians development of a “lack of interest in life” (Rivers 1922:101). The Melanesians birth rate had simply decreased dramatically. As possible reasons for this, Rivers mentions the abolishment of headhunting which previously was a centre for social and religious organisation and the labour trade which relocated large numbers of people to “civilized societies” before they were transported back “into savagery”

(Rivers 1922:105). According to Rivers (1922:104) the people themselves said "Why should we bring children into the world only to work for the white man?"

Many reasons are given for a decline in health and increased mortality in Solomon Islands in this period, however most sources identify introduced diseases as the main culprits (Bennett 1987, Cumpston 1923, Lambert 1934). Before 1900 there are few records that show the effects of introduced diseases, but looking at patterns of mortality from other colonized areas of the Pacific provides evidence for the notion that the population dropped dramatically in high contact areas (Bennett 1987:127). Bennett refers to a statement made by first resident commissioner of the Solomon Islands protectorate, Charles Woodford[6] who in 1909 stated that "The whole population of the British Solomons, with a few unimportant exceptions is entirely Melanesian and will disappear." He viewed the introduction of foreign diseases as an issue of grave concern and the main reason for the depopulation (Woodford 1922, in Bennett 1987:122). It has however been claimed that due to lack of proper population counts, the depopulation of the Solomon islands has not been as severe as some authors and researchers claim. There is however, general agreement that certain areas of Solomon Islands, experienced depopulation on a large scale after the arrival of foreigners and foreign disease.[7]

Introducing biomedical healthcare

As in most cases of the colonisation of a new area, introduced diseases arrived first and the medical responses to them arrived later, Solomon Islands was no exception. Biomedical healthcare arrived late and once it was introduced its improvements progressed slowly. In 1915 a hospital had been built at Tulagi in Solomon Islands. The hospital was built mostly to serve the white community but also served labourers who passed by (Bennett 1987:210). In the 1920s the Solomon islanders became taxpayer to the British government and in that way could expect to receive some returns, however, in terms of healthcare, the development was slow. (Bennett 1987:210)

By 1928, Solomon Islands had only 6 qualified[8] medical practitioners in the whole island group who were stationed for the welfare of expatriates and plantation workers

[6] He held this position from 1896 to 1915.

[7] Groenwegen (1970) is one of the few who criticize this notion. He claims that due to lack of proper population counts in the early days of the Solomon Island protectorate the level of depopulation is hard to assess. However, he also says that some areas of the Solomon islands where badly hit and did indeed experience a significant depopulation, but he claims that not all areas experienced this like it might seem.

[8] Lambert does not elaborate on what makes a qualified medical practitioner but one can assume it would be a western man with some medical skill. It would not be persons native to Solomon Islands as this is stated in the text (Lambert 1928:364).

(Lambert 1928:364). According to Lambert there was a misconception about the 'medicine man' in the South Pacific area. "Instead of centring on the native welfare he contents himself with the health of the few whites among whom he may be settled and the prime object of his being, native welfare, is slighted or ignored" (Lambert 1928:364). Lambert also emphasizes the fact that any estimate given on the condition of health among Pacific islanders will only be approximate, inferred from data gathered from a small cross section of the population, as large parts of the region were unexplored and less than half of the population was "under control" (Lambert 1928:364). According to Lambert, the infant mortality rate was very high during this time, and he claims that in areas without biomedical services it could be as high as 50 %, but he also mentioned that the mortality rate appeared to be decreasing. A possible reason suggested by Lambert for the decline in mortality were the introduction of medicines for yaws, hookworm, dysentery and whooping cough in addition to improved sanitation (Lambert 1928:364).

In his article from 1934, Lambert states that the provision of medical care for the local population in Solomon Island was a difficult task for the government. Islands and villages were located far apart, and it was difficult to reach such remote settlements and find accommodation within them. Finding western medical personnel willing to stay in outskirt areas, over any significant amount of time, if at all, was difficult. The difficulty of living in an area without understanding the language or customs, deterred western health personnel from adopting positions in remote areas. Western medical personnel were also very expensive as they demanded high salaries for their work. According to Lambert (1934:37) it was possible to find "natives with the mental capacities" to study medicine, but this would not solve the problem as after a lengthy medical education in the western world they would demand the same high salaries as their European counterparts. In addition they would have acquired "western" habits and would therefore not want to return to their respective islands as they would no longer have the taste for bush life. The solution to this, as explained by Lambert, was the Native medical practitioner scheme at the Central medical school in Fiji[9].

By 1916 The Central medical school was established in Fiji, and it was agreed that 4 of the 40 students were to be from Solomon Islands (Hermant & Cilento 1930:726). However it did not seem that Solomon Islands could utilise this offer to its full potential, as during this

[9] The central medical schools scheme involved 8 south pacific groups in 1934, Western Samoa, Cook Island, British Solomon Islands, Gilbert, Ellice Island, Tonga, the New Hebrides and American Samoa. It was created in Suva in Fiji where they had a large medical centre. Initially they trained native young men from Fiji in order to send them out into rural areas serving as Native Medical Practitioners for a small salary from the government. The school was later opened to persons from the other pacific nations such as those mentioned above (Lambert 1934).

time there was no available schooling in the islands and very few Solomon islanders were sent out of the country to receive education, which would be necessary in order to attend schooling at a higher level. Lambert (1934:39) states that this was planned to be solved through sending bright, young boys, maybe as young as 10-12 years old, to Fiji for government schooling in the years prior to attending the Central Medical School. However the economic situation in Solomon Islands at this time was very difficult and even the low cost of sending a young man to the medical school in Fiji was often too high (Lambert 1946). But by 1934 the British Solomon Islands Protectorate had become a member of the central medical school scheme and had begun to receive graduates (Lambert 1934:33). Referring to the decline in Solomon Islands' population Lambert (1934:33) argues that the future of the population lay in the "extension of the Native Medical Practitioner system so that natives well trained in medicine may carry Western ideas of treatment and living to their own people."

But medical care was and still is costly. In 1934 New Guinea spent 18 % of the country's budget on medical services which, in the eyes of the British government of Solomon Islands, was far too high. In Fiji and Solomon Islands the best way to give healthcare at a lower cost than in New Guinea was to educate local people in medicine and then employ them under the direction of European medical officers through the Central Medical School scheme (Lambert 1934:35). In 1936 one of the first graduates from the Central medical school, Eroni T Leauli, returned as a native medical practitioner and started working on Guadalcanal, spending much of his time in the outlying areas (Bennett 1987:151), fulfilling the hopes of the people who initiated this scheme, by providing health care for people in areas where European medical personnel would not go.

Although by 1930 the government had started making improvements in regards to healthcare, their efforts were too small and far apart to have made a big difference for the local population. Instead they were more likely to receive medical attention from one of the many missions around the island. The missionaries usually brought a small supply of medicines with them wherever they went and could provide some help if it was needed. In the 1930s the government had employed three doctors and only seven dressers throughout the country, while the same amount of doctors, receiving no government subsidies were working through the Methodist and the Melanesian mission (Bennett 1987:210)

At this point mortality slowly began to decrease in Solomon Islands (Bennett 1987:177). Bennett (1987:211) states that by 1930 the British government was better staffed and better able to supervise the implementation of their policies such as the introduction of sanitation initiatives. These initiatives included the fencing of pigs away from the village,

spacing of houses, locating rubbish disposals far from houses, ensuring that cooking occurred outside the main house and creating an emphasis on bathing. This, combined with the population developing levels of resistance to some of the introduced diseases would have reduced the mortality rates when epidemics did occur.

Biomedical healthcare today, a national overview

Today, Solomon Islands has one main hospital, The National Referral Hospital, with around 300-400 beds. The hospital has specialized departments and doctors ready to receive most patients with severe injuries, who are referred from all over the country. The National Referral Hospital is located in Honiara, the country's capital. This is the only major hospital in Solomon Islands. Seven out of the eight other provinces have provincial hospitals. In these hospitals they only have one or two doctors and neither the nurses nor doctors are specialized. The smaller towns and the province of Rennell and Bellona have clinics. A clinic in Solomon Islands will usually consist of a small house located in various villages around the provinces. There are usually no doctors in these clinics, only trained nurses. Their equipment is often limited, but first aid, vaccinations and basic medicines are available here. It is also the place commonly used by local women to give birth, however if there are complications or a patient is in need of surgery they will need to be transported to a hospital. In areas with no clinic nearby they might have an aid post. The aid posts will contain very basic medical equipment, just enough to administer basic first aid such as the treatment and dressing of surface wounds or distribution of basic medicines such as painkillers. According to the Solomon Islands Human development report (SIHDR 2002:43) in 2002 the country had altogether 109 clinics and 114 aid posts. These facilities are all run by the government. In addition to this, three of the provinces have hospitals run by various church groups. In Choiseul there is one hospital with 32 beds supported by the United Church. Malaita has a hospital with 80 beds run by the Seventh Day Adventist Church and Western province has a hospital with 55 beds run by United Church. Although the biomedical healthcare available to the population of Solomon Islands today has drastically improved from what was available in the 1930's, the government is still facing several major challenges. In 1934 Lambert noted that the administration of healthcare was complicated by the isolation of islands and villages, and this situation persists to this day. Limited funding and the dual threat of both infectious and non-communicable disease further complicate the matter of providing adequate healthcare throughout the islands.

The tension

In terms of economy, Solomon Islands is recognized as one of the least developed nations in the Pacific with poor infrastructure, high population growth and "weak governance" making improvements in the economic situation difficult (Economic Affairs 2009). Towards the end of 1998 the situation became increasingly worse as what is commonly referred to as "the tension" broke out on the island of Guadalcanal. The reasons for "the tension" are complex and intertwined with Melanesian traditions, colonialism, poor governance and economic difficulties.

A few years after WWII Honiara on Guadalcanal was recognized as the capital of Solomon Islands and as increasing amounts of people arrived in the capital looking for work, particularly men from Malaita, the population reached more than 15 000 by independence in 1978 (Bennett 2002). As the population in Solomon Islands in general, and particularly in Honiara grew, conflict over land increased. In 1987 Guadalcanal landowners complained to the Prime Minister of the growing numbers of Malaitans on their land, however no legal action towards the settlers where taken as many of them where there after legal purchases and lease arrangements had initially been made. But as time had passed the men who initially had been allowed to settle there had brought their wives, children and relatives. After a few generations when Guadalcanal people sought to reclaim their land, they found it settled by Malaitan families and conflicts began to occur (Bennett 2002). Because the conflicts occurred mainly between these two groups of people it has been referred to as "the ethnic tension" however there are several authors who disagree with this notion, claiming that it obscures the underlying reasons for the conflict. (Bennett 2002). Bennett (2002) argues that instead, a corrupt and unstable government, unequal distribution of wealth in the provinces, increasing population leading to increasing pressure on limited land and recourses and lack of official law allowing traditional retributions such as compensation to flourish are also more likely reasons for the tension. The bloody and violent conflict lasted until 2003 and resulted in a massive displacement of people as the inhabitants of Honiara moved back to their respective islands. It is estimated that more than 23 000 Malaitans returned to Malaita during this period (Liloqula 2000:41) Furthermore, the conflicts brought the country's already failing economy close to collapse, broke down law and order and led to a complete failure of infrastructure (WHO 2004). In 2002 and 2003 Solomon Islands was referred to as a "failing state", but with

the arrival of RAMSI[10] in July of 2003 and their help in restoring law, order and the rebuilding of the economy, Solomon Island was never entirely reduced to a "failed state" (WHO 2004).

A new wave of unrest hit in 2006, between Solomon Islanders and the minority population of Chinese inhabitants, but the conflict was quickly curbed, although not without large numbers of Chinese businesses first being vandalized. Nevertheless, since 2003 the country has slowly regained law and order and the country's economic situation is slowly recovering. The effects of these events for the healthcare situation in the country will be further explored in chapter 4.

Methodological concerns

Getting there

As previously explained, the rural Solomon Island village of Kia is located in a region where very little research of any kind has been conducted. Evelyn Tetehu was born in Kia but has later moved to Australia where she is living with her husband, environmental scientist, Graham Baines. After having spent much time in the village themselves, experiencing the healthcare system of rural Solomon Islands they perceived a need for research based on medical anthropology. Knowing Professor Edvard Hviding at the Department of Social Anthropology at the University of Bergen, Graham Baines contacted him in order to see if he knew of a student who might be interested in such a study. As I was finishing my bachelor degree in social anthropology in the spring of 2006 I was contacted by Professor Edvard Hviding. He already knew of my interest in medical anthropology and suggested I do the fieldwork for my master thesis in Kia.

Previously I have done a one year course in medicine which I later combined with anthropology at the University of Bergen. When I was contacted by Professor Hviding I was completing my bachelors degree by studying medical anthropology at the University of Hawaii with a focus on infectious diseases in the Pacific. I was immediately interested and in the fall of 2007 I commenced my master thesis at the University of Bergen. Here I was also included in the Bergen Pacific studies research group which provided much useful

[10] Regional Assistance Mission of Solomon Islands, consisting of military and police from several Pacific nations, but mainly supervised and manned by Australian Defence Forces

information and ideas both before and after my fieldwork. I was introduced to Graham Baines and his wife Evelyn Tetehu, and as my fieldwork was approaching it became clear that Evelyn Tetehu would accompany me to Solomon Islands and introduce me to her family and to the village.

As a consequence of Evelyn accompanying me, my waiting period in the capital of Solomon Islands was limited, The waiting period of only two weeks could easily have turned in to four or six without the help of someone who is familiar with the system. When one's time in the field is limited the loss of one month, or possibly more, to organisational preparations would be both damaging to ones research, and not to mention very frustrating. Instead the two short weeks were filled with interviews with people from the healthcare sector and patients as well as a trip to Buala where I gained important knowledge of healthcare in the provincial capital of Isabel, and luckily by Evelyn's help I was quickly able to leave the dusty capital of Honiara for village life in Kia. Evelyn's help also ensured my quick acceptance in the village. She introduced me to many of the people who were to become important for my thesis and she assisted me in the field which helped me cross both cultural and language barriers.

As soon as we arrived in the village we were warmly received by Evelyn's sister, her niece, her niece's husband and their three little children who all shared one house. Evelyn's sister Ali is the oldest sister and the matriarch of the family. The women, especially the older women of a family have very important position in an Isabel family as the island of Isabel is unique in that the whole island is matrilineal. This means that land, which in most other places in Solomon Islands is inherited through the men, here is inherited through the women. Ali did not only have an important positions in the family as the oldest sister, she also held a special position both in the family and in the village as she has worked as a teacher in the village until her retirement a few years ago, and in addition she had extensive knowledge and skills in *kastom* medicine. She has far reaching knowledge concerning a multitude of aspects of life in Zabana, including *kastom* medical knowledge. She welcomed me into her family and made sure that both my fieldwork ran smoothly and that I was well looked after throughout my time there. At first my place in the family became that of a guest, they insisted that I recieved food first, that I always had a chair whereas others had to sit on the floor and insisted that I did not have to help cook or clean. Eventually however, as we all got to know each other better, I became familiar with Zabana way of life and I showed that I wanted to contribute to family chores, my role as a guest became more like that of a close friend, or part of the family. Nevertheless even during the last stages of my fieldwork my insistence on

working in the garden or helping with kitchen chores were frequently met with laughter. This might not only have been due to my role in the family but also due to my somewhat poor skills in typical activities such as walking in the bush or pounding taro.[11]

During parts of my stay I lived in Ali's house whereas other parts were spent in a vacated house in another part of the village. However, I still ate the majority of my meals with the family and much of my time was spent with them. Their openness gave me an amazing insight into the daily lives of the Zabana people.

In the village there was initially some confusion surrounding the reasons for my presence, however after having introduced myself and my project to the chief this was quickly resolved. I was placed in the role of health researcher, which most people seemed to respond very well to and many expressed that they where very happy that I was interested in their *kastom* medicines. In addition I became seen as a close friend and also at times as a part of Ali and Evelyn's family with whom I spent much of my time and who frequently accompanied me on my walks through the village.

After my arrival I was soon introduced at the clinic. The three nurses all seemed interested in my work and were all more than willing to let me participate in the goings-on of clinic life. Throughout my stay I spent countless hours in the clinic observing the nurses and their patients, conducting interviews, trying to help out in the best way I could or just trying not to be in the way. In a clinic with only one very small room in which examinations of up to three patients were done at the same time the latter could be rather challenging. But with the help of the nurses and patients who willingly shared their illness experiences with me, much important information was gathered here.

Although I have some medical knowledge due to my background in medicine I did not stress this factor, and did not want to acquire an authoritative role in any way at the clinic. Instead I stressed my interest in health and healthcare and in the "Kia way" of running a clinic. The nurses readily accepted my presence and I believe I was placed in a role of researcher and "clinic helper".

[11] For example, every time I got out my machete in order to crack open a coconut, trying to do it in the same effortless manner as Zabana people, I could see members of the family watching me with worry from the corner of their eye, scared that I would chop off my own finger in the process, and their sign of relief when the coconut finally broke open or when I, after struggling with it for far too long, handed it over to one of them who opened it with one single chop.

Language

Day to day language for most people in Kia is Zabana. As will be further explained later Zabana is the name of an area, it is also the name for the people from, and the language which is spoken in this area. Apart from Zabana language, people in this area speak Solomon Pijiin, nearly all members of the community are bilingual and fluent in both languages. In addition the younger members of the community have an understanding of English as this is the language commonly used in school, however my impression was that although they seemed to have a good understanding of the English language, most were very reluctant to use it.

After my arrival in the village I quickly learned Solomon Pijin and within a few weeks could converse easily with most members of the community. However I will mention that during a few of my interviews with certain older members of the community who were not comfortable using Pijin the interviews were conducted in Zabana through the help of an interpreter. Although some information might have become lost in these cases I felt the interpretations I was given were quite accurate as although the persons interviewed were not comfortable speaking Pijin, they could understand the language enough to verify what the interpreter translated back to me. I will also mention that the number of interviews conducted with an interpreter were very few. So in spite of the limitations commonly associated with the use of an interpreter, I do not believe these few cases to have hindered my research in any major way.

Conversations at the clinic would usually be held in Pijin. At the clinic one of the nurses native language is Zabana, one has a good understanding of it whereas the last nurse is from a different island and does not speak Zabana. Of the three nurses at the clinic, one nurse is a native Zabana speaker, one possesses a good understanding of Zabana and the last nurse who is from a different island has a limited understanding of Zabana. For this reason the conversation would naturally flow in Pijin, both between the nurses and between the patients and the nurses. However if only the nurse who is a Zabana speaker was present at the clinic, or if the patients were old and not entirely comfortable with using Pijin, the nurse would conduct the consultations in Zabana language. However, when this happened the nurses would always make sure I understood if there was something which was unclear to me.

Interviews and participant observation

During my fieldwork an important method was the use of interviews. Interviews were conducted as both structured and open ended interviews, however I found the open ended interviews to be more useful both due to their more informal construction, but also because this method opened up a wide range of topics which otherwise may not have been discussed. A very large part of my fieldwork also consisted of unstructured interviews. As I participated in the daily lives of Zabana people I was in constant interaction with various community members who shared their knowledge, their thoughts and their ideas with me.

As I was included in the daily lives of families, patients and caregivers I was immediately involved in participant observation. I consciously decided to take part in, not only health related activities, but also in all the activities which make up the life in Solomon Islands. I participated in the daily activities of family life; cooking, looking after the children, going to gardens, travelling to outlying islands, gathering coconuts, going to church, evening storytelling, and also making trips to the clinic, or to a *kastom* practitioner in the case of illness. In this way I was not reduced to only receiving information of life in rural Solomon Islands from the oral accounts of interview objects. Instead the interviews worked as a way of clarifying or elaborating upon aspects of life which I had already observed and taken part in.

Obviously participating in someone's illness is impossible and illness in the village could only be observed, but as chance had it I, myself, became sick during my stay in the village. In this way I was able not only to observe the healthcare system of Kia, but also to have a personal experience, acquiring "embodied knowledge" of the pluralistic healthcare available in the village. My experience of illness in Kia will be further discussed in chapter 3

Names

The island and the name and location of the village are stated in the thesis. These have not been changed as the particular location, the size and the history of Kia are important factors in the analysis of the Zabana peoples health related knowledge and practise. However due to the sensitive nature to some of the issues addressed in this thesis and to ensure the anonymity of my informants I will not use any names apart from the names already mentioned in this chapter. Instead I will state the gender of the person I am referring to, and in situations where I see it necessary I will add the age group to which the person belongs.

Research area

The clinic

An important location during my fieldwork was the village clinic. As previously mentioned there were three people working at the clinic; the head nurse who was from another province in Solomon Islands, a nurse aid from the Kia village itself and a nurse from a village on the island of Isabel located on the southern side several hours away from Kia outside the Zabana area.

The first biomedical clinic in Kia was set up in the 1950s. It was a small house in the middle of the village close to the church. The clinic had only one worker, a local woman with limited training. The clinic operated in this house until the 1990s and eventually received trained nurses. At this point a new clinic was built. This clinic was built on the eastern side on the periphery of the village and this is the clinic which is in use today. The clinic consists of 4 rooms, one for male in-patients, one for female in-patients, one is the maternity ward where they deliver babies and there is one communal room for all the out patients. On busy days all 3 nurses work in this small communal room receiving patients, examining patients, giving them injections and other medication. This leads to an overcrowded work place for the nurses, making examinations and treatments very difficult and provides absolutely no privacy for the patients. Apart from this there was also a small room serving the purpose of a radio room and file storage. The toilet facilities were two outdoor toilets built behind the clinic. The toilets were a bit away from the main building and complicated the situation for inpatients, especially mothers that just had given birth and very sick or old people who were not be able to walk very far. According to the nurses, the clinic has long needed renovations, but there was never enough money. It is a question of getting money from the government and for a rural village this is not always easy. However, as will be discussed in chapter 4 the desperately needed renovations at the clinic was finally begun during my stay which dramatically improved the state of the facilities.

The clinic functioned as a meeting place in the village both for people and for *kastom* and biomedical healthcare. My time spent at the clinic inspired and shed light on many of the interesting aspects of health and healthcare in a pluralistic healthcare setting which will be examined throughout this thesis

The village

The layout of the village.

The Church is the large white building in the centre. The clinic and the school are situated to the far right of the photograph, at the end of the village. To the left, the village continues for another 3-400 metres.

A few weeks after arriving in Solomon Islands, having been sent from government office to government office in order to receive the correct papers enabling me to conduct my research I was finally ready to go to the village of Kia, the location of my fieldwork. I waited at the airport with Evelyn. She had accompanied me all the way from Brisbane and was now going with me to Kia to introduce me to her family living in the village. It was over 30 degrees and we were all anticipating the airlines message, was the plane departing that day or not? The plane for Kia is supposed to leave once a week and holds up to 9 passengers. However if there is or recently has been any rainfall at the airstrip at the other end, the plane will not depart. Several of the airstrips in the provinces are only grass fields and without suitable irrigation the fields easily become unsuitable for landings in the case of rain. Another obstacle in the case of air travel is that if there is not enough passengers booked for the flight the airline will simply put the plane on hold until enough passengers have reserved seats on the plane. This could mean one must wait an extra day or in some cases one simply has to wait for the flight the following week. We were lucky and the plane left on time, heading for the airstrip of Suavanao on the island of Isabel.

Geographically the island of Isabel is located north of Guadalcanal province with the capital Honiara, between the islands Choiseul and Malaita. According to the last census, Isabel had about 20 000 inhabitants (SIPHC 1999)[12]. The provincial capital is the village of

[12] According to the last population census conducted in 1999 Isabel province had a population of 20 198. According to Solomon Islands National Statistics Office estimates, the population of Isabel province would have reached 24 542 by 2007, however without a more recent count I will continue to use the number estimated in 1999.

Buala located on the north-eastern end of the island. The village of Kia lies in Zabana area which is located in a narrow passage on the western end on the island of Isabel about 150 km from Buala which is accessible only by boat. It is estimated by many to be the largest village in the country, but there presently exists no official population count. At the census in 1986 it was estimated that total Zabana population was 1348. Although speculative, the nurses at the Kia clinic and other members of the community estimated the size of the current population to be somewhere between 1500 and 2000 people.

The Zabana area stretches from the village of Baolo on the northeastern side of Isabel to the village of Samasodu on the southwesten side of Isabel. The people within this area speak the Zabana language and make up what is referred to as Zabana people. Throughout my thesis I will be using Zabana people apart from cases in which I refer only to the people living in the village of Kia which I will refer to as Kia people.

Isabel Map

(Bob Vincent, Eddie Kakai and Mick Saunders 2009)

As we landed at the airstrip in Suavanao we could see several little boats with outboard motors waiting to pick up friends or relatives arriving by plane. Suavanao airstrip is not located close to a village, but at a logging camp. For most of the passengers they still had a long distance to travel before they reached their final destination and many were going to Kia which is located about 2 hours by boat from Suavanao, depending on the weather and the size of ones outboard engine. For most of the Zabana people, travel by air is out of reach because it is far too expensive. The other option is travelling by ship. With uneven intervals ships leave Honiara destined for Isabel. According to some villagers the ship is supposed to arrive once a week, however during my stay it often took more than a week between each arrival. The journey takes over 24 hours one way and can be uncomfortable as the ship often is crowded with no ventilation and only one toilet.[13]

After arriving in Suavanao we got picked up by Evelyn's brother and began our journey towards Kia. During the journey Evelyn's brother fished for tuna to take home for the evening meal. He pulled out fish after fish and was amused by me wanting to document his catch with my camera. As we travelled along the coast of the island we frequently saw little houses and settlements emerging from the lush vegetation. Zabana people, with very few exceptions, all depend on subsistence farming and fishing supplemented by "cash work" at logging camps or catching or growing produce and then selling it, which allows them to buy simple necessities from one of the small village shops such as kerosene, cooking oil, tinned fish and meat, rice and soap.

We arrived in the village and the first thing that stood out was the large, white church which occupied a central position in the village. Compared to all the little houses surrounding it which are nearly all built from traditional material, it almost seems a little out of place, but after experiencing the local devotion to the Anglican faith, I came to understand that it perfectly symbolizes the central importance of Christian religion in the lives of the Zabana people. We passed the church and continued straight to the house of Evelyn's sister Ali. Ali's house, like a large proportion of houses in Kia, is built on poles over the water, allowing one to dock boats directly to the side of the house. It was in this way, climbing from the boat into the living room of a small house on the water, that I landed in Kia for the first time.

[13] During a conversation with a few of the women in the village about travelling with the ship to and from Honiara they stated that it could be uncomfortable travelling by ship as one could not follow traditional rules of conduct. For example they mentioned the toilet which in the village is a very private affair and men and women have separate toilet houses. In the ship one had to share toilet and as the ships are crowded, men would frequently stand outside as women used the toilet facilities.

Layout of the thesis

Chapter two will explore how notions of health and actions taken in order to treat illness are constructed and understood differently depending on the culture in which they exist. Further it aims to provide an ethnographic description of the *kastom* medical system in Kia. It explores the pre-contact medical paradigm and how it is understood and practiced today.

Chapter three explores the current reality of medical pluralism in Kia by showing how *kastom* medicine and biomedicine are coexisting. While indigenous and biomedical healthcare systems are commonly viewed as existing in opposition to one another, I argue that in Kia they are not perceived nor experienced in this way by the Zabana people. The chapter further deals with the involvement of religion in the medical paradigm in Kia today and argues that the Zabana people have a pragmatic approach to healthcare. Finally I will analyze healthcare in its historical context in order to explain how the current medical paradigm has evolved.

In chapter four I will examine healthcare in Kia from the perspective of critical medical anthropology where the rural setting is examined in the context of political economy. By using Grønhaug's (1978) field theory I will explore how these factors affect the rural healthcare situation and how they affects the interactions between *kastom* medicine and biomedicine

Finally in the afterword I will bring together the previous chapter and suggest some directions for future research.

2

Kastom medicine in Kia

Introduction

In this chapter I will give a thorough ethnographic examination of the *kastom* medical system of Kia, its healers and its treatments.

In the previous chapter I have argued that in order to properly examine a population's system of healthcare, a locally grounded, ethnographic analysis is needed. In chapter 3 I will examine the coexistence of *kastom* medicine and biomedicine in Kia. It is necessary first, however, to elucidate the nature of *kastom* medicine. In this chapter I will examine the *kastom* medicine of Zabana, and the Zabana understanding of health and illness.

Firstly I will discuss the notion that biomedicine consists of objective truth, and the importance of rejecting this notion as it makes a comparative analysis of medical systems problematic (Good 1994). This leads to an exploration of *kastom* medicine. I will show that the *kastom* medical system of Kia is coherent with and influenced by many other aspects of culture and everyday life. Zabana people's ideas of health and illness are not separate fields, but rather domains of knowledge and practice that include and interact with a myriad of factors such as personal and spiritual relationships, religion and behaviour and all that which constitutes daily life. Therefore a holistic approach will be needed in the exploration of the *kastom* medical system.

The biomedical hegemony

No human being, no matter what culture, class or historical period they belong to, can avoid experiencing illness and death. Brown (1998:5) argues that all populations, independent of what technology they have available, will develop ways to deal with sickness and death in the form of medical systems. This includes both biomedicine and so called "indigenous" medical systems. Thus there are vast numbers of medical systems in the world today, however among these biomedicine has acquired a hegemonic role and its assumptions are often understood as reflecting the truth. According to Lock (1988:3) the biomedical system is characterized by having the idea that "science represents an objective and value free body of knowledge" and is in this sense universal. Allan Young (1982:260) states that "epistemological scrutiny is suspended for Western social science and Western medicine." However, the hegemonic role of biomedicine is today heavily contested. It has been argued that all medical systems, including biomedicine, should be explored as cultural constructions as to avoid "uncritically accepting some of the assumptions of biomedicine" (Johnson & Sargent 1990:2).

Following Good (1994) it is difficult, but nevertheless essential to avoid the notions that "our own system of knowledge reflects the natural order", as such a belief renders the comparative analysis of different systems of medical knowledge very difficult. In this thesis I focus on *kastom* medicine and its meeting and cohabitation with biomedicine. While not dismissing the utility and importance of the biomedical system, I will, again, following Good (1994) avoid the notion that biomedical understanding of health is objective and of more value than other local medical systems and keep in mind that even the common conception of scientific knowledge as objective truth is shaped by culture.

Capra (1982:333) argues that "Any system of healthcare, including modern western medicine, is a product of its history and exists within a certain environmental and cultural context". Western biomedicine is an international, dominant medical system (Brown 1998:108). There is no doubt about its success rate nor about its major contributions to health, however it is important to keep in mind that it is only one among many other medical systems. According to Bastien (1992:96), for about 90 % of the world's rural population it is indigenous healers who continue to function as the primary healthcare providers.

Young (1976:6) states that exploring a non-biomedical system from the point of view of the biomedical paradigm can be problematic for two reasons. *Firstly*, it will lead researchers to explore their topic "in a fragmentary way", as it will be areas of focus and interest to the biomedical paradigm which will be considered. *Secondly*, the biomedical

paradigm can only help explain practices seen as useful in the eyes of biomedicine, whereas practices with no obvious benefits to health cannot be explained or understood.

In societies where biomedicine, with its focus on science and high-tech technology, is the primary mode of treatment, the use of plant medicines in order to treat illness would usually not be the first option, and if applied it would to many seem irrational. In these societies, scientifically proven medicine or treatments involving technologically advanced procedures and practitioners with technological skills have more authority and will be favoured (Loustaunau and Sobo 1997:95). While for example surgery is an important and valued form of treatment in many places throughout the world, typically in areas where technology is much utilized and highly valued, it can be perceived differently in areas where technology is not so important. Surgery has for example not become a valued approach among most Zabana people. Many of my informants in Kia expressed their dislike of surgery and I saw several cases of people not wanting to go to a hospital for surgery, although the nurse had recommended that option.

Macpherson and Macpherson (1990:4) argues that it is the culture, being "the complexes of beliefs and values shared by human groups", in which an illness occurs that provides the paradigm which explains the illness and what course of action that needs to be taken to cure it. The use of plant medicines in *kastom* treatments in Kia exemplifies this idea. As I have previously explained in chapter one, Kia is a remote, rural village situated in Solomon Islands. Before the arrival of Europeans, Zabana people survived by subsistence farming and fishing. According to the Solomon Islands Population and Housing Cencus (SIPHC) in 1999, 77 % of the total population over the age of 14 did not participate in the country's cash economy, the most important reason for this being that they were occupied with household chores and unpaid work such as agriculture and fishing. This indicates that a large proportion of the population is entirely dependent on subsistence agriculture. The report further states that, in general, the great majority of all households in Solomon Islands produce food for their own use. This shows that Solomon Islanders to a large extent still depend heavily on their natural environment. According to my observations, nearly all families in the Zabana area were partially or entirely dependent on subsistence activity.

In Zabana, both food and shelter depends on being able to make use of the natural resources. Their continuing dependence on nature is clearly reflected in the houses in the village today. In 1993, 137 of the 171 houses in the village were built solely from traditional materials (Baines and Tetehu 1993). In 2008 the situation was much the same. The village has grown, there are more houses and certain materials such as iron roofing have become popular,

but still the traditional materials dominate the housing constructions in the village. Zabana people's diet is another example of their dependence on the environment. Although certain imported items such as rice and tinned fish have become important in the diet of Zabana people, local foods still make up an integral part of food consumption. From an early age both boys and girls are taught how to make use of their surroundings, rendering them capable of growing, gathering or hunting for food in the area in which they reside. In the *kastom* medical paradigm, use of various plants, herbs and trees make up a significant part of their medical treatments. Historically and also to a large extent today, nature provides Zabana people with everything they need such as food and shelter. Medicine is a natural continuation of the list of resources gathered from the surroundings. An example from a day in Kia exemplifies the close relationship between people and nature.

> In the early hours of the morning two men from the family are getting the boat ready in order to go fishing. A little later two of the women are getting ready, they are going to the gardens about 25 minutes from the village. In order to get there they use their dug-out canoes made by male relatives. They will do some weeding and get *kumara*[14] and *cassava*[15]. Some of the children are going as well, they will help carry back brown coconuts needed to make cassava pudding for the following day. The women arrive home in the afternoon, the men a little later. They have caught much fish. The women prepare the fish. Some of it is put in a pot and the rest is wrapped in leaves brought home from the gardens. The fish is taken out into the kitchen house that is built entirely of natural materials. The pot of fish is hung over the fire made from firewood gathered in the bush. The pot will be ready for dinner that evening and eaten with the *kumara* the women already have cooked. The fish wrapped in leaves is put in the home made stone oven. Burning hot stones are carefully removed from the fire with wooden thongs made form a tree that does not burn easily. They are placed under, around and over the parcels of fish. The whole pile of fish and rocks is then covered with rice bags and palm leaves not to let the heat out. The parcels of fish will be ready the following afternoon. When the pot of fish is finished it is eaten in the main house. The whole family is there and we are all sitting on the floor in the house which, apart form the iron roofing covering the back part, is made entirely of traditional materials. A woman comes in. She is one of the cousins in the family. She is bringing a pot of shellfish she has gathered from one of the island outside Kia. She had paddled out there earlier in the day in her dug out canoe. It is a soup of shellfish and coconut milk. Later in the evening, after the food is eaten and stories have been told, the family are ready to go to sleep. Some of the members of the family and me have foam mattresses that we sleep on top of grass mats made by the women from a particular plant, while others, especially the older members of the family sleep straight on the grass mats.

[14] A sweet tasting tuberous root, in English referred to as sweet potato. Native to Africa and Asia.
[15] A tuberous root originally South American.

As shown in this section, Zabana people exhibit a high level of dependence on nature, and the use of medicines sourced from their natural environment is an extension of this aspect of their culture. A very large part of Zabana people's medicines are derived from the herbs and plants that surround them. In the same way food is planted and harvested from the gardens, or sometimes found growing wild in the bush, so are their medicines. Certain ailments can only be dealt with by persons with extensive knowledge of *kastom* medical plants but common problems such as cuts, bruises or slight aches or pains have well known treatments, and a large part of the adult Zabana population knows one or more herbal treatments in order to cure them.

Although for the purposes of description I draw a distinction between different medical systems (biomedicine and *kastom* medicine in this case) it is important to realize that medical systems are not static entities. Both biomedicine and other medical systems have fluid boundaries and will overlap with each other and with other aspects of life. Medical systems are continuously in a state of change, and if new and effective solutions get introduced they will more often than not be accepted into the existing body of medical knowledge (Polgar 1963). Issues concerning the fluid and flexible nature of medical systems will be addressed throughout this thesis.

The concept of health in a Melanesian context

When studying any area's healthcare system, it is important to understand that health can be defined differently depending on the culture of a society, and that "once the relativity and subjective nature of the concept of health is perceived, it also becomes clear that the experience of health and illness is strongly influenced by the cultural context in which it occurs" (Capra 1982:352). The term health has been defined in a variety of ways within different perspectives and areas of the world.

Since 1948 the World Health Organisation has used the following definition of health: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1946) When examining the WHO's definition of health it becomes obvious that this is an utopian idea (Singer and Baer 2007:64) and for most people in the world it is an unattainable ideal if one wants to be labelled healthy. Furthermore it implies that being healthy is static and absolute with no variations (Dunn 1976:133). In Kia I found that the WHO's definition was not in any way applicable. In Kia it seemed quite

normal to live with conditions, which in another context could have labelled the person sick, but which in Kia did not signify the absence of health. Living with a cough, a lightly aching leg or an arm, or possibly a rash did not seem to necessarily label that person unhealthy, rather this was considered a normal state. However according to WHO's definition, patients living with similar conditions would not fall into the "complete physical well-being" category and therefore not be labelled healthy.

Baer et al (2003:5) state that "Health is not some absolute state of being, but an elastic concept that must be evaluated in a larger sociocultural context". This statement emphasizes the flexible notion of health which is different within different cultures and areas of the world. Polunin (1976:120) mentions this by stating that "the judgement about what constitutes health varies from group to group. In most societies, disease is conceived as a departure from the usual state of health. Thus, a morbid condition which is common may not be perceived to be abnormal and to need a remedy". This can for example be seen in the Dominican Republic where intestinal worms is very common and according to the local understanding worms and humans live in a symbiotic relationship and "all humans should have some intestinal worms at all times." (Quinlan et al 2002:78) In Norway on the other hand intestinal worms are not very common. If someone is found to have intestinal worms they would immediately receive treatment to remove them as this would be considered a departure from what is seen as a healthy state in Norway.

An example of this is the case of malaria in the Solomon Island. Malaria in Solomon Islands is so common it is considered endemic. From a biomedical perspective, if fevers occur every couple of days, and night sweat is a nightly occurrence, the patient would be categorized as ill (Kakkilya 2005) and the patient would immediately be advised to get treatment. However, according to Dulhunty et al. (2000:188) when malaria occurs on such a grand scale and on a regular basis like in Solomon Islands, the malaria symptoms might eventually become the norm, and not necessarily a sign of illness. When locals were asked how common malaria was in Malaita the answer was; "Malaria is something that will be with us for the rest of our lives" (Dulhunty et al. 2000:188). After observing and discussing the presence of malaria in Kia I found similar results. If an adult experienced light symptoms, often associated with malaria it would most likely not interfere with their daily lives in any significant way. A woman explained to me that such symptoms were "nothing" if it happened to her she would just take some painkillers and go to the gardens to do her work.

During an interview with a doctor who had grown up in Kia but practised in Honiara, he defined health as "when you do not need a doctor". He continued by explaining that being

sick and having to see a doctor were different in various places. “In the West one runs to see the doctor for a little wound while in Kia you are not sick until you are bedridden.” Although the doctor’s statement might have been a bit exaggerated in order to emphasize to me that there is indeed a big difference, it nevertheless signifies the same attitude toward health as I found in Kia.[16] Having injuries or bothers which are considered minor, such as in some cases malaria, was not enough to be classified sick.

In the Solomon Islands Human Development Report (2002) it is stated that “good health means the living of a long, healthy and productive life in a physically, psychologically and spiritually healthy environment”. Although this definition exhibits circularity in including the term healthy several times in its definition of health, I still believe it reveals something important about what health means in the Solomon Islands; that to be healthy, one must be productive.

This idea can also be found in other studies of Pacific Island communities. In his essay on traditional medicine in the modern Pacific, Finau (1994:55) defines illness as “a physical, social, mental and spiritual state that society and the individual agree will *adversely affect relationships and performance of duties*.” (italics added) As already mentioned subsistence farming and fishing make up very important parts of the lives of most Solomon Islanders. Their possibility of getting food and also shelter depends having the physical ability to acquire and create them. In a situation where oneself and ones family will not be fed if one does not go out to get food, minor injuries such as fever, headaches or aches are rendered unimportant and will not classify a person as sick or not-healthy.

Another important aspect of health in Solomon Islands, also mentioned in the Solomon Islands Human Development Report (2002), is attention to the spiritual environment. This is a feature which is usually absent from biomedical definitions of health. Taber’s cyclopedic medical dictionary (1997:845) defines health as “A condition in which all functions of the body and mind are normally active,” focusing on the functionality of the individual body parts. Helman (2007:127) states that “In many non-industrialized societies, health is seen as a balanced relationship between people, people and nature and between people and the supernatural world.” A disturbance in these relationships can lead to illness or some sort of physical or emotional symptoms. In many ways this is applicable to the understanding of health of Zabana people. Biomedicine can be understood in contrast as it applies a reductionist approach in determining whether a patient is healthy or sick, meaning

[16] After saying this the doctor explained that the high threshold for going to see a doctor was not necessarily a positive thing as this in many cases led the patients seeking medical care when it was too late.

that the focus will be on the particular individual patient, a particular organ, a group of cells or a region within the body and other factors such as the patients family, their social network or their community rarely will be taken into consideration (Helman 2007:123). For Zabana people, health is dependent on much more than only the smooth functioning of the various organs and body parts. Their bodies are in constant interaction with people around them, with nature and with supernatural forces, those being within the realm of Christianity or *kastom* beliefs in spirits and ancestors. Straining any of these relationships can lead to illness and in some cases even death. Zabana understanding of the origins of illness will be examined later in this chapter

Differing explanatory models

A natural continuation of Macpherson and Macpherson's (1990) argument that culture provide the paradigm in which illness is explained and dealt with, is that being healthy or being sick is a culturally bound experience and therefore illness can not be studied outside of its cultural context, or as stated by (Stoner 1986:46) "Illness is never a discrete category that can be isolated and treated outside of its social, cultural and political contexts". In order to examine the notion of illness in a given population, a notion which can be entirely different for people from different cultures, Kleinman's (1980) explanatory model can be used. Explanatory models are the notions about an episode of sickness and its treatment, that are employed by all those engaged in the clinical process (Kleinmann 1980:105), according to Pelto & Pelto; "The explanatory model is constructed or assembled by the participating individuals in order to deal with and make decisions about particular individual illness episodes" (Pelto & Pelto 1997:153).

In order to exemplify the cultural construction of illness and the differing explanatory models of illness in different cultures, I will use the case of malaria understood through the perspective of *kastom* healthcare in Solomon Islands, in contrast to malaria in the eyes of a biomedically based healthcare system. I will use material from my own fieldwork in Kia, studies done by Dulhunty et al (1999, 2000) on the island of Malaita and some material from Edvard Hviding who has conducted research in Marovo, Solomon Islands (personal communication).

Malaria is considered to be endemic in Solomon Islands and it is believed that it was endemic also before the arrival of Europeans. Malaria has for many years now been estimated

to be one of the leading causes of death in the country. For a few years in the middle of the 1990s it looked as if the number of malaria cases was declining, but in the last 8 years the numbers have only gone up. In 2004 the number of malaria cases was 90 606 and in 2006 the reported number of malaria cases in the country was 75 337 while the estimated number for cases that year was 106 000 cases (World Malaria Report 2008). According to Solomon Islands National Health Strategic Plan (2006) the numbers of malaria cases are still increasing.

From a biomedical point of view, the disease of malaria is caused by parasites from the group of Plasmodium parasites. It is understood that a person becomes infected when bitten by an infected mosquito. These mosquitoes must have been infected through a previous bloodmeal taken from an infected person. The mosquitoes themselves do not get sick but the person bitten by the infected mosquito does. In the biomedical realm the typical symptoms of malaria are fever, flu-like symptoms and body aches. Typically the patient will show symptoms every second day. Other symptoms might be headache, nausea, shaking, chills, sweating and weakness (Kakkilya 2005). If a person is diagnosed with malaria a treatment of various malaria medicines will be subscribed. According to one of the doctors interviewed in Honiara, the most important medicine for malaria in Solomon Islands today is quinine.

The idea of the disease malaria is not something that has been created by the arrival of biomedicine to Solomon Islands. There are several accounts from different islands that malaria was recognized as an entity of its own before the introduction of biomedicine. As will be discussed later both in Malaita (Dulhunty et al 1999), in Marovo (Edvard Hviding, personal communication) and in Kia, there exist local names which refer to malaria. The symptoms of malaria recognized by people in Malaita and Kia are generally the same as the symptoms described by biomedicine, this is also reflected in the local names of malaria. Zabana language have two names for malaria, one of these is *fogara nanariha*. Directly translated this means “illness the day after tomorrow”, and refers to the symptom of malaria where the patient shows sign of illness every other day. In Marovo the local name for malaria is *reparepae*, which directly translated means “occurring every second day” (Edvard Hviding, personal communication). This shows that Zabana people and other groups of people around Solomon Islands recognized the disease of malaria by its characteristic symptom of making the patient feel ill every other day.

The symptoms of malaria recognised by biomedicine and *kastom* medicine correspond closely, however the understandings of the origin of malaria does not. Before the arrival of biomedicine, malaria was traditionally believed to be caused by witchcraft. This was the case

in Malaita (Dulhunty et al. 2000), and according to people in Kia they too used to have a similar notion of the origin of the disease. During an interview with a middle-aged woman in Kia she explained the pre-biomedical notion of malaria to me.

> "Before, we did not know that it was the mosquito that made us sick, we used to think it was black magic. People had to be very careful with their rubbish, like their hair. If somebody got a hold of it they could magic you and you would get sick."

The second Zabana name for malaria reflects the perceived correspondence between black magic and malaria. The other Zabana name for malaria is *agharana*. Directly translated, the name means "outside" or "away from the village", and it refers to a general feeling of sickness which occured after one has been away from the village. The woman talking to me about malaria explained that people were scared of getting *agharana* when they left the village, because when you left the village you were at greater risk of entering *tambu*[17] areas protected by black magic. If a person were to enter an area which was *tambu*, the illness would strike. You were also at greater risk of meeting strangers and according to my informants and Bogesi (1950:31) it was generally believed that it was people from other areas whom conducted black magic, not Zabana people. The issue of black magic will be discussed further later in this chapter.

Today Zabana people are well aware that the mosquito is the transmitter of the disease, and malaria is no longer associated with black magic. However, it is interesting to note that malaria is still associated with leaving the village as this is where the mosquitoes are believed to be. According to my observations and statements from the nurses in the village this is to a large extent accurate as there are noticeably more mosquitoes in less inhabited areas outside the village and a higher frequency of symptoms of malaria in people having spent time in these areas than in inhabitants who have not left the village.

Today the majority of the population on Malaita also recognizes mosquitoes as the transmitter of malaria, but in addition to the belief that mosquitoes transmit the disease there are several other understandings about how one can get infected with malaria. Explanations such as exposure to hot, cold or wet conditions, poor hygiene or eating some special kinds of food could also put a person at risk of getting malaria (Dulhunty et al. 1999). After the introduction of western medicine, others forms of explanations for malaria had emerged. Some respondents in the research conducted in Malaita blamed the different malaria programs

[17] "*Tambu*" is the Solomon Island version of the English word "taboo" and Pacific word "tabu". Its definition will be provided later in this chapter.

for the presence of malaria. Some said that the use of insecticide in the bed nets caused malaria and that the wide spread use of chloroquine tablets in the treatment of malaria actually caused malaria. Others claimed that malaria did not even exist until the introduction of DDT spraying of the houses (Dulhunty et al. 1999).

In Kia it seemed that everybody believed the mosquito to be the sole mode of transmission of malaria and there was to my knowledge no differing explanation of the origin of malaria, however there were certain aspects of the biomedical explanations of transmission that did not seem to be understood or adopted entirely. According to a doctor from Kia interviewed in Honiara, there is a widespread understanding that the mosquito causes malaria. However, he explained that not many know that it is actually the parasite in the mosquito that is transmitted when one is bitten by an infected mosquito. This can be a problem as it is not well understood that after the mosquito has bitten you, your blood becomes infected, and if another mosquito were to bite you and then move on to bite one of your family members, that person will also get sick. Because of this it is very difficult to make adults sleep in mosquito nets as there is no understanding of that in doing so you are also protecting your family. The doctor's story corresponded closely with what I observed in Kia where very few adults use mosquito nets, it is almost used exclusively for very young children.

The traditional view of the cause of malaria is no longer prevailing in Solomon Islands[18] and biomedical drugs have become commonplace in the treatment of malaria, however *kastom* medicines are still widely used, both in Malaita (Dulhunty et al. 2000) and in Kia. Previously massage would commonly be used in Kia in order to treat a person of malaria. The treatment would begin by massaging the affected body part and if the patient had a headache and malaria was suspected, a Zabana healer would also massage the head to spread or crush whatever was in there causing the pain. This treatment is still used today for various ailments, and also for suspected cases of malaria, however the treatment of malaria is today combined with either biomedical of *kastom* plant medicines. Interestingly, about 40 years ago a new *kastom* plant medicine for malaria was developed in Kia, exemplifying the dynamic existence of the medical system. The development of this medicine happened after Zabana people had learned of the biomedical explanation for malaria and tasted quinine[19], the medicine given for malaria. Today malaria medicine is given in pill form, but around that time, quinine in liquid form was given to patients with malaria and according to Zabana

[18] Not to say they are completely gone, such notions might still exist, but this is no longer the main explanation.
[19] A bitter medicine derived from the cinchona bark and used as an anti-malarial (Taber's cyclopedic medical dictionary 1997:1618).

people who remember this medicine it tasted very bitter. The new *kastom* treatment for malaria was developed based on the experience with quinine. It was the use of a plant that tasted very bitter, similar to quinine. This *kastom* treatment is still very much in use today. Another *kastom* treatment that also is popular for malaria today is chewing seeds from the pawpaw fruit. They also have a very bitter taste and are believed to cure malaria.

These cases of new *kastom* treatments based on treatments derived from the biomedical sphere underline the flexible and adaptive nature of the *kastom* medical system. Next I will explore further the *kastom* medical system of Kia.

The *kastom* medical system in Kia

Kleinman (1980) argues that to understand any medical system, including its healers and patients, the entire system must be understood on the basis of the cultural environment. Based on this I will now give an ethnographically based description of the *kastom* medical system of Zabana people. As explained in chapter one, our knowledge of the *kastom* medical system of Zabana people before the arrival of traders and missionaries is very limited, however by using Bogesi's (1948, 1950) sources from Kia and Bugotu and information from my informants I will trace the *kastom* medical system from the knowledge of the *kastom* medical system before or immediately after the arrival of missionaries and traders, to how it is organized today.

The agency of illness

As previously explained, the notions of health and illness in Kia are not distinct, separate categories but rather fluid ideas which intersect with a myriad of factors which together form daily life. In order to stay safe from illness it is not enough just to keep your body fit and safe from accidents, in addition one has to make sure to live ones life in a way which would not make another want to inflict harm on you, live in accordance with *kastom* and with the church and refrain from *tambu* areas or *tambu* activities. Failing to live ones life accordingly can put a person in harms way. According to Bennett (1987:18) in the medical system of pre-contact Solomon islanders nothing was believed to occur by chance, instead nearly all bad occurrences where due to someone's connection with the powers or spirits or following Bogesi (1948: 330), because of the spirits or the ghosts themselves.

According to Bogesi (1950) and my informants from Kia, the explanatory models of pre-Christian Kia was, like that stated by Bennett (1987) - dominated by belief in the super natural. In Bogesi's article from Bugotu (1948) he divides illnesses into three groups, one is due to spirits and ghosts and one due to black magic and the last one is due to natural reasons. By natural reasons he refers to simple and non life threatening conditions which could occur without any meddling by either ghosts, spirits or peoples use of black magic. Black magic was always suspected when a sickness or illness could not be cured. Sickness due to natural causes was generally treated with herbs and this was also the case with illnesses caused by ghosts. Black magic illness was not treated with herbs but with prayer, charms and a certain type of rituals (Bogesi 1948). In his Kia material he states that the sphere of magic, religion and disease is exactly the same in Kia as in Bugotu. He explains that in Kia, similarly to everywhere on the island of Isabel, spirits were blamed for many diseases whereas common conditions such as coughs, colds and common fevers were believed to be due to natural causes. (Bogesi 1950:32)

According to Bogesi (1950:28) ghosts, who were called *Nazahi,* were believed to be the souls of the dead whereas spirits, called *Mamadeuna,* were believed never to have adopted a human form. According to *kastom* religion it was ghosts or what can also be called ancestors, who were worshipped and prayed to. In this way there was never a universal religion for people in Zabana, but each clan had its own cult of various ghosts believed to have been ancestors of the clan in the distant past, and each family worshipped their own ancestral ghosts (Bogesi 1948:327). Ghosts and spirits where blamed for sickness, the black magic of people was conducted through the help of spirits or ghosts, and it was said that sickness caused by spirits was the most common and the worst way to die if one had been cursed in the name of an evil spirit (Bogesi 1948:328). Bennett (1987:18) states that although spirits and ghosts could cause misfortune independently, sorcery, where a person caused misfortune by the help of a spirit or a ghost (which is also known as black magic), was much more common. When discussing traditional beliefs before the arrival of missionaries with my informants they painted a similar picture, where spirits, ghosts and black magic were important components of disease but other, minor and generally non-life threatening conditions were understood to issue from natural causes. However if a disease for some reason could not be cured, meddling by ghosts, spirits or people with powers of black magic would always be to blame. This belief continues to some extent to day.

In order to stay healthy or restore health, prayers would be given to the ghosts. Such a prayer in Zabana language would be: *"O siakale gu, O barakale gu, O mana gini …."*, this

means O peace, defend and empower …. (the ill person's name). This prayer would be said in order to restore that person to health (Bogesi 1950:28). Prayers to the ghost could be used by itself or in combination with various treatments which will be discussed later in the chapter.

The attribution of supernatural causes, or spirits as the causes of illness is by no means exclusive to medical beliefs in Kia or in Solomon Islands. A study done by Murdock (1980) shows that out of 139 societies through out the world, only two did not believe spirits to be a involved in causing and treating illness. This can also be seen in Tonga where spirits were and still are a frequent part of explaining disease, both as punishing people for actions which are seen as wrong or inappropriate, but also just harming people on their own accord (MacGrath 1999:494).

According to Bennett (1987:18), sorcery or black magic was greatly feared in Solomon Islands. Bennett states that black magic worked as a form of social control by restraining the most exploitative members of a community by using the fear of sorcery to conform to the rules and norms of social life. Similarly the notion that a spirit or a ghost could punish you for doing something which was perceived as a challenge to the norms of society would keep the population in place. As previously mentioned, in this paradigm, only very rarely was illness attributed to what Bogesi (1948) call "natural causes" while most illnesses would be attributed to people wanting to inflict harm on the ill person or to spirits harming the ill person due to bad behaviour or a break of *tambu*.

In order to understand how people became ill, or tried to avoid illness, the concept of *tambu* is important. Similarly to McGrath's (1999:493) account from Tonga one must be sure not to break *tambu* in order to ensure health. White (1991) defines the term *tambu* according to its use in Maringe area of Santa Isabel, to be a prohibition, primarily of an area, but he also mentions prohibition of behaviour which is backed up by the threat of spirit or ancestral retribution. According to conversations with my informants I find this definition to be applicable also to Zabana. It is however important to mention that the word *tambu* today is also used in situations where it holds no spiritual meaning, such as if a child gets too close to the waters edge, or runs away from his mother, the mother will frequently use the word *tambu* to signify that it is not acceptable for the child to behave in that way. However, when I discuss the concept of *tambu* later in this chapter, I will concentrate on situations where it still holds some spiritual meaning, for example in cases of the transgression of either *tambu* areas or of zabana norms or *kastom*.

After the introduction of Christianity, beliefs involving spirits and ghosts were encouraged to be abandoned, but although Zabana people today have entirely embraced

Christian religion, certain aspects of their past still remain. White (1991:108) notes that after the arrival of the church, missionaries or priests would commonly attempt to remove the *tambu* of certain sacred areas by giving them a Christian blessing. However such blessings does not seem to be permanent or were not "fully granted" as White states, and many people still today avoid areas which are known to have been restricted due to *tambu*s. Similar attitudes can be found among Zabana people. The house, in which I slept by myself during periods of my fieldwork, was located close to a burial area. Several times during my stay I was asked if I was not worried to sleep in the house by myself. When I questioned why I should be worried, the proximity to the burial area was mentioned, which according to Zabana traditions commonly were *tambu* areas.

*Tambu*s on behaviour are also still present and one has to be careful of ones behaviour to prevent becoming ill. Today, behaviour which is disapproved is associated with current social and religious life and such *tambu*s are often associated with behaviour which is condemned by the church. An example of such unwanted or *tambued* behaviour is for a woman to become pregnant out of wedlock. Previously, women who ended up in this situation would be excluded from receiving the weekly Holy Communion in church, which nearly the whole village participates in and is very important to people in Kia. During my stay in Kia I observed that this was no longer frequently practiced. However, it is still not approved for an unmarried woman to fall pregnant and women and their families in this situation would feel ashamed and uneasy. A few months prior to my arrival in Kia a woman had become pregnant out of wedlock. The woman was worried about her pregnancy and felt as if she had done something wrong. A few months into the pregnancy she fell as she was walking in the bush and hurt her stomach. When she went to the clinic for a check-up, the nurse could not find the baby's heartbeat and told the woman that she had to go to the hospital to see if everything was alright with the baby. The woman was very worried and told me that she believed the reasons she was having problems with her baby was because she had not become pregnant in "the right way". Although she did not mention who or what was the causative agent in her misfortune it was clear that she believed that it was due to her poor behaviour and breaking of the churches *tambu*, that her unborn child might not survive and that she was being punished.

During my stay I was also able to observe how *tambu*s can be used and enforced actively by people and the church. In relation to a conservation project protecting certain marine areas it was decided that certain reefs were to become off-limit to fishing and collection of other marine resources. In order to enforce this it was decided to place the reefs

in question under a *tambu* which was blessed and thereby enforced by the church. When discussing the matter of these *tambu*s and how they work, I was told a story of a man who had been spear fishing in an area which was *tambu*ed by the church and during one of his fishing expeditions he had been attacked and nearly killed by a shark. It was claimed that the reason he had been attacked was because he had been breaking the *tambu*. The nature of the shark was also questioned as it might not have been a real shark but a spirit. In this way the practice of the *kastom* belief system becomes incorporated in the current day Christian discourse, and when this man broke the churches *tambu* he seemed to have lost the churches protection and was therefore at the mercy of malevolent spirits. The nature of spirits is also to some extent reinterpreted today to coincide with the belief in Christianity. During interviews and conversations in the village I found that spirits would often be associated with the devil which represents their incorporation into the Christian paradigm.

Although many of the *tambu*s are associated with the church there are also a number of *tambu*s which are not related to Christianity. One example of this group of *tambu*s is related to pregnancy. According to the pre-contact *kastom* paradigm there were a number of *tambu*s or prohibitions related to pregnancies which a woman had to adhere to. According to Morton (2002) this group of *tambu*s are related to "sympathetic magic" which means that the mothers actions will directly affect the unborn baby. Several times during my fieldwork I was given examples of *tambu*s for pregnant mothers. A pregnant woman should not wear necklaces during her pregnancy, if a woman wears a necklace, the baby's umbilical chord can wrap around the baby's neck in the same way and endanger the baby's life. My informants also expressed that it is not only the actions of a mother which affects the child but also her emotional and physical state. If the mother was cold, the baby would be cold, and if the mother was sad the baby was sad. It is also understood that the child will learn from everything the mother sees and does. Another *tambu* prohibited pregnant women from eating crabs. The hermit crab walks backwards and eating these can lead to the child moving backwards in the womb when it is time for it to be born. A woman should also never stand in the doorway when she is pregnant. She can move through it, but never stand in the middle because the baby will learn from the mother's behaviour and this can lead to the baby staying in the "doorway" during birth, and not coming out of the womb.

The *tambu*s of Zabana people are very similar to Laderman's (1987) descriptions of sympathetic magic in a Malay society. However in the Malay society the husband is viewed as equally connected to the child and must also be careful with his actions. In Kia the pregnancy and its associated *tambu*s is the mother's responsibility, but the precautions taken

are similar. Laderman (1987:295) states that similarly to Kia, a Malay husband must not sit in the doorway as this may close the entrance to the womb and wives are advised not to wear a scarf as this might cause the umbilical chord to wrap around the baby's throat and strangle it.

Previously these *tambu*s were very important to follow, however today they are not given so much attention. Several woman I talked to stated that people no longer believe in these *tambu*s. However when discussing these *tambu*s with women who were pregnant (the same women who early during my fieldwork had stated that they did not believe in the *tambu*s) they told me that they still preferred to avoid doing these things.

The breaking of *tambu*s is one way to become ill according to the *kastom* medical paradigm, and although the belief in these *tambu*s is no longer as strong as it was in previous times they are still present in the day to day lives of Zabana people. Next I will discuss another aspect of the *kastom* medical paradigm which still can be found in Zabana explanation of illness today, that is black magic.

Black magic is called *basa* in Zabana language and is an aspect of the pre-Christian belief system which at first glance might seem to have disappeared entirely from the lives of Zabana people, however when one becomes more familiar with the way of life in the area, traces of continued belief in and fear of black magic become visible. Some people have dismissed the idea of black magic entirely while others still consider it to be a possible threat.

From discussing the topic of black magic with my informants I received the impression that black magic is generally associated with areas and people outside or away from Zabana area. This corresponds with Bogesi's notes from 1950 who states that black magic was generally associated with other areas than Zabana, but could be purchased if one wanted to use it. Today it seems that the areas which are particularly known to have a high level of black magic are areas where people live in the bush and are considered less influenced by the church and more "heathen".

The association between black magic and areas considered to be more "heathen" might be part of the reason why, when discussing the topic of black magic a general reaction from the respondents was showing slight discomfort and laughing it away. People today are devout Christians and talking about the continued belief in practices associated with "heathen times" could therefore be uncomfortable. Another factor in explaining the discomfort was told to me by one of my informants who stated that people who were involved with black magic

were involved with the devil. As previously explained, during my interviews, people often associated spirits with the devil, thereby as a consequence, black magic which is believed to be performed through the power of spirits, will also be associated with the devil. In this way black magic becomes, similarly to spirits, incorporated into the paradigm of the church. People in Kia do not want to take part in or be associated with activities connected to the devil and are therefore uncomfortable in discussing it.

The continued existence of black magic in society became apparent as I was told several times, not of people who knew how to do black magic, but of people who knew how to reverse curses of black magic. Black magic is no longer as important and feared as it was before the arrival of Christianity and some Zabana people dismiss it completely. However, I found that there are certain cases where black magic will frequently be suspected such as in cases of grave misfortune or illness which does not seem to improve or react to any treatment.

Healers and healing practices

According to my informants there was a variety of ways in which one could treat an illness in pre-biomedical times. What treatments were sought and what treatment were administered would depend on the illness and what was believed to be the cause of the illness. The different types of healing techniques were herbal treatments, bone setting, massage, touch and prayers. There was a great variety of healers with different fields of specialization. Today there are still people in Kia with knowledge of all of these different healing techniques, however it seems that the healers today are to a lesser extent specialized within various sub-disciplines than healers in pre-Christian times.

Which healer was sought at a particular time would depend on the condition and previous experiences by oneself and ones friends and family. If this treatment was not successful, one would simply seek treatment form someone else. This approach to healing persists today and will be explored further in the next chapter.

McGrath (1999:491) explains that there are over 200 healers in Tonga today. Finding a number of healers in Kia would be impossible as the "healer" category is rather vague. Certain people with known powers and effective treatments tend to be called "*kastom man*" or "*kastom woman*". A *kastom man* or *woman*, which I will refer to as *kastom* practitioners are men and women who are perceived to have extensive knowledge of *kastom* healing processes. Although there are some exceptions, people in this category are also perceived to have a special power or *mana*, which make their healing abilities more effective. The concept of

mana will be discussed further below. In addition to this category of healers there is also a very large category of people who have some knowledge of treatments but to a lesser extent. People in this category would not be named *kastom* men and women but they still possess the knowledge of certain *kastom* medicines. In this setting where nearly everyone knows something about *kastom* healing it is difficult to distinguish who is a *kastom man* and who is "only" a man with some knowledge of *kastom* medicine.

The labelling of a *kastom man* or a *kastom woman* is related to the pan-Austronesian concept of *mana*. *Mana* is not originally a Zabana word but a word from the Bugotu language, however this word is used in Zabana language today. The word *mana* has been interpreted and defined by a variety of different writers. According to Keesing (1982:46) *mana* can be a noun whereby it refers to a spiritual power or influence, however Keesing argues that a more common use of the word in Austronesian languages is as stative verb whereby an ancestor "*mana-s*" someone or a person or an act is *mana.* In this case *mana* refers to efficacy (Hviding 1996:91). From his work on Isabel, White (1991:120) defines *mana* as personal or spiritual power, which refers to "the most potent form of activity and efficacy", however he continues by explaining that it is more like a state of mind than an actual power. Here I will define the term as it is being used in Kia. Bogesi (1948:327) defined *mana* as used in Bugotu as power or influence. Bogesi states that it is impersonal and beyond the power of a human being. A direct translation of the word *mana* in Kia also would also be power, the Zabana people themselves use the word power when translating *mana* into pijin or to English. However for Zabana people *mana* is something that can be possessed by a human to some extent, especially for *kastom* men or *kastom* women. In an interview with a Zabana woman about the word *mana* she explained that she understood it to mean the power to heal or the power to "look into" someone. According to interviews with my informants and my experience in Kia, *mana* was previously understood to be power from ancestors, but is today understood as a gift from God and is closely associated with healing. This is very similar to the understanding of *mana* in Tonga where *mana* can be understood to "allow the healer to act as a vessel for the healing power of god (McGrath 1999:493). A *kastom man* or a *kastom woman* in Kia is seen to have special *mana* which makes them especially equipped to find or cure certain illnesses. A person can have *mana* which makes him or her generally powerful in treating ailments or a person can have a type of *mana* which makes him or her especially powerful in treating one particular condition as will be shown below.

There are few accounts of how healers traditionally obtained their knowledge and their *mana*, but through discussion with elders in Kia it seems that the way knowledge and *mana* is

being passed on today has not changed to a great extent to the way it was before. The understanding of how knowledge and *mana* are passed on varies from healer to healer and from family to family. In certain families medical knowledge gets passed down through the women which coincides with this area of Solomon Islands being matrilineal where decent and inheritance of land and propriety is traced through the maternal line, and as can be viewed in the following example in some cases also knowledge. One lady explained how her knowledge was passed on from mothers to their daughters who again pass it on to their daughters. The knowledge could also be passed on to the sons, but the sons could not pass it on to their children as a sons children are not seen as being part of their fathers family, but as being a part of their mothers family. Although sons cannot pass the knowledge on she emphasized the importance of both sexes having the knowledge as both men and women get sick and in certain cases it would be *tambu* for a man to heal a woman or vice versa. This woman explained that the power could not be passed on to someone from outside the family because the treatments would not work. In other families both the sons and the daughters could learn it and pass it on.

For the woman mentioned above, the treatments and the *mana* for healing were seen as part of a whole and when passed on to the "wrong" people the treatments would lose their *mana* and they would no longer work. For other healers in Kia there is a distinction between herbal treatments, other treatments and the power that exists in a person. Certain treatments, especially herbal treatments, can be passed on and used by all people, these treatments are frequently used for the most common conditions which are also usually perceived to be due to natural causes, such as coughs, diahorreah, and cuts. In almost every family I interviewed there was someone who had one or more remedies for common conditions such as these. The herbs used were often the same in various households. In these cases the knowledge could often be taught for free, or the person with the knowledge would demand a sum of money in order to pass their knowledge on to someone from outside their family.

One *kastom man* that is well known in the village for being able to cure a multitude of conditions told me that his herbal treatments could be learnt by anyone who was willing to train with him, however this man has a special *mana* that allows him to "feel" or "see" what is wrong with a person and in that way make a diagnosis which ensures that they receive the right treatment. This *mana*, he explained, cannot be passed on to anyone even if he wanted to,. It is something embodied in him and him alone. As was common for most people in discussing *mana*, he explained the fact that he had such a strong *mana* as a gift from God.

While looking at medicinal plants outside the house of one of the *kastom* women in Kia I mentioned that she had many treatments. She answered "Yes, some are around me and some are in me", referring to not only having plants that could cure, but also possessing *mana* that would ensure the effect of her treatments. Possessing *mana*, this internal, personal ability to heal also seems important to Zabana people seeking health care. It is well known throughout the village which person has special abilities and what conditions they are especially good at healing. An interview with one of the *kastom* men in Kia exemplified the concept of *mana*, the transferring of power and the ability of certain people to cure certain conditions.

> There are four of us sitting inside the house of one of the *kastom* men in Kia. He has agreed to share some of his *kastom* knowledge with me. He explains how he has been given his knowledge and his *mana* from his family. The powers can only be passed on to children of his family and traditionally the knowledge and the *mana* is passed on through the daughters in his family because the family line follows the women, but the men can also learn. If anyone outside the family wants to learn they must pay. Before they had to pay *bulau, (*armrings), *bakiha*, (necklace), or other jewellery but today people pay with money. The man explains that to transfer the *mana* he must hold the persons hand, and it is important that he 'in his heart' wants to transfer *mana* to this person. Only when he really wants to will their *mana* become strong, but if a person from outside the family wants to learn a particular treatment their *mana* can never become as strong as for a person in the family. Some people have strong *mana* for certain diseases and this is well known in the village. He has many treatments, but he explains that he has especially strong *mana* to cure centipede bites, and many people have come to him for their treatment. A centipede bite is very painful, according to the man a person bitten by a centipede will be in terrible agony. To cure it he will use something sharp, before he would use a sharp shell from a shellfish, but today he uses a knife or an axe. You must hold the sharp item and make a cutting action against the area where the centipede bit without touching the skin. The man is making cutting action in the air while he is explaining. Then you must count one hundred cuts and for each cut you must think of cutting off each of the centipede's teeth, then you do the same while thinking of the centipede's eyes. He explains that these actions will remove the poison of the centipede and the patient will feel the poison go back to the bite site, then they will feel feverish and tired and fall asleep. When they wake up after sleeping they are cured.

Payment for the transferring of knowledge and *mana* to someone from outside ones own family is common in Kia, but demanding payment for the healing itself is not. A *kastom man* or *woman* who is approached by someone in need of their help will not charge anything for their services. According to Baer et al (2003:339) it is common for healers to adopt

entrepreneurial characteristics in the meeting with the world system where goods and services are exchanged for money. Using examples from the Kung tribe in Africa and the Washo Indians in the United States, they describe how healers in these tribes prosper financially by healing for profit. This practice has also been noted in the Pacific, for instance in Samoa where healers living in urban settings charge their patients high fees for their services (Macpherson 1990:108). A similar tendency has also been noted in Solomon Islands capital, Honiara. Although not yet commonplace, some have found the niche of *kastom* medicine a lucrative business, however not all are genuine *kastom* practitioners. In august of 2009 the national newspaper, Solomon Star (2009) reported that the police warned the public of a woman who claimed to be able to heal people in return of a hefty fee, however she was not a genuine *kastom woman* and none of her "patients" had been cured. This practice is not accepted among Zabana people.

In Kia, having knowledge or *mana* which enables a person to heal someone, is seen as a gift and should not be exploited. Using healing powers for economical or material gain is believed to result in a loss of *mana*. One account of such an incident was relayed to me through several different interviews, on each occasion the person telling the story displayed condemnation of such behaviour. While having tea and biscuits with one of my informants and several other women they told the story of a woman who had started charging her patients for making treatments for them. In the end she lost her power to heal and people did not go to see her any more. The women explained that if someone starts charging money, they will loose their patients trust and the patients would not go to this *kastom man* or *woman* any more. The understanding of a loss of *mana* if it is exploited for personal gain is not exclusive for Kia. A similar condemnation and loss of trust in a healer can bee seen in McGraths account of the healing practices in Tonga (1999:491) and in the MacPhersons' account from rural Samoa (1990:103). While it is unacceptable for a *kastom man* or *woman* to demand payment for their services it is quite common for the patients to bring something to them as a symbol of gratitude if the treatment was a success. While discussing this practice with the women mentioned above they emphasized that such a gift was not necessary but if the patient wanted to give a small gift, usually some type of food item such as some fish, vegetables or fruit this would be accepted by the healer and not viewed as payment. Money, however, would not be given in this situation. However, there is one exception. *Kastom* midwifes, who make up an important group of *kastom* practitioners in Solomon Islands are today being paid for some of their services. We will now turn our attention to the role of *kastom* midwives in Kia.

Kastom midwifes

Whereas in Papua New Guinea it seems that, having *kastom* midwifes, or traditional birth attendants was not practiced in pre-colonial times, and the woman in labour went into seclusion to give birth by herself (Denoon 1989) women in Solomon Islands enjoyed support from close female relatives and *kastom* midwifes. According to Zabana *kastom* of pre-colonial times, a woman would give birth in a small hut in the bush, away from the house. Simbo had a very similar ritual during child birth and according to Dureau (1998) it was the husband of the pregnant women's responsibility to build these huts in Simbo (Dureau, 1998:249). According to Bogesi (1950) this was the same in Kia. When the birth was close, the husband would go out into the bush and build a small house. The house was called *malau peka* or *malau rusa* which means that it was a place of avoidance, or it was called *sugana rekaha* which means a house for a child or a baby (Bogesi 1950:35). When the woman could feel that her labour started the women and the *kastom* midwife would go to this small hut in the bush. When the baby came out the *kastom* midwife would cut the umbilical chord with a piece of bamboo and stop the bleeding from the umbilical chord by using warm leaves.

According to one of my informants a woman would be perceived as unclean or polluted after birth and mother and baby would stay in the bush until the woman was considered cleaner and when the baby started becoming more responsive to its surroundings. During the woman's stay in the bush, new huts would be build, each a little closer to the village and she would move to a new hut 3 or 4 times during her exclusion from the village. They would stay in the bush until the baby started recognizing the people around it, responding to playing and started to laugh. This would usually happen when the baby was about 3-4 months old and only then would mother and baby be ready to come back to the house.

After the arrival of biomedical clinics it seems that in many areas of the Pacific the use of *kastom* midwifes has become less frequent and important (Morton 2002) However in Kia this is not the case. *Kastom* midwifes are an important group of the *kastom* medical practitioners and have become included in the biomedical clinic in Kia. They work with the nurses as a part of the clinic staff during birth and it has been decided that they should also receive pay for their work. They are however not paid by the government (like the other nurses) as their role at the clinic is not initiated by the government, but initiated locally by the nurses in Kia. They spend 3 full days or more with mother and child and are paid for their

services by the mother and her family. Their role surrounding births at the clinic will be further discussed in the next chapter.

The dual power of mana

Being a *kastom* practitioner, especially a *kastom* practitioner who is perceived to have a strong *mana,* can place the healer in an ambivalent position. With a powerful ability to heal, comes also an ability to do harm and associations to black magic. As Lambert (1946) describes, when biomedical doctors arrived in Solomon Islands in order to carry out vaccination campaigns, they experienced this ambivalence. "The needle", referring to the hypodermic needle which was used in vaccinations, quickly became well known for its effect as the various campaigns against diseases, which will be described in chapter 3, cured disabling endemic diseases like for example yaws. But as people recognized its effectiveness and thereby also its great *mana,* it also made them fear it. Lambert gives an example from Malaita where a man fell ill, who might not ever had been given any kind of treatment by a biomedical doctor and most probably died of a natural condition such as an heart attack. His tribes men blamed the "stick medicine" (the hypodermic needle) and wanted to take revenge. Sometimes these situations could be calmed down, but other times it ended in injuries and even bloodshed (Lambert 1946:300).

According to my experience in Kia, biomedical healthcare personnel today are not usually suspected of using black magic, but the *kastom* practitioners however can be victims of the association between healing powers and black magic. During my stay in Kia, one event highlighted the continued presence of black magic and the ambivalent role of *kastom* practitioners, when a *kastom man* with strong powers in the ability to heal stomach problems was accused by another man of black magic. Two of this man's relatives had died, and before they had passed away, both had complained of stomach related problems. The man therefore suspected this *kastom man* of having caused their deaths. In addition to being a *kastom man* another factor which might have increased the suspicions against this man is that he is not from Kia but from another island in the country where it is known that parts of the population are still living in the bush, which as previously explained, can be associated with being more "heathen".

When discussing this case with one of my informants he expressed great sympathy with the man who had been accused of black magic and was clearly not in agreement with the accusations. He said that the man behind the accusations and the mans father had believed in

the devil and in black magic, they had gone to church but clearly it had not been wholeheartedly. The matter became a public debate in the village and everyone seemed aware of the accusations of black magic. According to my informants most people did not believe the accusations and found them ridiculous, whereas others were somewhat suspicious and not sure what to believe. Finally the matter was raised in church. The priest addressed the question of black magic after service. He was angry and told everyone that the accusations were false and that this man had done nothing which could inflict harm on anyone, and if anyone had such suspicions they should not go around talking about it or trying to do something about it on their own, but rather come see the priest or the chief of the village. The church and the priest are also believed to have strong *mana* and few in the village would dare to go against the priest. After this the accusations died down and my informants explained that it was because the priest had said that it was not true, causing everyone to realize that the accusations were false.

This case shows the continued belief in aspects of the *kastom* religion associated with spirits and black magic. However it seems that by being associated to the devil these practices have been incorporated into and reinforced by the Christian paradigm, and although any practice which is associated with the devil is condemned by both people who consider themselves Christians and by the church, this integration makes room for its existence without disagreeing with church doctrine. This case also exhihibts the authority of the priest and exemplifies the notion that a priest is perceived to have strong *mana*. This shows another point of integration of *kastom* concepts into the Christian realm. A small number of priests are seen to be "extraordinary men of *mana*" and these are the ones who have used Christian rituals in order to remove sorcery and neutralize shrines and areas known to have malevolent spirits (White 1991:121). During my stay in Kia I was told of an instance where the priest, set out to eradicate black magic in the village. The following event was narrated during an evening of discussion where we happened to touch upon the topic of black magic.

> "A few weeks ago the priest started talking about black magic in church. He was angry and said that if any person in the village had any thing to do with black magic, anything that can hurt another man, they had to throw it out. If you do not do this you will become sick and your bodies will rot, but your minds will not die with your rotting bodies"

The people I was talking to were saying that they thought it was good that the priest discussed this in church, because if they had any black magic items they would definitely throw them

out because they did not want to become sick in this way. However they said that they did not understand why the priest suddenly began to talk about this. Who was performing black magic in Kia? They said that they did not believe that black magic was a big problem in Kia, but there had to be a reason for the priest to bring it up in church.

This shows that priests are believed to possess *mana,* which in some cases can counteract magic. It also reveals that the church can reinforce *kastom* beliefs such as in this case, black magic. The alignment of *kastom* practices and the current Christian paradigm will be further discussed in the next chapter.

The treatments

As previously explained there is a variety of ways in which to treat illness within the *kastom* medical paradigm in Kia. The healers also tend to mix various treatments together in their healing procedures. Firstly however I will examine how healers develop and find new treatments.

During an interview with one of the well known *kastom* men in Kia, I asked how one would find new treatments, either new treatments for old diseases or finding a treatment for a disease that had been recently introduced into the village. He explained to me that by using common sense he could find out what plants he should try and by using the method of trial and error he would find the right treatment for the condition in question. Several times I was able to observe that if one of the healers learned or heard of a new treatment, or simply had a hunch about something, he or she would try it on themselves or on someone close to them. The trial and error approach was, however, to my knowledge only attempted in situations where they themselves or the person they where trying it on were not severely sick, but maybe displaying symptoms indicating discomfort or light to moderate illness.

Similarly to McGraths (1999:491) account from Tonga, another way of finding new treatments is through dreams. Dreams are traditionally an important way of receiving information about the future and communicating with ancestors (Bogesi 1950:34). Although dreams no longer receive as much emphasis as in pre-colonial times, they are still important to Zabana people and are still often discussed and interpreted. A treatment can be revealed in a dream to the one who is sick or it can be revealed to the person performing the healing. During an interview a *kastom woman* of Kia told me a story of one such event.

> "I have a treatment for gonnoreah, but this treatment is not really mine. Somebody else found this treatment. Some time ago a young woman in Kia got gonnoreah. When she was sleeping, a woman came to her in a dream. It was an old *kastom* woman from Kia who had passed away. She told the young woman of a treatment for her sickness. The *kastom* woman told her that she should come and see me and I would know how to do this treatment. I was in Honiara at that time but the young woman waited one month for me to come back. When I returned the young woman came to see me and explained her dream to me. The young woman had not recognized the plant in the dream and she thought it was banana leaf, but I realized it must be *tegomo* and I treated her."

The most common treatment I observed was a mix of plant medicine and prayer. Previously the use of plant medicines would have been used in combination with prayers to the ancestors, however today the *kastom* men and women pray to the Christian god. No matter what treatment was employed, one would always have to pray first or go to the church and have the plant that was going to be used blessed. Bone setting, massage and various methods of touching the patient were also used (although to a lesser extent), and these were also performed in combination with prayer and often in combination with herbal treatments. While sitting with one of the *kastom* women in Kia, a mother came in with a coughing baby. That particular *kastom woman* was known for her ability to remove coughs and she showed me how to treat the cough by using a combination of plants and touch.

> While we are sitting in the main room of the house, a young woman comes in with her baby and asks if the kastom woman can do something about the baby's cough. The kastom woman explains to me that she will need to find 3 leaves from the *Baehai* plant in order to treat the baby. She goes out into her garden, fetches three leaves and comes back. The woman takes one of the leaves and heats it on the side of an oil lamp, with the baby in front of her she strokes the leaf two times from front to back on the right side of the baby's neck and one stroke on the left side. She then heats the leaf again and strokes it front to back, two times on the left side and one time on the right side. This is repeated with all three leaves. After this the woman blows her hands as if to blow away the sickness she just removed. She explains to me and the mother of the baby that this will have to be performed once a day for three days. She turns to me and explains that she can feel how sick the patient is through the leaf in her hands, if the leaf sticks to the patient she knows that the patient has an especially bad cough.

Another treatment that demonstrates the combination of prayer, plants and touch was explained to me by an elderly *kastom man*

> "Every plant I use must be blessed in the church" the man explains to me, "if not the treatment will not work". "If a man has stomach problems I need the leaves from three different plants to

> treat him. This treatment is not ingested", the man explains to me, as all of the other plant treatments he has previously explained to me must drunk by the patient. "This time the leaves must be heated and they must be stroked in a downward motion across the man's belly"

Although a variety of different treatments were often used, the most common mode of treatment was plant medicine. During my time in Kia I documented the use of more than 60 different plants for medicinal use, and I do not expect this to be even near a complete list of all the plants used for medicinal purposes in the area. Several of the plants had a multitude of uses, some could be used for more than 10 different conditions. Many of the plants could be used in a great variety of combinations with other plants in order to cure specific conditions. A few of the plants where very common and most people with the knowledge of *kastom* medicine knew one or more ways in which to use them. The repetitive use of the same plants for one condition within different families was often the case when dealing with common diseases that would have existed in Kia for a long time, for example conditions related to pregnancies. However, other plant treatments differed greatly and these were frequently treatments for conditions that would have arrived in Kia in recent times.

Conclusion

Illness is a universal phenomenon. It affects all human beings, no matter what culture they belong to or what time period they exist in. Accordingly, populations everywhere have developed different ways in which to interpret and deal with health, illness and healthcare.

In this chapter I have explored Zabana understanding of health and illness and the *kastom* medical system of Zabana with its healers and its treatments. While some of the pre-Christian practices have changed or disappeared, I have argued that a large part of the *kastom* medical system is still in use today, although sometimes reinterpreted in accordance with the introduction of the Christian paradigm.

Within the pre-contact medical paradigm, the religious and the medical realm were closely intertwined. As argued above, the current *kastom* medical system also incorporates religious practices, although today large parts of *kastom* religion of the past have been reinterpreted in the framework of Christianity. Although the focus of their beliefs has changed, the dual nature of the framework of *kastom* medicine remains, incorporating both natural and spiritual aspects into a single holistic understanding of health and healing.

In addition to *kastom* medicine, biomedicine is also an important part of healthcare in Kia. The combination and interaction of *kastom* medicine, biomedicine and Christianity will be further discussed in the next chapter.

3

-“It is all a gift from God”

Medical pluralism in Kia

Introduction

It is early afternoon and the sun is high in the sky. I have been out conducting an interview with a man in the village. It is still early and I have more people I would like to see today but for some reason I do not feel so good, so I start walking back to the house which I occupy by myself these days. Half way home I get a dizzy spell which nearly make me pass out. I sit down for a bit, wait for the dizziness to pass before I continue back to the house. When I get back I go straight to bed, hoping it will pass for the next day.

When I wake up I still feel awful, and can’t get out of bed, so I try to get some more sleep. I get woken up around midday by one of the young girls from the family which I usually spend most of my time with. Ali, the matriarch in the family, had become worried when I was not there for lunch. I told the young girl to excuse me, and to tell Ali that I was sick and could not come to the house today. The young girl left, but shortly after she returns with one of the boys from the family, with Ali and with another woman who is known as a *kastom woman* in the village. Ali had become very worried when she heard of my sickness and told me that the woman would use some *kastom* treatment on me to loosen the blood in the painful areas and get the sickness out of my body, and the woman starts massaging my neck and my back. While the woman is massaging me Ali distributes little containers of water to the young boy and girl and tells them to sprinkle some in every room and in every corner. I ask what it is and she explains that it is holy water, blessed by the priest. By sprinkling it in the house it will keep it safe, like a protection.

They leave me some food which they have brought and tell me to get some rest. I go back to bed and stay there until I, later in the afternoon, get another visit. It is one of the nurses from the clinic. She tells me that she had heard form Ali that I was sick and she wanted to check up on me. She has brought some antibiotics which she tells me to take and says that if that does not help I might also need to take medicines for malaria.

At the end of that day I realized that from my bed, I had been able to observe what I perceived to be three foundationally different bodies of knowledge and practice concerning healing; *kastom* massage, blessings from the Christian priest and biomedicine, being used in collaboration as the Zabana people attempted to help me recover from sickness.

The notion of dichotomies

In studies conducted on health in terms of medical pluralism a recurring dichotomy can be found, traditional medicine versus modern, old versus new or humanistic versus scientific, and these are often understood as opposing sets of ideas, knowledge and practices (McGrath 1999:484). In this thesis these two categories could be understood to be *kastom* and biomedical knowledge. Firstly, this dichotomization implies that the boundaries between the two approaches are well delineated (Stoner 1986:45), secondly it "conveys a sense of fixed timelessness" (McGrath 1999:484). In this chapter I will, by using my ethnographic material from Kia, show that the boundaries between *kastom* and biomedicine are not clearly delineated and argue that they do not fall into discrete categories. In addition I will show that medical traditions, such as biomedicine or *kastom* medicine are anything but fixed and constant categories, rather they are in a state of constant change.

When I first arrived in Kia I initially perceived a dichotomy between the *kastom* and biomedical traditions. *Kastom* medicine appeared to me as fundamentally different and separated from biomedicine. The distinction between the two medical systems seemed so clear that I did not question it at first. Biomedicine belonged in the clinic with the nurses, their needles and their medicines. *Kastom* treatment was not so easy to define due to the variety of treatment methods and healers but it nonetheless appeared to me as distinctively separate from biomedicine. During my first interviews, questions concerning Zabana people's preferred method of treating an illness, with *kastom* or clinic medicine, seemed appropriate. However, the answers I received did not provide any clear understanding of which was the preferred choice. Some answered that all people in Kia would always go to the clinic first, others explained that they would try *kastom* medicine before going to the clinic. Most, however, seemed dumbfounded by the question, not really understanding what I was asking. Early one morning in the beginning of my fieldwork I talked with a woman who explained to me that she had a very sore knee and that it was bothering her. I asked her whether she would prefer to use *kastom* treatments or clinic treatments in order to treat her ailment. The woman seemed confused by my question. She laughed and said she was not sure. She explained to me that a *kastom man* came down to her house, twice a day to treat her knee. I then assumed that *kastom* treatment was her preferred way of dealing with a painful knee and wondered why she had been confused by my question. A little later in the conversation I had to reconsider my initial assumption as the woman told me that one of the nurses from the clinic also had been by her house. He had been there five times to check her knee and give her medicines.

When discussing the use of clinic versus *kastom* medicine with the chief of Kia and his wife, the chief said; "Sometimes we use *kastom*, sometimes we go to the clinic." This statement sums up the impression I received from asking this question in Kia, simply that in some situations one would choose *kastom* whereas other times one would go to the clinic. The somewhat confused reactions to my question made me realize that the problem, creating this confusion when I asked about their preferred treatment, was not a lack of understanding due to a language barrier, but rather confusion created by the fact that my question did not make sense to them.

In the sphere of academia there exists a general understanding of traditional healing regiments (consisting of folk practitioners, lack of academies, academic training and state legitimation) as "diametrically opposed and in competition" to biomedicine, yet for the people who seek this kind of treatment this sharp distinction does not exist (Finkler 1994:179). Although Finkler (1994) in this case is comparing Mexican spiritualism with biomedicine I see her argument as applicable to the situation in Kia when she states that: "Unlike academians, who regard the two healing regiments as diametrically opposed and in competition, the people who seek treatment do not distinguish the profound epistemological differences between sacred healing, such as spiritualism, and biomedicine" (Finkler 1994:179).

Similarly to Finkler (1994) I found that the two healing regiments in Kia coexisted without conflicting with eachother, however, I found that their non-conflicting coexistence was not only experienced by the local people seeking healthcare, but also by the biomedically trained nurses at the clinic. Western biomedicine is an international, dominant and hegemonic medical system (Brown 1998:108). In many cases biomedical practitioners view their approach as superior to other forms of healing, as explained by Singer et al. (1988) who examined biomedicine and folk illness in Haiti and found that biomedically trained personnel scoffed at folk health beliefs. Despite these observations I found that this was not the case in Kia. I will mention however, that the attitude at the clinic in Kia is not necessarily representative for all of the Solomon Islands and later in this chapter I will show that in other areas the coexistence of *kastom* medicine and biomedicine is not so unproblematic.

Kastom medicine and biomedicine

In Kia, *kastom* medicine and biomedicine coexist and interact on several different levels within society.

On the individual level people constantly combine *kastom* medicine and biomedicine. Singer et al. (1988:381) states that at the level of people seeking treatment it is well known that these two bodies of knowledge and practice are integrated. An example of this can be given from Kia. An elderly man in Kia had been sick for a while with what both the nurses at the clinic and a *kastom man* had diagnosed as tuberculosis. The nurses had recommended that he go to the hospital in order to get treatment which he agreed to, but before he left for the hospital he went to see a *kastom man*. There he was given an herbal medicine which he was to drink every night. Afterwards he went to the hospital. At the hospital he was treated by a doctor, and quickly felt better but was advised to stay at the hospital for a while to make sure he was well. The man agreed, stayed at the hospital, but at the same time he sent one of his relatives to Kia to see the *kastom man* and retrieve more *kastom* medicine, which he soon recieved at the hospital. A while later the man was released from hospital.

When this story was told there was no emphasis on which of the treatments he received it was which cured the man, but rather that both were efficient treatments and both ensured the recuperation of the patient. It shows that on the individual practical level biomedicine and *kastom* medicine are integrated in the choices of healthcare available to the people.

On the professional level in Kia a similar pattern was observable. Zabana people experience and use treatments from the different systems of healthcare without distinguishing, or making clear boundaries between the two. This was a phenomenon which I also observed within the clinic. Although the first line of treatment at the clinic would usually be biomedical, they still did not dismiss, but rather accepted and even included the use of *kastom* medicine.

The acceptance of *kastom* medicine at the clinic was clear as often the patients spoke very openly to the nurses about the kinds of *kastom* medicines he or she had used, what had worked and what had not worked at all. There did not seem to be any judgement whatsoever from the nurses side and no shame or attempt to hide the use of *kastom* medicine from the side of the patients. All three of the nurses explained various *kastom* treatments to me, and they all expressed belief in the efficacy of certain treatments. In certain cases they even preferred the use of *kastom* medicine over biomedicine; during an interview, one of the nurses explained an illness called *Dadaru* in Zabana language, that she translated to oral thrush[20],

[20] Oral thrush is an infection of the mouth or throat, especially common in young children, caused by candida albicans. The condition is characterized by white patches on the tongue and other mucosal surfaces (Taber's Cyclopedic Medical Dictionary 1997:1949)

which is a very common condition in infants in Kia. She explained that they have biomedical medicine for this condition in the clinic, but it does not work very well. The parents are encouraged to try the clinic treatment but if it does not work they are recommended to use *kastom* medicine which the nurse stated was more efficient. She explained that she has a *kastom* treatment she recommends or she tells the parents to go and see a *kastom man* or woman to get rid of it. During an outbreak of chickenpox in the village the nurses also recommended the use of *kastom* medicine, as certain *kastom* medicines are believed to work very well in preventing the disease in developing further in the patient.

It is important to mention that the open attitude toward the use of *kastom* medicine both in the clinic and by the patients in Kia has not always existed. One of the nurses at the clinic told me that a few years ago an older woman had worked at the clinic. She was strictly against the use of *kastom* medicines and according to the nurses who are working there today, she would get angry if she found out that anyone was using it. She claimed that using *kastom* medicine was dangerous and that it would make an illness worse because there were no guidelines to define proper dosage or the correct times to be administering the medicine.

An important factor which influences attitudes towards *kastom* medicine is age. Today all the nurses working at the clinic are under the age of 40 and they all seemed to have an open attitude towards *kastom* medicine. The nurse who did not accept the use of *kastom* medicine was older and had now stopped working as a nurse. During an interview with the youngest nurse at the clinic he explained that previously the nurses were taught not to accept the use of *kastom* medicine. However, during his training his teachers had encouraged the students to cooperate both with *kastom* men and women and also with the church, but that they should also use common sense and not let anybody do things that could lead to infection or in any way put the patient in danger. I believe that a factor that has influenced this change in the education of healthcare practitioners is the Solomon Islands government official acceptance of the use of *kastom* medicine in 1979 (WHO 2009). If this is correct, then nurses who received their training after the official acceptance of *kastom* medicines would have received training which was more open towards their use. This law will be further discussed later in this chapter

The coexistence and interaction between *kastom* medicine and biomedicine can also be seen from the perspective of *kastom* medical practitioners. Singer at al (1988:381) argues that the integration of indigenous and modern medicine is common at the level of folk healers. This pattern could also bee seen in Kia. The wife of the *kastom man* described in the previous chapter who has the ability to “feel” what is wrong with a patient and thereby diagnose him or

her, explained her husbands attitude towards biomedicine. This *kastom man* collaborates with a biomedical doctor in Honiara. After having diagnosed the patient the *kastom man* will prepare *kastom* medicine for the patient before recommending that they go to the doctor, clinic or hospital, depending on what he believes to be wrong with the patient. The doctor himself recommends that patients from Kia initially go see this *kastom man* before they decide to come and see him in Honiara. According to the woman, the doctor has said that from experience he knows that the *kastom man*'s diagnoses are nearly always correct, and in cases where other doctors have not been able to identify the problem, or misdiagnosed a patient, this man's diagnosis has been correct.

During my stay in Kia I experienced a case which illustrates the incorporation of *kastom* medicine and biomedicine by nurses, *kastom* practitioners and patients. As shown in chapter 2, *kastom* midwifes used to be important *kastom* practitioners for the people of Solomon Islands. However, after the arrival of biomedical clinics, it seems that in many areas of the Pacific use of *kastom* midwifes has become less frequent and less important (Morton 2002). In Kia this is not the case. The use of *kastom* midwifes is accepted, encouraged and even included with biomedical practises at the clinic in Kia.

Since 2006 the clinic, in collaboration with a *kastom* midwife have initiated a project in which a *kastom* midwife is present at nearly every birth at the clinic. There is one main *kastom* midwife who works closely with the nurses during births, however if she is not available they have an agreement with another *kastom* midwife who will come to help. The *kastom* midwife palpates the stomach of the pregnant mother and estimates how far from delivery the mother is. She also gives the woman *kastom* medicine to ensure a safe and quick birth. The delivery itself is performed by the nurses, but as soon as the baby is out the *kastom* midwife takes over, administering *kastom* medicines to both mother and baby.

Usually the mother and the baby will return home only hours after the birth, however the continued use of a *kastom* midwife in the days after the birth is encouraged by the nurses. Throughout a woman's pregnancy they encourage the woman and her family to save 100 SBD[21]. This is the price they are expected to pay the *kastom* midwife for her help during the birth and for having her stay with the mother and the baby, helping out with the baby and making sure that both mother and baby are ok for about 3-4 days after the birth.

During my time in Kia almost all the pregnant mothers took advantage of this opportunity and one of the nurses explained that ever since they started this work in 2006 very

[21] The equivalent of 74 NOK or 8,5 EUR in 2008

few women had declined the opportunity to receive help from a *kastom* midwife. While discussing the use of *kastom* midwifes with one nurse, she explained to me that in Kia they have three ways of assisting a woman in labour; firstly the use of nurses and medicine from the clinic, secondly the use of the *kastom* midwifes and thirdly in cases of difficult births they could call for the priest who would come and pray for the safe delivery of the baby. This reveals another important aspect of healing in Kia where religion is an important part of healthcare. The inclusion of religion in healthcare will be discussed later in this chapter.

The incorporation of *kastom* medical practices at the biomedical clinic exemplify the pluralistic medical setting in Kia where the two bodies of medical knowledge and practice are not seen as opposing each other but are rather incorporated into a whole by both patients, *kastom* practitioners and biomedical nurses alike. The cases discussed here support the idea, that in practice, *kastom* medicine and biomedicine coexist and interact without significant conflict. This not only applies to the local population or what Finkler (1994) has termed "treatment seeking people" but applies also to the health practitioners of *kastom* medicine and biomedical healthcare workers in the village.

I have now shown how *kastom* medicine and biomedicine are intricately intertwined and used together in the practice of healthcare in day to day life in Kia, however the conglomeration of *kastom* medicine and biomedicine does not only happen on the practical level. Through conversations and interviews I realized that this mix also occurs on an ideological level.

People in Kia do not perceive the sharp distinction between biomedicine and *kastom* medicine as is often understood within the academic community[22]. To them they are perceived as part of a whole. The nature of the relationship between biomedicine, *kastom* medicine and also to Christianity was explained to me during an interview with an important man in Kia, who outlined the holistic understanding of the various healthcare options available to Zabana people.

> "In Solomon Islands we have three types of treatments. There is western medicine (biomedicine) with doctors and nurses, there is *kastom* medicine with *kastom* men and women and then we have Christianity with God and the priests. The plants and the medicine and Christianity, it is all a gift from the Big Man (God)

[22] See Finkler (1994:179)

Although the man in this case separates between the three types of treatments he emphasizes the fact that they are all parts of a whole as they all come from the same source, which is God.

The nurses in Kia also expressed this attitude, in which biomedicine, *kastom* medicine and religion were seen as integral parts of their modes of healing; one nurse explained to me that at the clinic they had three ways of healing; biomedical treatments, *kastom* treatments and prayer.

As shown in the previous chapter, religion is deeply embedded in the *kastom* medical system, and as shown in the statements above religion is also associated with the biomedical sphere of treatment. In several interviews and conversations with informants religion was mentioned as an important and integral part of healthcare in general. In the next section I will examine religion within the healthcare discourse of Kia.

Religion's position in healthcare in Kia

Christianity is the main religion of Solomon Islands. 92 % of the population is estimated to be associated with one of the Christian denominations in the country (RIRFSI 2008). As shown from the statements above, healing is perceived as closely related to Christianity by both Zabana people and the healthcare personnel in the village. Therefore when examining health and healing in Solomon Islands, Christianity must also be considered.

As shown in chapter 2, according to Zabana people's ancestral traditions, *kastom* healing was traditionally intertwined with *kastom* beliefs, in which a belief in spirits and ghosts formed an important part (Bogesi 1950). Although today, the focus on *kastom* beliefs is minimal in relation to *kastom* medicine, the perceived power of *kastom* medicine was nevertheless previously derived from what the church has defined as heathen or *kastom* belief. In this context Christianity and *kastom* medicine might seem contradictory, however for Zabana people, and the church their relationship is not experienced in that way. Here I will show how *kastom* medicine and Christian practice are combined by Zabana people.

Christianity is often combined with healthcare practices in Kia. When discussing healing and the use of *kastom* treatments with *kastom* men and women in Kia, the importance of Christian faith was frequently emphasized. One *kastom woman* explained to me that while using any one of her *kastom* treatments she had to pray if they were to have any effect. She would always pray to the Father, the Son and to the Holy Spirit. She openly explained to me that previously one would have prayed to spirits, ancestors or ghosts, whereas today one must

pray to the Christian God. Another woman explained that before using any plants in medicines she would always go to the church and have them blessed by the priest. In this way the church is actively used in order to ensure the effect of the medicines.

On an ideological level it seems that the church does not perceive a conflict to exist between Christianity and *kastom* medicine. This can be seen from an example of one of the men in the church. This man has an important role within the church organization in Kia, and conducts church related work nearly every day. At the same time he is a well known *kastom man*. He has a wide range of treatments and as I passed by his house I would often see him giving *kastom* treatment, either in the form of herbal medicine or in the form of massage, to patients.

In Solomon Islands, Christianity has historically been closely related to biomedicine. As will be discussed later in this chapter, Christianity and biomedicine were introduced together, and for this reason the Solomon Islanders have always experienced a close connection to exist between them.

A pragmatic approach to illness

As shown above Zabana people have an inclusive and holistic understanding of healing which means that their decision-making related to treatment is not based on the *kastom* versus biomedicine dichotomy. Instead I argue that the primary value in the decision-making process is the utility of the approach. This approach is not always present within medically pluralistic societies. Medically pluralistic societies where ones choice of treatment is much more restricted have been described by Brodwin (1996) and MacLaren (2006). Brodwin describes medical pluralism in rural Haiti. Here the various healing practises are closely related to religions such as the Catholic Church, the Pentecostal Church and voodoo faith. But here, choosing one kind of healing over another has its implications. As Brodwin (1996:199) states it: “People must constantly choose which gods to worship, and which forms of healing power and moral legitimating to accept, and they know the practical consequences of embracing one over the other.”

Also within Solomon Islands there are examples of contrasting approaches towards seeking healthcare. Kwaio people of Malaita, who retain their ancestral culture and religion, must choose between seeking medical treatment at the Adventist hospital which is close to them, or remain true to their traditional Kwaio beliefs and stay away (MacLaren 2006).

According to MacLaren many sacrifice their opportunity to have wider range of healthcare options and choose the latter option.

In these two cases the oppositions existing between the various healthcare options and their associated religions become determining factors in the choice of what treatment to seek. In these cases the different bodies of practice and knowledge concerning health contradict each other, and by choosing one, the validity of the other is necessarily diminished. This is not the case in Kia where Christianity, biomedicine and *kastom* medicine have been incorporated by the local population into a single holistic understanding of healing. To them the primary concern is the utility of the approach - cultural and religious concerns are secondary.

Choosing ones mode of treatment

I argue that the nature of the treatment alone, it being *kastom* medicine or biomedicine, does not determine a patients choice in the process of seeking healthcare in Kia, and that people are free to choose what they see as best in their particular situation. Here I will examine some factors I found to be important to Zabana people when seeking healthcare.

Based on interviews and conversations with Zabana people, one of the main determining factors in their choice of treatment was the proximity of care. Living far away from the clinic increased the likelihood of a person first using *kastom* treatments in order to cure illness. “For my family kastom medicine will always be our first option, we will wait to go to the clinic, the clinic is too far away.” This was stated by a woman living on the opposite side of the village from the clinic, but living very close to a well respected *kastom man*. To her, the clinic was too far away when *kastom* medicine was available nearby. Her statement shows that she does not exclude clinic medicine, but because it is further away *kastom* medicine is her first option. However, she stated that if the *kastom* treatment did not work she would make the effort and go to the clinic to seek treatment. This response was very frequent when I asked people what treatment they would seek. When I interviewed people who lived close to the clinic they more often named the clinic as their first option for healthcare.

When I interviewed people who lived outside the village they almost always answered that they would try *kastom* medicine first, and only if the condition did not go away or became worse would they go to the clinic. A woman living only a few minutes walk from the clinic explained that she would try to go to the clinic first if she was sick and then try *kastom* treatment if she was not cured. She continued by explaining that if she was far away from the

clinic, like at Mamafara[23], she would try *kastom* medicine first and then go to the clinic if she did not get better.

In a quantitative study on villagers' responses to illness in Roviana, Western Province, Slomon Islands, Furusawa (2006) recognized that the presence of a nurse was one of the factors affecting the use of *kastom* medicine. In the village where the study was conducted there was not always a nurse present, but when a nurse was there this resulted in a negative effect for the use of *kastom* medicine. In Kia there is always one or more nurses present, however the clinic experienced a frequent lack of medicines. Several times during my stay the clinic ran out of medicines. When this was known in the village it had a negative effect on the use of the clinic and a positive effect on the use of *kastom* medicine. During an interview with two women in the village they explained to me that they never go to the clinic unless they know that the clinic has medicines, and that they preferred to use *kastom* medicines. In periods where the clinic was out of medicines the nurses recommended the use of *kastom* treatment more often which as I will argue in the next chapter, resulted in an increased use of *kastom* medicines in these periods. The proximity of care and lack of medicine at the clinic are aspects of healthcare in rural Solomon Islands which will be further explored in the next chapter.

Severity of illness is also a factor affecting the choice of healthcare. In Kia I found that in many cases of mild illness no treatment or *kastom* treatment was the preferred choice. However if the illness was perceived as severe a nurse would immediately be contacted. In his study Furusawa (2006) also found that the perceived severity of an illness affected the choice of treatment. Biomedicine was used more frequently and *kastom* medicine was used less frequently for treatment of cases of illness that was perceived as severe, coinciding with what I found in Kia. It was interesting to note however, that if a patient was terminally ill or if a patient suffered from a chronic condition, *kastom* treatment would be preferred.

A factor I experienced as being very important to Zabana people's choice of treatments was the understanding that different illnesses required different treatments. Furusawa (2006) found that in Roviana, certain illnesses called for certain treatments from certain domains. In cases of headache, fever, cough and rhinitis, biomedicine was preferred, while for skin disorders and wounds, *kastom* medicine was preferred. For abdominal problems either biomedicine or *kastom* medicine was used. Although I did not find village wide consensus of which illnesses belonged to the *kastom* or biomedical category as seen in

[23] A settlement outside the village

Furusawa's study, I did find however, that on the household level there was a clear understanding of which illnesses required certain types of treatment.

In his article Furusawa makes generalizations for the village based on individuals. Having the individual as a unit of analysis is common in biomedicine, in social science however a larger unit of analysis such as family or household is more common (Brown 1998). I found that in Kia the household would be the most useful unit of analysis as decisions concerning health, particularly in the case of severe illness were made by the household and close family rather than on an individual level.

During an interview with a woman in the village she explained to me that if she or someone in her family knew that a certain condition could be cured by a certain *kastom* treatment administered by a certain *kastom man*, then she would seek treatment with that individual. She explained to me that this knowledge would either come from previous personal experience with that illness, or through another's experience with that illness. This highlights the notion that *kastom* medicine is a dynamic body of knowledge, and unlike the strictly regulated methods of biomedical practise, *kastom* individuals exhibit more flexibility in their methods and efficiency of treating certain illnesses. In other words, although biomedical practitioners can develop a reputation for efficiency in diagnosis and communication, their methods of treatment once a diagnosis has been reached are restricted by guidelines and in the case of Kia, limited medical resources.

However, the reputed efficiency of *kastom* practitioners is not the only factor that influences a patient's decision concerning which method of treatment they will pursue. Other factors, including proximity of care, severity of illness, and availability of medicines also play a role. An example of this is a *kastom woman* in Kia who is known for having a very good treatment for coughing babies. Before a woman goes to the clinic with her baby she will often see the *kastom woman* first, but not always. The choices of healing approaches are variable and different individuals may choose different treatment options for the same illness. The same individual will also change approaches depending on the circumstances relating to the factors mentioned above. It is also important to mention that the process of treatment is not always organized hierarchically, but as the introduction to this chapter, describing my own illness shows, different approaches to healing will frequently be employed at the same time.

McGrath (1999:483) has described healing practices in Tonga and she claims that illness in Tonga is approached in a pragmatic manner. I argue that the people of Solomon Islands have the same approach. If a person becomes sick he or she will try different

treatments, biomedical, traditional and religious, until a cure is found.[24] There is no one medical system that can give all the answers when it comes to illness and health. Some treatments work on certain occasions and not on others. When faced with an illness which one method is not able to cure, a person will look elsewhere in the search of a solution. After the introduction of biomedicine in Kia, the village's population has received a wider range of treatment options to choose from, but the decision of what treatment to use is not based solely on the origin or nature of the treatment, whether it is from the biomedical realm, the sphere of *kastom* knowledge, or what religion it is associated with. Treatment is chosen on the basis of what is most effective and useful in that particular case. Like in Tonga, "Individuals and families try all available therapies, both traditional and biomedical, until one works" (McGrath 1999:483), or as stated by Finkler (1994:179) "In the search of the alleviation of pain, pragmatism prevails"

However, I will mention that aspects related to the religion, or simply the origins associated with the different healthcare options are not always entirely excluded from the process of decision-making for everyone in Kia, although I did not observe this during my stay. A woman interviewed in the village stated that a recently deceased woman in Kia had never been to the clinic apart from the birth of her 2 last children. This woman had said that she did not see the use of biomedicine and relied instead solely on *kastom* medicine. Despite not believing in biomedicine the woman was a devout Christian. In this case I believe however that the changing generations plays a role as this woman was very old and grew up in a time when biomedical healthcare was not an option and she was therefore unaccustomed to biomedicine. Although I acknowledge that certain religious or the perceived origin of the treatment are factors can play a role in the process of choosing treatment I believe that the primary cause in decision-making is perceived utility.

Reasons for Zabana people's pragmatic approach to healing

As shown I argue that Zabana people do not perceive sharp boundaries to exist between their available treatment options, but rather view them as part of a whole, and to a large extent this is the case among the lay population, the clinic, and the church. My hypothesis is that part of the reason for the development of medical pluralism found in Kia can be derived from history;

[24] This is not a trend unique to Solomon Islands, also in the west this approach is used where the amount of so called "alternative healers" are as well represented as biomedical doctors.

in particular they way in which Christianity and biomedicine were simultaneously introduced to Kia.

Christianity and biomedicine arrived together

In most rural areas of Solomon Islands their first experiences with biomedicine were introduced through missionaries arriving in their villages who usually brought a small amount of medicines with them wherever they went (Bennett 1987). The populations' first experiences of biomedicine occurred when missionaries arrived in their villages. The missionaries brought medicines to the villages and it was in this way Christianity and biomedicine arrived together in the Solomon Island and was perceived to be parts of a whole. The Christian priests were also often trained physicians, such as Henry Welchman, an Anglican priest and trained physician who spent a great deal of time in the Bugotu area of Isabel and also travelled around the island spreading the word of the Lord, while at the same time administering injections to the people (White 1991:253).

The weakening of kastom beliefs

During the initial stages of Christianisation there seems to have been a weakening of belief in *kastom* knowledge and practice. One might easily assume that the weakening of belief in *kastom* was a direct consequence of Christianity's arrival, however my hypothesis is that faith in *kastom* religion and practice was only weakened <u>indirectly</u> by the arrival of Christianity, due to the diseases introduced by the missionaries and other foreigners in the islands.

As shown in chapter 1, when the first major wave of foreigners started arriving in Solomon Islands they brought with them a wide range of diseases new to the area. The local population had no immunities against these diseases and their *kastom* medicines had little, if any, effect. Although people also previously succumbed to various illnesses, after the arrival of foreigners this began to occur on a much larger scale. This could have resulted in a weakened belief in *kastom* medicine. Religious beliefs were as previously explained, intricately intertwined with medicine and notions of health and healing. Several times during my fieldwork was I reminded that all medicines, both *kastom* and biomedicine, were gifts from god. The one could not be separated from the other and therefore it is likely that traditional religion would also have experienced a loss in power when the traditional ways of healing no longer appeared to work.

The local belief system was also weakened as large numbers of white men began to arrive in Solomon Islands. The white men, not knowing of, not understanding or quite often not bothered by the local customs and religion, repeatedly broke *tambu*s which Solomon Islanders were sure would lead to misfortune and death (Bennett 1987:115). Sorcery did not affect them either. The most powerful sorcerer could use his most powerful magic, but even the strongest black magic did not affect the white men. The high mortality, limited efficacy of local medicine and the inefficacy of traditionally dangerous and mortal powers most likely played a part in the Christianisation of Solomon Islands. However, as will be shown, although belief in *kastom* might have been weakened this does not mean that it was entirely left behind. Bennett (1987:115) emphasises the fact that although local belief systems could not explain these events, many people from the older generations continued to adhere to old ways, while it was more often the younger generations who started finding new answers within the realm of Christianity.

Conforming to Christianity did not only happen as young people were searching for answers. It also happened for practical reasons. Conforming to Christianity would ensure access to missionary schools. Already in the late 1800s and early 1900s, Solomon Islanders began to develop a desire to learn how to read and write (Bennett 1987:258). Some hoped to find the source of European wealth and power while others followed the growing trend of conformity, wanting to see if the new ways had anything to offer (Bennett 1987:336,337). As will be shown next, medical aid was another attraction of Christianity (Bennett 1987:337) and formed an important part of the Christianisation of Solomon Islands.

Biomedicine reinforced Christianity

The early missionaries brought some medicines with them, however before the arrival of antibiotics and other bacteria-inhibiting drugs their range of medicines were limited to certain diseases (Bennett 1987:98). According to Bennett (1987:177) some of the medicines used were often the traditional European remedies of this time such as the use of Epsom salt and castor oil to treat ailments such as dysentery. None of these treatments would have had much effect on the local health situation. However there were other medicines in circulation with much greater effects. One of the drugs used in this early era of foreign arrival in Solomon

Islands was quinine[25], which was used to treat malaria with great efficacy. As previously explained malaria was endemic in the Melanesian region and an ailment causing much suffering, especially for infants and children. The malaria treating drug has an important place in the tales of how Santa Isabel was Christianized. In Santa Isabel the mission strategy of converting people through their chief worked particularly well as some of the chiefs with whom missionaries engaged were renowned and had much of the power. If those chiefs were converted their relatives and followers would follow (White 1991:92). The following story is of the influential chief Soga who according to Wilson (1932:228,229) was a remarkable man and was recognized as the paramount chief[26] of Isabel and the role of quinine in his conversion to Christianity.

> Soga became ill, whereupon he moved at once to a small island to get out of reach of the malicious tidalo[27]. The Bishop, hearing of his illness, went off to see him, and suggested the further remedy of quinine and brandy. Soga was quite willing to give the white man's power a chance, so the Bishop mixed and tasted it, followed by the others in attendance, which must have made inroads on the bottles, and finally the dose reached and was swallowed by the royal patient. Then the Bishop knelt down and prayed that the medicine might be blessed, and the prayer was answered. The result was most happy: Soga, in his gratitude, not only sent a canoe full of presents to the Bishop, but gave permission for a school to be started, and from that time was a firm friend to the mission. He began to attend school and set himself to learn to read and write, not satisfied until he could do both really well; put away all his wives save one, and in 1889 was baptized with his wife and seventy of his people.
>
> (Wilson 1911:102, 103)

This exemplifies the importance of medicine in the process of converting Solomon Islanders to Christianity. As seen in the previous chapter, according to the local belief system, *kastom* medicines were inseparable from *kastom* religion and the belief in ancestors, spirits and ghosts. According to the local paradigm of healing it was the power of their ancestors, spirits or ghosts, and their connection with them which ensured the efficacy of their medicines. In this way it would have seemed coherent that the powerful medicine of the white men signified the strength of their God, which in effect affirmed the Christian faith. This occurred because Christianity was introduced simultaneously alongside efficacious

[25] During the 300 years between its introduction into Western medicine and World War I, quinine was the only effective remedy for malaria (Encyclopædia Britannica).
[26] A paramount chief is a chief with island wide influences, however it is not an indigenous Isabel practise. It this case it is a product of missionary and colonial influences. (White 1991:1,2)
[27] Ancestor spirit (White 1991:103)

biomedical techniques and medicines. While discussing Welshman's role as both priest and doctor White (1991:253) suggests that although Welshman himself might have preferred to focus only on the word of the lord, his ability to heal must have had a confirming effect on the local perception of his personal spiritual power, and I assume that it would also have confirmed the power of the Christian God. There are several examples of this, especially after the arrival of antibiotics and vaccinations.

In the late 1920s the Rockefeller Foundations medical team started a campaign against hookworm and yaws (Bennett 1987:210). Throughout the 1920s and 30s the native practitioners, the campaign officer Gordon White and a range of missionaries administered thousands of injections throughout the country to eradicate yaws and hookworm (Bennett 1987:277). Yaws was an extremely painful and disfiguring disease and the yaws injections were extremely efficient, only one injection could cure the disease (Bennett 1987:277). Health improved dramatically and word of the new, powerful medicine travelled fast. According to Black (1956) the treatment of both malaria and yaws was so effective that it advertised itself. Traditionally these diseases where seen as a manifestation of some sort of black magic. Black (1958:141) states that in areas where quinine was administered it was soon known that quinine was an efficient form of counter-magic. The treatments were usually administered at a church or a mission station and thereby while receiving treatment they also learned about the Christian God who no doubt must be very powerful in order to treat such disabling, "black magic" diseases so quickly

The power of western medicine in converting the natives to Christianity and the possibility of using it as a form of public control did not go unnoticed by the European government. They recognized medicine as a tool in strengthening the governments control over the people. As previously shown the treatment for yaws was very effective and word usually spread quickly of its effects so most people needed little encouragement to come and receive treatment. Lambert (1928:368) explains how in Malaita the district officer and his assistant were killed in 1927. Lambert states that while the old response to such actions would have been a punitive expedition whereby, in the hope of setting an example, innocent people would have been slaughtered while the perpetrators most likely would have escaped. He states that in this case however, the responsible men were arrested and given a fair trial at the seat of government and four months later the government sent two units to Malaita to treat yaws and hookworm, in the hope that the news of these new medicines would spread and the savages from the inland finally, after many years resistance, would come down from the bush and be "pacified and civilized by the humble hypodermic and medicine measure". Keesing (1992)

however presents a different version of Lambert's "fair trial" where he tells of a communal outrage among all the Europeans in Solomon Islands at the time, whereupon European planters, mostly Australians, volunteered to take part in a punitive expedition which became known as the "Breathless Army". Keesing explains that a few men were brought down to the coast and arrested but up in the bush there were massive killings of men, both guilty and innocent and also women and children.[28]

Although biomedicine was seen as a powerful kind of treatment it did not become a replacement for the use of *kastom* medicine. One reason for this is simply because there was no steady supply of biomedicine. In Kia, although they would have had infrequent access to some biomedicine, its introduction was slow. As mentioned in chapter one, the first clinic in Kia was established around 1950. Before that time their access to biomedical medicines was in the hands of the ships passing through, possibly supplying the church or the school with some medicines, or in the hands of the very sporadic arrivals of the medical ship *MV Hygeia* or vaccination groups as discussed in the previous section. Overall their access to alternatives to their own *kastom* medicines must have been at best sporadic. After the arrival of the clinic the supply of western medicines would have been somewhat more reliable but the presence of a wide range of treatments is unlikely. According to the elders interviewed in Kia what they perceived to be most important function of the clinic was that the women no longer needed to go out into the bush to give birth.

Another example of limited availability of medicines was explained to me by some of the older women in the village. During an interview they explained that they did not know about the mosquito causing malaria until after their children had been born, around the end of the 1970s, at least 20 years after the arrival of the clinic. This indicates a very gradual introduction of biomedicine into Kia. The gradual introduction of biomedicine meant that Zabana people did not suddenly stop using or forget the *kastom* healing techniques as they were still in the need of medical aid. In this way the biomedical treatments introduced in Kia became an addition, not a replacement for the treatments already in place.

[28] Lambert was the Deputy Central Medical Authority of the Western Pacific High Commission in 1928 as he wrote of this incidence in "The medical journal of Australia". And after reading his somewhat understated narrative of the incidents in Malaita in 1927 one may be inclined to believe that the punitive actions initiated in Solomon Islands were to some extent covered up by the colonial power.

The conglomeration of Christian practises and kastom ways.

The churches approach in converting the local population has also influenced the development of the healthcare available in Kia today. In their efforts to convert the local population priests, catechists and missionaries recognized traditional practices and promoted the use of a Christian equivalent (White 1991:113). The Christians would use prayers, hymns and blessings to replace or supplement the traditional healing where spirits would be summoned to ensure the good health of the patient. As seen previously in this chapter, the use of a priest, prayers and blessed holy water as a supplement both to biomedicine and *kastom* medicine are still widely used in Kia today. When providing a Christian counterpart to the *kastom* rituals of the native population the European missionaries tended to see them as a replacement or a substitution for what was there before, however for the local population the use of the Christian paradigm did not necessarily exclude the *kastom* ways, therefore to them the Christian rituals became an addition rather than a replacement. In this way the *kastom* ways were changed and modified in order to conform better with the newly introduced Christian religion, but at the same time, aspects of Christianity were transformed in order to deal with aspects of *kastom* such as fear of ghosts and spirits in the shape of protective rituals.

Around the turn of the century Christianity began to find its foothold in the region around Kia. Wilson (1911:113) explains that Christianity initially was introduced by a woman from Bugotu who had fallen in love with the son of the chief of Kia. After moving to Kia she managed to convince her father in law to set up a school near the village in 1904[29]. In 1907 Dr Welchman arrived to inspect the school and found it to be satisfactory and consequently accepted nine candidates for baptism. However, he stipulated one condition. Dr Welshman demanded that they destroyed the most sacred place nearby as proof of their loyalty to the church.

> The heads were all collected and heaped in the middle of the ridge, while the axemen cut firewood. Then came the work on the tombs. Here there was a hesitation, for it is not a pretty matter nor a trifling one for a man to desecrate the tomb of his ancestor. And this one was that of the great-grandfather or uncle of Tivo, whose name had long been held in reverence. It was but momentary; I took the first slab and threw it down the hill into the sea, thus uncovering the tomb; then the others joined, and I had no more to do. Stone after stone tumbled down the hill, and in a few minutes nothing was left but the foundation. All the bones were taken out and added to the heap of skulls; and the other tombs were treated in like manner. Then they made a large bonfire

[29] Although other sources says it happened in 1903 (White 1991:105).

> over the relics of saints and victims, conquerors and conquered, and as the smoke ascended into the bright sky, we gathered round the pyre and offered up a prayer to the Father of all men that He would accept the sacrifice.
>
> (Dr.Welshman in Wilson 1911:115, 116)

This scene presents with an interesting paradox. Despite the fact that the missionary wanted these men to prove their allegiance to the church by desecrating a previously important religious area of the past, he at the same time confirmed the importance and power of that place by offering it as a sacrifice to the Christian God. And although the participants in this event publicly mark their allegiance to Christianity, it does not necessarily imply that the importance of *kastom* disappeared. Similar processes have also been described elsewhere in the Pacific such as in Fiji where the conversion to Christianity did not necessarily mean that ones traditions, or in this case *kastom*, would be left behind (Toren 1988). White (1991:104) argues that instead of signifying the end of *kastom* ways, this event signifies "the ascendancy of one set of institutions and practices over another". While certain religious aspects of the *kastom* ways might have been weakened and some might have disappeared after the initial meeting with Christianity, other aspects survived and continued to coexist in practise with Christianity, without compromising the status of one's Christian faith. According to Bennett (1987:336), by 1970, about 90 percent of the local population of Solomon Islands was associated with one of the Christian denominations, but although Christianity was widespread, many Solomon islanders continued to hold on to certain aspects of their old beliefs. Bennett (1987:337) states that "Christianity is a valued system that has provided answers to many of their problems, but since some practices of the old religion still seem effective, why dispense with yet another way of minimizing the many risks of the world-seen or unseen?"

Conclusion

In this chapter I have argued that the dichotomy frequently described in studies of medically pluralistic societies, in which local knowledge and practice concerning health is seen as existing in opposition to an introduced body of knowledge and practice, (usually biomedicine) does not find application in Kia.

At first glance it may seem that the dichotomy exists and that Zabana people live in or with two worlds. Those worlds being biomedicine and *kastom* medicine, Christianity and

kastom, “the past” and “the present” or “the old” and “the modern”. I found that instead, Zabana people constantly shape and adjust to their surroundings creating a flexible, dynamic and unified view of the world. By looking at history we find that Zabana people have, and still are, adjusting and transforming both *kastom* and Christian ways and shaping it into “one way”. This integration is seen both at the level of patients, *kastom* practitioners, nurses and the church in Kia.

In the current medical paradigm which incorporates both *kastom* medicine and biomedicine, Zabana people are free to choose between treatments options in a pragmatic manner. However there are some restrictions, and as we will see in the next chapter political and economical aspects “restrict” the availability of optimal healthcare, and influence decisions made by the local population concerning treatment options.

4

Rural healthcare in the context of political-economy

Introduction

> "The clinic is very far away, it is very busy and the clinic does not have any medicines, so I don't feel like going to the clinic."
>
> Informant statement

In this chapter I will explore the political-economy of health, healthcare and attitudes towards healthcare on the village level. I will argue that the way people choose to deal with an illness episode is not only influenced by the cultural and historical factors which have been discussed in the previous chapters, it is also strongly influenced by political and economical factors.

By following the perspective of critical medical anthropology which pays especially close attention to the "vertical links" that connect the local community to the larger regional, national and global human society (Singer and Baer 2007:33) I will seek to establish some connections between the macro and the micro level in Solomon Islands. In order to do this I will use Grønhaug's (1978) field theory, discussed in chapter 1, which emphasizes the importance of understanding various fields' interconnections.

Grønhaug (1978) uses the example of a drought in Herat which exemplifies the interrelations between the different social fields and regions of the Heart valley and the relations between life in the villages and international economical and political factors. Similarly I will use events such as the tension to show how healthcare in Kia is connected to events on a national and international level.

Grønhaug (1978) uses the term `scale` when referring to the size of the various fields. For example we can say that the field of *kastom* medicine is a field of a smaller scale than the biomedical field and the economical field which, as will be shown have important consequences in their interrelations with other fields. I will also go further by dividing scale into 4 different levels which I see as useful for the purpose of my analysis. Although not identical, my division is based on Singer (1995). Throughout this chapter I will focus on the macro level of global political economy, the national level of political structures, economy and policy making, the institutional level of the healthcare system with hospitals and clinics and the micro level of illness behaviour which refers to the way in which a person chooses to deal with an illness occurrence.

It is important to mention that separating society into different fields and levels will only be for analytic purposes. As I have argued throughout this thesis, the various fields in Kia such as religion, biomedicine and *kastom* medicine are fluid and dynamic, similarly the levels which I have just mentioned are not clearly delineated. I argue that by examining fields such as *Kastom* medicine, biomedicine, economy and politics we can find "networks and patterns of organisation that extend far beyond the village level (Grønhaug 1978: 88)

By using my empirical data from Kia and Buala, both places which can seem relatively isolated from events occurring on a national and a global scale I will, following Singers (1986) assumption that any separation of the micro and the macro level is artificial, show how remote areas like Kia are very much influenced by events on the macro level. In this way, local phenomena are not only generated locally, but rather by a set of interrelations between various fields of different scales (Grønhaug 1978).

The political and economical situation in Solomon Islands

Solomon Islands is classified as a developing country and based on the country's GDP, it is estimated to be the least developed economy in the Pacific[30] (Economic Affairs 2009). It can be argued that GDP is not an accurate indication of factors such as the standard of living in Solomon Islands due to the fact that 79% of the population in Solomon Islands live in rural areas (WHO 2004:331) and rely largely on subsistence economy. However I mention it here as it does show the economic reality the country is facing in terms of limited financing for

[30] Based on the fact that in 2007 GDP of Solomon Islands was 369 million US dollars. Comparatively Vanuatu had 452 million US dollars while Papua New Guinea had a GDP of 6261 US dollars. (Economic Affairs 2009)

(among many other things) healthcare. The country (but as will be shown, not its rural population) is entirely dependent on aid and according to the WHO 82% of the governments healthcare allocations are funded by foreign aid. Compared to other countries in the Pacific, Solomon Islands have a generous part of the budget allocated to health.[31] Several of the last sitting governments have seen health as a priority and as a right of the country's population and during the years between 1991 and 2001, the health allocation have been between or 3-5 % of GDP (SIHDR 2002:44). Although the governments health allocations in percentage of GDP are higher than other countries in the Pacific their total health spending per capita is low compared to other countries in the Pacific (SINHSP 2006:18), the Ministry of Health recognizes this and understands the need for improvement, but their budget is still very limited compared to the many major health related challenges the country is facing. As will be explored in this chapter, the strained economic situation in Solomon Islands has direct implications on the rural healthcare situation in the country.

While conducting their survey on health in Solomon Islands in the late 70s and 80s Friedlaender et al. (1987) were critical towards the sitting politicians' attitudes towards healthcare. They state that healthcare was only understood from the curative perspective while efforts to introduce preventative measures were forgotten or ignored. Expensive and cost-ineffective measures such as building hospitals and buying x-ray facilities are favoured while cheap, cost-effective preventative measures such as health educators receive no support or funding. "We have succeeded in imposing all the faults of Western health services on a society which is only 100 years away from the Stone Age."(Baker in Friedlaender 1987:63). The curative focus benefits people in the urban areas or people who can afford to travel far distances to hospitals in the main centres, especially Honiara, whereas people living in the rural areas with no major healthcare facilities nearby become ignored.

In 1998 Solomon Islands was hit by what today is referred to as the "tension", a time of civil unrest which erupted, especially on the island of Guadalcanal where the country's capital, Honiara is located[32]. This period lasted for 4 years until 2003 and had a devastating effect on the country's healthcare both for people in urban as well as in rural settings.

The main sources of income in Solomon Islands economy in the 1990s were palm oils, fishing and fish cannery, logging, copra, cocoa, coffee, gold/silver mining and tourism, but when the tension hit in 1998, the country's economy headed for a total collapse

[31] In 2005 Solomon Islands spent 4.3 % of GDP on Health. In comparison Fiji spent 4.0% and PNG spent 3.2% of GDP (WHO)
[32] For more information see chapter 1.

(WHO 2004:331). It was not only the economy which experienced a collapse, also the system of law and order fell almost completely apart. As the system collapsed, funds were mishandled, in particular those funds designated for health and education. The economic and political collapse during the tension resulted in a severe lack of funding to the healthcare sector which again resulted in a dramatic lack of equipment and supplies, a low level of maintenance of health facilities and the country's healthcare workers not receiving their wages.

According to the SINHSP (2006:9) the tension period's main implication was a negative impact on people's health throughout the nation state. In some areas of healthcare this was apparent such as the maternal mortality rate which in 1999, before the tension was 125 per 100 000 live birth, in 2003 was 295 per 100 000 live births (WHO 2004:331). The effects of the tension were experienced differently by the urban population, in particular the population of Honiara, and the rural populations. As a large proportion of the healthcare staff was located in hospitals around the country, especially at the National Referral Hospital in Honiara, the population in the capital experienced a severe lack of manpower as many of these nurses and doctors returned home to their villages due to the unrest in the capital. In the rural areas which are the focus of this chapter, the effects of the tension were not so obvious. According to my informants in Kia the tension was noticed in times of severe illness when medicines were unavailable, that transportation to other healthcare facilities was very difficult, by the arrival of relatives who usually resided in town coming to live in the village, and that the already unreliable shipments arrived with even less frequency. As will be discussed later in this chapter, the limited availability of imported food, fuel and medicines led to an increase of rural subsistence farming and use of *kastom* medicine as people returned to traditional foods and medicines.

Although the tension was felt differently in the urban and the rural setting the tension period was a setback for the country as a whole and for the healthcare of both urban and rural populations. However the country is slowly regaining both political and economic stability which is reflected in increased attention towards health care. In 2004 the situation improved somewhat, and from having close to nothing during the tension period, the Ministry of Health and Medical services received 52 980 902 SBD (WHO 2004:333). In 2005 the budget increased again this time to SBD 87 087 310 which was a 73% increase from the previous year (WHO 2005:319).

Although the healthcare budget increased as the severity of the tension decreased, the Human Development Report (2002:44) stated that the health sector system still had a

tendency of prioritizing high-cost activity which did not give best value for money and only benefited a fortunate few. However the report states that although a significant part of the budget is directed towards the curative system of hospitals, with for example 30% of the budget being allocated to the central hospital in Honiara (SIHDR 2002:45) there has been a slight change in focus in recent years towards a preventative rather than a curative health system and the Ministry of Health and medical services have taken some initiatives to implement such an approach as the social and economic benefits are believed to be great (SIHDR 2002:41). In 2006 the Ministry of Health reconfirmed their belief and focus on this new perspective through stating that they would "Emphasize, strengthen and promote preventative healthcare through all appropriate avenues." (SINHSP 2006:4)

The government's funding for health has increased since the period of tension, but the challenges within healthcare in Solomon Islands are large and demand even more political attention and economical support. Infectious diseases have been and still are the leading causes for morbidity and mortality in Solomon Islands, however, in recent years there has been an increase in the prevalence of non-communicable diseases such as cancer, diabetes, mellitus, hypertension, tobacco related disease and mental illness. In 2005 WHO (2005:312) stated that this group of diseases were increasing noticeably and were major public health problems in terms of mortality. Having to deal with the dual control of infectious diseases and the increase of non-communicable diseases poses a major challenge to the Solomon Islands government, who, as has been shown, are dealing with very limited resources (WHO 2006:319).

A lack of funds and human resources

The country's strained economic situation has had several consequences for healthcare in rural areas. Buala is the provincial capital of Isabel province and it is in this village that the Provincial Hospital is located. I travelled to Buala prior to my departure for Kia and met with both patients and staff at the hospital. The country's tight economic situation and the government's lack of attention to provincial health is apparent on the institutional level in Buala. According to the chief of nurses at the hospital in Buala, the Isabel province health sector received 1.6 million SBD last year. This budget must cover doctors, nurses, nurse aids, helpers, housing for staff, maintenance of the hospital, maintenance of all clinics and aid posts, equipment and medication for all of Isabel and the province's approximately 20 000

inhabitants (SIPHC 1999). The chief of nurses explained that the strained economic situation has had a great impact on the health care of people in the province, firstly, they are unable to hire enough healthcare personnel and secondly, they are not able to keep the province with the medicine and the equipment which is needed to provide adequate care.

A recurring theme in documents reviewing the healthcare in Solomon Islands is the country's severe shortage of healthcare workers (WHO 2004-2008, SIHDR 2002). The last estimate of number of healthcare workers in SI was made at the end of 2005, and estimated the number of doctors for the whole country to be 89 (WHO 2008:420). The minimum number of doctors needed in the country is according to WHO (2004:335) 75, but although the minimum amount of doctors is reached the number does still not amount to more than 1 doctor per 5263 patients. The minimum number of nurses needed in the country is still not covered. In 2005 the number was estimated to be 620 nurses, whereas the WHO (2004:335) had estimated that the country needed a minimum of 730 nurses for the whole country. An important factor contributing to lack of healthcare personnel was the tension. As violence increased in Honiara, Solomon Islands experienced what can be characterized as a "brain drain" as large numbers of educated healthcare personnel fled and found work in other Pacific countries (Cato Berg, personal communication)

According to an interview with the permanent secretary for health, Dr George Malefoasi in Islands Business , the Ministry of Health has the highest number of vacancies at 196 vacant positions in 2007, among these are at least 30 vacancies for doctors. (Wasuka 2007). Lacking human capital is negative for any country's economic and social development, lacking personnel in the health arena is increasingly negative as they are responsible for improving the health of others and thereby ensuring their contribution to the wider society (Connell 2008:2). The Solomon Islands Government are trying to fill up the gaps, for example by importing foreign healthcare workers from Cuba through a health treaty (Wasuka 2007). Unfortunately, the available positions in the provinces are not popular as most doctors prefer to work in the country's capital, thereby the provinces are once again left without attention. In order to reach people in outlying areas there have been several initiatives involving health teams travelling around and focusing on specific illnesses such as for example eye disease (Baker 2005). However, these teams tend to go to areas with high population density such as areas in Malaita or areas in Western Province such as Gizo. Less populated provinces such as Isabel Province with a dispersed population do not receive as much attention, and to my knowledge no teams visited the province during my stay.

In January 2008 the Isabel Province had only one doctor for the whole island. I met with the doctor on Isabel at the Buala hospital one day in February 2008.

> As usual it was warm and humid. We met in the doctor's small office. He had a fan in his room, but as the power kept shutting off it was not much use. Without showing signs of resignation he explains how he is the only doctor for a population of over 20 000 people. He says it as a matter of fact, that is how it is, it is not surprising. But he says that the responsibility for the island is too much for one doctor. There should be two or three doctors on the island and at least one should be placed in Kia on the other side of the island. The doctor explains that it is too far away and there are just too many people for one doctor.

According to the doctor, the budget allocated to health care in the Isabel province has allowances for the employment of two more doctors in the province, but the positions are still vacant because nobody wants the job. The healthcare system in Solomon Island today is marked by a shortage of well trained medical professionals, especially in rural areas. The few people who get through the medical study tend to go overseas to work, to Fiji, New Zealand and Australia because the pay is much higher in these countries. The Solomon Island Human Development Report (2002:43) recognized the difficulties in attracting trained healthcare personnel both to urban but especially to rural areas and states that the reasons for this are low salaries, lack of incentive and poor working conditions. As healthcare workers in Solomon Islands assess the career alternatives open to them, the limitations of work in rural areas and also the limitations of work in the country encourage a drift away from the rural areas and away from the country. The difference in income for a healthcare worker in neighbouring countries is three times higher, which entices doctors to go overseas to work. This has resulted in severe lack of doctors, especially in rural areas which are the least popular areas of employment.

> The doctor in Buala explains that the system is not made to accommodate medical staff. There are not enough doctors and not enough nurses, neither in towns nor in rural areas. Even if they manage to find someone who wants to come and work in rural areas there are no houses for them. And the few who end up working often do not work for long. There is not enough staff so they get overworked and tired and the pay is very low. The doctor believes much can be solved with more staff and better housing. The chief of nurses agrees with the doctor. He explains that the salaries of the staff are very limited. If there was better housing and better pay for the medical staff things would look a lot brighter. In addition, the doctor feels that most of his time is spent doing paperwork. There is only one doctor and the government requires paperwork, which means that he gets very limited time with the patients. The doctor himself is from Isabel,

> that is why he has come back here after he finished his schooling, but he cannot picture himself there much longer than a year or two, he will also go overseas. He seems certain. Then he smiles and adds that a positive thing about working here is that he can wear casual clothes to work. Wearing a t-shirt is not a problem.

The clinic in Kia has, as previously mentioned 3 employees. 2 trained nurses and one nurse aid. They are responsible for a large part of the north western tip of Isabel. While discussing their job with the nurses they expressed their thoughts on being a nurse in Solomon Islands and they explained that being a nurse is a very demanding profession. One of the nurses explained to me that a nurse working in Kia receives 580 SBD a month[33]. The nurse explained that the pay is very low, which makes it difficult to take care of a family. Working at the clinic means that you are busy a minimum of 5 days a week working from early morning until the late afternoon, giving you limited time to do other things. The nurse explained to me that working at the clinic means that she has no time to work in the gardens. She can only go there one or two days a week. Others go to the garden every day. Because of this she can not provide vegetables and other food for her family. With the money she earns she can buy some food, but the pay is not very high, and there is no market in Kia, so even if she had the money to buy vegetables every day she could not do so. As previously explained much of the day of an adult in rural Solomon Islands is spent out in the gardens, in the bush or out at sea in order to provide shelter and food for the family. Accomplishing these things becomes difficult for the nurses as much of their time is tied up at the clinic. In order to make up for the low income and the limited time that can be spent gathering food, all of the nurses in Kia are trying to increase their income whatever way they can. They sell second hand clothes, ice blocks (which are very popular especially at feasts and village gatherings) and keep chickens which they sell.

Whiteford (1990) describes the healthcare situation in the Dominican Republic which like Solomon Islands, is experiencing a lack of staff in rural areas. In the Dominican Republic healthcare staff is unwilling to work in these areas as they end up being both socially and spatially isolated from their assigned communities. In this setting they find themselves waiting at their outpost for hours without seeing a single patient. This combined with lack of medicines and needed equipment makes the rural setting undesired as a workplace for healthcare personnel. In Kia however, the situation is somewhat different. As shown, like the Dominican Republic, Solomon Islands are experiencing a lack of health staff in rural areas

[33] This is the equivalent of about 430 NOK or 50 EUR

and as in Buala, the nurses in Kia are concerned with the lack of staff. However, rather than not having enough patients, nurses in Kia feel that the workload of the individual nurse is too high. They explained that when the workload is high it makes many nurses question whether it is worth it, and many are thinking about quitting. The location of the clinic, in one of the biggest villages in Solomon Islands results in a waiting room which frequently is over crowded, especially on days where the clinic has children's clinic or in periods when the village is experiencing an outbreak of a particular disease. The nurses would work without rest from early morning until late in the afternoon.

According to the Ministry of Health and Medical services of 1996, the health service coverage of the nation was "fairly well distributed", with about 1131 people per healthcare facility (PHCRSI 2001:10). In Kia however, the situation is slightly different. As mentioned previously Kia is estimated to be one of the largest villages in Solomon Islands. In the village alone there is about 2000 inhabitants and the clinic in Kia is in addition responsible for all the settlements in a large radius around the village. This has implications for the staff's ability to provide the attention needed by each individual patient. Problems associated with the lack of healthcare personnel were apparent during my time at the clinic;

> One afternoon I was at the clinic with one of the nurses. It was Thursday which is the day for ante natal examinations at the clinic. This means that all pregnant mothers from a certain area have come to the clinic for checkups and all pregnant mothers from the whole area who are more than about 8 months pregnant. Usually on such a day the waiting room would be full of expecting mothers, but that day they all seemed to have stayed at home. Instead of all the mothers that we would usually expect on Thursdays, there were a few sick children with their parents waiting outside. Solomon Islands government has developed a standardized procedure for how to examine sick children. This plan is called IMCI, Integrated Management of Childhood Illness. The nurse took the child in and started examining him. As he examined the boy he explained the use of the IMCI forms to me. He explained that the forms are good for noticing illness in children, but they can be very difficult to use. If one were to follow the forms exactly, one check up would take between 30-60 minutes. At the clinic in Kia this is almost never possible so they can only be used when there are few patients. The nurse explained that if the clinic had more nurses it would be possible to follow the IMCI.

IMCI is an approach which is developed by WHO and UNICEF, both international organisations which can be understood to operate at the macro level, and has become implemented on the national level as part of the healthcare policy in Solomon Islands since 1999. Over the last few years Solomon Islands have experienced a decline in childhood

mortality and morbidity. This decline is to a large extent attributed to the focus on the Integrated management of childhood illness (IMCI) approach (WHO 2007:395). However as exemplified here, the full potential of this approach might not be obtained in certain areas on the institutional level, due to the lack of personnel needed to implement this approach. As will be discussed later, this will also have consequences on the micro level.

Doctors and nurses are not the only categories of personnel needed within the healthcare sector. Already during my first encounter with the nurses they explained to me that they were expecting the arrival of a microscopist. The microscopist's prime objective is to check blood samples for malaria parasites in order to ensure that patients sick with malaria receive correct diagnosis and treatment.

> Today there are only a few other patients waiting, so the nurse takes his time with the sick boy. The little boy is about 3 years old, has high fever, a cough and light diahorrea. The boy breathes with a wheezing sound on both sides of the lungs, this is a sign of pneumonia. At the same time he has high fever. The mother has administered panadol[34] twice but the fever has not gone down. If the boy had only pneumonia the fever should have gone down, however if it does not go down it is a sign of malaria. The boy is displaying dual symptoms of both pneumonia and malaria. The nurse explains that if the clinic had a microscopist they could have checked if the boy had malaria in 10 minutes, but because the nurse's suspicion remains unconfirmed he decides not to administer malaria medicines. The nurse explains that first he will treat the boy for pneumonia and hopefully he gets better. If his situation does not improve then the likelihood of the child having malaria is high and he will then be given medicines to cure malaria. The reason he does not receive treatment for malaria right away is out of fear of the boy not having malaria and then developing resistance to the malaria medicines he was given.

There was money allocated in the budget for the clinic in Kia to have a microscopist, but none had been employed so far. The nurses explained that the reason for this was that there was no house for the microscopist. There is no housing allocation in the budget. The villages in need of healthcare personnel are themselves responsible for providing housing for the medical staff. There is a house designated for the microscopist close to the clinic, but it is an old leaf house that is almost falling apart. With resignation one of the nurses explained that one microscopist had even come from Buala to Kia, but when he saw the condition of the house he returned to Buala. According to the nurses, it is the villagers, under the command of the chief to build and maintain the houses of the healthcare workers. However in a village as

[34] Panadol is a pharmaceutical paracetamol (*para-acetylaminophenol*), which is administered to reduce pain and fever.

big as Kia, processes involving community leadership and co-operation were not always easy to achieve and often took a long time, which in this case resulted in lesser quality healthcare for the population residing in that area.

The lack of staff was not the only problem. Lack of equipment was another concern both at the hospital in Buala and at the clinic in Kia. During my stay in Buala I met an Australian medical student who had come to Buala hospital for 5 weeks as part of her medical training[35]. She compared her experiences in Buala to the conditions in Australia and there was a stark contrast. She explained to me that the equipment available in Buala was very limited and one constantly had to improvise. She told me the story of a man who had come in with chest pains. They were scared that there was something wrong with his heart and he needed an ECG test [36]. The hospital has an ECG machine, but when they came to use it the machine did not have the paper needed in order to generate the results. The man did not receive a test and was treated based on what the staff believed to be the problem. The medical student said there were many possible reasons for the lack of paper. It could simply have been one person who forgot to order more paper, "However," she said, "It was not a one time occurrence". According to the medical student this was the norm rather than the exception. It could be due to lack of funds for buying more paper, lack of shipments or on a larger scale, a lack of an organized infrastructure which would ensure the steady supply of medical equipment to hospitals, clinics and aid posts in rural areas. The issue of communication and logistics will be further discussed later in this chapter.

In Kia the lack of funding was particularly evident in the state of the village clinic (as described in Chapter 1). Already in 1989 the Government conducted an infrastructure Development review which showed that more that 80 % of the health facilities were in poor shape and needed renovations. The repairs have been heavily delayed due to lack of funding to the provincial health grant (PHCRSI 2001). But this year, according to the nurses, through the help of RAMSI, money had come through to the clinic of Kia. Renovations started and were due to be finished by the end of July 2008. The work done in the clinic has dramatically improved the facilities. The maternity ward has been expanded to twice its size and now includes both a sink and toilet inside. Both the male and the female inpatient ward has been upgraded. All the toilet facilities are now connected to the clinic so the patients don't have to leave the clinic in order to reach the toilet, and the injection, examination and radio room have

[35] This student had not arrived through any collaboration or by the help of the Solomon Islands government. She had organized her stay herself through e-mail correspondence with the doctor at Buala Hospital.
[36] ECG stands for Electrocardiogram and is used for diagnosing heart conditions by recording the electrical activity of the heart.

been expanded. For both nurses and patients the improvements are dramatic as there are now more space, more privacy for the patients and more hygienic conditions, especially in the maternity ward.

The changes and challenges experienced by the clinic in Kia clearly demonstrate the extent to which the field of biomedicine is influenced by events occurring on the national level such as economic and political policies.

Communication and logistics

The Solomon Island population are spread across a great number of islands in the nation state, and due to the nature of the distribution, delivering adequate healthcare to the people can be a challenge. The improvement of access to and quality of care and service is therefore important in the improvement of Solomon Islands healthcare. This is not a recent discovery, already in 1923 Dr Cumpston stated that in order to improve the health of the population of the Pacific, the communication facilities between doctor and patient had to be improved both on land and by sea (Cumpston 1923:1397). Although many improvements have been made since that time, a large amount of the population in rural areas still do not have adequate access to healthcare facilities. A study conducted by RAMSI in 2008 showed that 42% of the population did not have a health centre within their community and were unable to reach one within an hour (Peoples Survey 2008).

One day while I was helping out at the clinic, a mother came in with her little daughter. Her case exemplifies the difficulties for people living far from the village of getting to the clinic.

> A woman came into the clinic with a 3 year old girl. The nurse asked what was wrong and the woman explained that the girl had a bad cough. When the nurse asked how long she had been sick, the woman said that the girl had been coughing for over 2 months. The nurse examines the little girl and explains to the mother that she should have brought her in earlier. She explained that they wanted to come before, but they did not have a canoe with an outboard engine so they had to paddle, but because of the strong wind over the last few weeks it was very hard and difficult to paddle. Luckily the wind had settled a bit today.

During the period of time mentioned by the mother, Kia had indeed experienced quite a bit of wind, unfortunately blowing against the area where the family lived making it very difficult

for them to paddle the long way to the clinic. This, combined with the fact that the mother had a condition causing her to have sore and swollen joints, making the paddle even more demanding, resulted in the mother waiting for 2 months before she came to the clinic. Luckily the little girl recovered completely from her illness, but this case nonetheless illustrates the difficulties in access to healthcare in this area.

Lack of medicines

Poor infrastructure and difficulties with communication in Kia can also create difficulties in getting equipment and medicines to the clinic. As previously mentioned, the clinic in Kia is located about eight hours away from the hospital if travelling in a boat with an outboard motor. It would take a day and a half to reach the hospital in Honiara if one was travelling by ship. There is no telephone connection in Kia so the nurses' sole mode of communication with other healthcare workers and healthcare facilities is by radio. The clinic has its own radio, but during my stay in Kia the radio was broken the entire time. It was still possible to use the radio but the sound quality was poor making it difficult to understand what the person on the other end was saying, sometimes the sound quality was so bad that communication was impossible. This severely restricted the nurses' ability to inform the larger hospitals about the situation in Kia - both about patients and the supply of medicines and equipment. The clinic in Kia is entirely dependent on the hospital in Buala and a pharmacy in Honiara for their supplies of equipment and medicine. If communication is impossible, it results in absence of equipment and medicine at the clinic in Kia. This became evident to me almost as soon as I arrived in Kia.

During one of my first conversations with the main nurse at the clinic, he told me that the clinic had been out of medicines for two weeks already before my arrival, malaria medicine in particular had been a problem to obtain and they had had nothing with which to treat malaria for the last 2 weeks. He explained that they were waiting for *MV Isabella*[37] to arrive with new supplies, but so far the ship had not brought anything. The nurse believed that there was a shortage of medicines in Honiara as well and this could be the reason they did not receive anything in Kia. A few days later *MV Isabella* arrived and both the nurses waited anxiously at the dock, to their disappointment also this ship arrived without any medicines.

[37] *MV Isabella* is a small ship that travel between Honiara and Isabel province transporting everything from medical equipment, building materials, food, alcohol, mail and people.

The following week the situation became increasingly worse. The clinic ran out of almost all medicines; everything apart from antibiotics in injection form and panedol. The main nurse was openly frustrated. He said that sometimes the problem was that the pharmacies in Honiara were out of supplies, but this time it was the pharmacists in Honiara who were responsible for sending medicines who were not doing their jobs properly. He explained that he had tried to call on the radio and complain but nothing had happened.

3 weeks after my arrival and 5 weeks after the clinic in Kia first ran out of medicines they received a new shipment of medicines. For the nurses the period of not having medicines had been difficult. Almost every day for the last 5 weeks they had to explain to patients that they knew what was wrong, but because they had no medicines they could not treat them. The nurses expressed that they felt this was both straining and demotivating. For almost two months the clinic had a steady supply of medicines, but in May they ran out of medicines once again. This time they did not stay without medicines as long as the last time, the shipment took a few weeks, but this exemplifies the difficulties employees in rural clinics are faced with.

In order to deal with the long distances between various settlements and the clinics, the doctor, who is located at the hospital in Buala, is supposed to do a tour of the island to all the major villages 2 times a year. Such a trip takes about 1 week and for that time the hospital is without a doctor. These trips are difficult to organize and often do not happen as regularly as planned. During my time in the village no such visit was executed, and from conversations with staff at the clinic and people in the village it had been a long time since any doctor had visited the Zabana area. In addition the nurses at the various clinics and aid-posts are responsible for arranging trips to the areas and villages surrounding their clinic. This initiative is called ‘satellite clinic’. According to the nurses, the satellite clinic is supposed to take place about once a month and it was widely discussed at the clinic since the first day I got there, but during all of the 5-6 months that I spent there it did not happen once. There are several reasons for this. Firstly, petrol for the boat is expensive and at first they did not have the money to go. Secondly, during most of my stay, the clinic did not have their boat. The boat had been taken by another nurse who worked at the Allardyce secondary school about two hours away from Kia, but instead of returning the boat she had taken the boat to Buala where she stayed with her husband for a long period of time. By the time I left, the boat had still not been returned. This limited the mobility of the clinic staff considerably. The consequences were that they were not able to perform a single round of satellite clinic during my stay. However, the nurses where very good at performing home visits to sick people within the

village. And several times they made repeated visits to sick people in order to check up on them and give medicines. People in the outlying areas on the other hand, were left to their own accord and were themselves responsible for getting to and from the clinic in case of suspected or actual illness.

In this section I have explored the interrelations between infrastructure and the field of biomedicine by showing how poor infrastructure on a national and institutional level has an adverse affect on biomedical healthcare on the institutional level.

Being a patient

I have now explored some of the challenges the Solomon Islands healthcare system is facing due to its political and economic circumstances, but what is it like being a patient of the healthcare system discussed above? And how do they choose to deal with the occurrence of illness. Based on my experiences and interviews conducted in Kia I will now explore how the healthcare system is experienced and dealt with by Zabana people on the micro level.

The costs of healthcare

Healthcare in Solomon Islands is free. According to the Solomon Islands Government a patient seeking treatment at a healthcare facility provided by the Solomon Islands government should not need to pay for the treatment he or she receives. In Kia going to the clinic is free, however the clinic operates with a system of contributions where patients are encouraged to give a small sum of money when they visit the clinic. On the wall they have a list named ”Contributions” where they list the various prices for the various groups of people.

CONTRIBUTIONS:	
Kia catchment area	1 sbd
Outside catchment area	5 sbd
Loggingcamp, foreigners, Asians	20 sbd
Others (SI)	5 sbd
Admission fee	6 sbd
Mothers/baby book	10 sbd

The prices are not fixed and I saw them vary several times. The only times that I noticed that a payment was expected by the nurses, was when they were visited by labourers, especially

Asian labourers, from logging camps, however this was never problematic as they always paid without being asked every time they visited the clinic.

I discussed the system of payment with the head nurse and he explained that the clinic is free and that they would not refuse anyone who does not have money. The system of contributions was there to give the clinic a little bit of income, for the benefit of the patients, in order to do renovations needed in the clinic and also for items such petrol for the boat in order to conduct satellite clinic trips. He explained that contributions were not expected from older people, who usually have no cash income, but that young people who had the opportunity to contribute a small amount were encouraged to do so. I observed a few times that people did not bring money but that they rather brought goods such as fish and vegetables for the nurses in the place of money. The head nurse explained that this was also an acceptable form of payment and very much appreciated by the nurses who spend their whole day at the clinic and therefore have no chance of going to the gardens or out to sea to get food themselves.

To my knowledge the system of contributions did not have any, whatsoever, negative effect on the populations use of the clinic. During none of my conversations with my informants did any of them mention the cost of the clinic as being a reason for not going or delaying going to the clinic. The clinic is thereby free for people who live close enough to walk or paddle to the clinic, for people living further away however, the situation is somewhat different. In interviews with people living in settlements outside the clinic, they explained that the actual visit to the clinic was technically free, but the economical hurdle in terms of trips to the clinic was the cost and availability of petrol as well as time lost in travelling back and forth to the clinic. Manderson (1998:1024) labels these costs ‘indirect costs’ which include transport, time lost in wages or the care of children etc. I argue that these indirect costs, which can be placed within the field of economy, have an important place in Zabana people’s decision making process concerning how to deal with an illness episode.

Availability of petrol was a constant problem in Kia. The availability of petrol in the village depends on whether a few storeowners have ordered shipments of petrol to sell to people in the area. In 2008 the price of petrol rose on the global market, and in Solomon Islands the prices soared and increased by 46 % from June 2007 to June 2008 (Central Bank of Solomon Islands 2008). This meant that store owners no longer could pay for large amounts of petrol, and as the price of transporting petrol to the village also increased dramatically, Kia experienced long periods where none of the shops in the village had any petrol for sale. The people who had not bought more than they needed while it was still

available, just had to wait for the next shipment. This period severely limited Zabana people's mobility. When petrol was available and someone living outside the village needed to go to the clinic it came down to a question of money. Money is scarce in Kia and many families scarcely have any cash income. Depending on where the sick person lives, a trip to the clinic will easily amount to over 100 SBD, a very high price to pay for almost any family. As the price of petrol soared, I heard people mention on several occasions, that they would rather try *kastom* and home treatment than going to the clinic because the petrol needed in order to go there was so expensive.

This example demonstrates how events on the macro level such as rising global fuel prices influence events on the micro level as for example Zabana people preferring to use *kastom* medicine because the transport costs required to reach the clinic have become too high. This picture may present an oversimplification, for there are other factors which play an important part in the decision making of Zabana people. However, it does exemplify the importance of including the macro level of political-economy in ones analysis.

The experience of a lack of healthcare personnel and medicines

Apart from the obvious cost of petrol, the journey itself, to and from the clinic, either by boat or foot can be both straining and time consuming. In addition the wait can be long once you get there. Even people living relatively close to the clinic (about a 15 minute walk away), expressed that they were reluctant to make the effort of a trip to the clinic. The clinic is scheduled to be open from 8 in the morning to 4 in the afternoon, but some days the nurses are not there before 9, and there can already be a long line. If one is unlucky one might have to spend hours getting there and waiting to be seen by a nurse. The day of a Zabana man or woman is very often spent doing necessary work such as fishing or working in the gardens. Fishing involves going out to sea and in many cases the men will stay out all day. Many of the gardens of Zabana people are also located away from the village, and a journey to the gardens often require that they leave early in the morning and arrive back in the afternoon. A trip to the clinic will interfere with their work and most likely they will not have time to do important work such as fishing or gardening that day. The time spent reaching the clinic makes many of the Zabana people postpone a trip to the clinic until it is deemed absolutely necessary.

The frequent lack of medicines and equipment in Kia also had an effect on the patient's use of clinic. During a conversation with two women about malaria and their

preferred treatment, they explained that if the symptoms were not very strong they would just use panedol at home as the clinic never seemed to have any medicine and there was no microscopist to check your blood to see if you have malaria. However, if somebody told them that the clinic did have medicines, then they might go right away. They explained that this would be the same even if they had symptoms that made them sure they had malaria. "We won't go unless we know they have medicines there". I found that arriving at the clinic and then possibly waiting in line before seeing the nurse just to discover they can not give any medicine seemed to have a very demotivating effect on the patients and made them more reluctant to come back for treatment in the future. Whiteford (1990:223) found the same results in the Dominican Republic where the primary healthcare centre became underutilized as patients lacked confidence that either the doctor or medicines would be available.

> It is early in the afternoon and I am visiting some of the older ladies in the village who are having a little "get together" on this particular day. They are drinking tea and telling stories. I am sitting next to one of the ladies, a woman of about 70 who have become a good friend during my stay. She is complaining to me about "belle sore" which is a general term for belly ache. I ask her if she has gone to the clinic. *"Klinik hemi farawe tomas, hemi bisi tomas ana klinik hemi no garem meresin. Mi les foa go long klinik, ia"* This is the informant statement used in the beginning of this chapter ; "The clinic is very far away, it is very busy and the clinic does not have any medicines, so I don't feel like going to the clinic."

This informant's statement emphasizes my argument that lack of medicine, staff and distance to the clinic has a demotivating effect on patients' use of the clinic facilities.

During the periods when the clinic was out of antibiotics in pill form, for parts of the time they still had antibiotics in injection form. When antibiotics are injected it is required that the patient returns to the clinic every day for 5 days in order to complete the treatment. For people living close to the clinic this was a reasonable option, but according to my observations there was still many of the patients that did not come back for all of the 5 injections. An exception was mothers with sick children, who tended to come back to make sure their children got well. For people living far away however, this was an almost impossible solution.

It was during one of these periods that the young boy described previously in this chapter arrived at the clinic, the continuation of his story exemplifies the situation at the clinic.

> The little boy needs treatment with antibiotics for pneumonia but for the 5th week in a row the clinic has no medicines. The only antibiotics available at the clinic at this time are antibiotics in injection form. The nurse explains that this is very demanding for the parents. If the clinic had antibiotics in pill form he would send the parents home with the treatments, but as long as they are unavailable the parents must bring the child back every day for the next 5 days. For families who live far away from the clinic this can be very difficult.

This particular boy had a grandmother who was willing to bring the boy to the clinic every day in order for him to receive treatment. The nurse was happy that this could be arranged both because it would ensure that the boy received treatment and would allow him to keep an eye on the boy's condition to make sure he got better and was not at the same time infected with malaria. For other families this would not have been possible, and several times during my stay in the village did I see individuals and parents with children not returning the following day for the next injection. This leads us onto the issue of patient compliance. We will now look at the issue of patient compliance in further detail.

Patient compliance

In many cases when patients do not seek the help of healthcare personnel, or if they do not follow the treatment subscribed to them, in biomedical settings the behaviour is frequently labelled "non-compliance". This refers to a patient's ignorance, lack of motivation or unwillingness to cooperate with the health care personnel (Farmer 1999). What is usually ignored when a patient is labelled non-compliant is the surrounding circumstances affecting the patient's ability to cooperate. In Farmers (1999) study of Haiti it is argued that the patients are not unwilling, but unable to take the prescribed amounts of medicines because they are too expensive. Six weeks of medications cost the same as one year's income for an entire family. The situation is somewhat different in Kia, but similarly to Farmer (1999) I argue that patients failure to follow the nurses demands in Kia is most of the time not due to unwillingness, but rather circumstances which render the patient unable to cooperate. In Kia medicines are free, however getting to the clinic can be very costly, both because of money spent on petrol, but also because of time spent at the clinic which would otherwise have been spent providing food for oneself and one's family. The political and economical circumstances in Solomon Islands resulting in lack of equipment, medicines and personnel, further complicates the situation by demotivating patients in seeking help at the clinic.

In the question of non-compliance the matter of a pluralistic healthcare setting also complicates the issue. Dressler (1980) puts forward the hypothesis that in a community with multiple medical systems, the more a person is committed to what he labels as an "ethnomedical" belief system, the less likely that person is to be compliant with treatments prescribed within the realm of biomedicine.

In Kia I found that a person's commitment to *kastom* medicine did not necessarily make him/her more or less compliant with biomedicine, however the presence of the highly valued *kastom* medical system did seem to have an effect on their attitude towards and their use of biomedicine. This played out as patients did not take the medication in the pattern prescribed by the nurses but rather in a pattern which was derived from the *kastom* medical system. When taking *kastom* medicine, the doses are administered more loosely which is not believed to have a negative impact on the patient. The concept of "resistance" to a type of medicine is to my knowledge not present in *kastom* medicine. Non compliance with biomedical prescriptions was frequently a problem in Kia as many patients did not take antibiotics in the way prescribed by the nurses. If the pills did not work within a day or two many patients would stop taking them although the nurse had administered pills for 5 or 7days. On the other hand, if the pills did work immediately patients would also stop using them as soon as they felt well, as they did not see the use of taking more medication when they had already recovered. This coincides with the course of many treatments of *kastom* medicine described to me, in which the treatment would end as soon as the patient felt better. The pills left over from previous treatments would also frequently be saved and used in cases of future illness.

How political-economical factors affect the use of *kastom* medicine

In this section I will examine the influence of political and economical factors on the use of *kastom* medicine. I will use the example of the tension period in Solomon Islands to argue that in the face of political and economical factors on the macro level and national level, the Zabana peoples' response to illness changes on the micro level and the use of *kastom* medicine increases.

In the decade from 1989 to 1999 Bougainville in Papua New Guinea experienced a period of guerrilla-warfare today referred to as the Bougainville-crisis. During this period, similarly to the to the tension period in Solomon Islands, the county's infrastructure

collapsed and services in all sectors were disrupted. Because of the collapse of the infrastructure people were forced to rely on local resources, including traditional medicine (Mcfarlane and Alpers 2009). I have found no research from Solomon Islands which discusses the implications of the tension on the use of *kastom* medicine, however my hypothesis is that during the tension in Solomon Islands, following the collapse of law and order, the economy and the country's logistics, local traditions (thereby also the use of traditional medicines) would have experienced an increase. Whereas Grønhaug (1978) used the event of a drought in the Heart valley to show the interconnections of various fields and regions, it is possible to use the event of the tension in Solomon Islands in order to show the interrelations of the fields of economy, politics, infrastructure, biomedicine and *kastom* medicine. Interviews with my informants confirmed my hypothesis as they explained that in the absence of equipment and medicine at the clinic they had turned to *kastom* medicine. During my stay in the village an event occurred which underlined Zabana people's flexibility and the way in which they turn to "traditional ways" in response to outside events which interfere with their current way of life.

In 2008 the world was hit by what in the media was referred to as the "global rice crisis". The price of rice soared all over the world and in Solomon Islands the price of rice increased by 67% from December of 2007 to June in 2008. Shortly after the rice crisis affected Honiara it also reached Kia. Rice is today one of the main staples in Solomon Island diet. In the village nearly every single meal served is accompanied by rice. As the rice crisis hit, rice became increasingly expensive in Kia and after only a few weeks there was no more rice available. The high price, and lack of rice was a frequent topic of conversation in the village. Some families in the village who had access to money stocked up on rice as the crisis hit, however for most families in the village this was not an option. Almost immediately Zabana people's diets began to change. The use of sweet potato and cassava increased and replaced the use of rice. Both cassava and especially sweet potato were important parts of the diet before the rice crisis, but one of the more noticeable changes was the increased use of taro, both cultivated and wild taro. Before the rice crisis hit I had only seen taro served once, however during the rice crisis, taro became a frequent addition to dinner. I was even served what Zabana people referred to as swamp taro. Previously I had heard several stories of this taro and it is the subject of many jokes. The swamp taro is very hard and it must be boiled for many hours before it is soft enough to eat . An old woman told me that eating swamp taro is like chewing on a rock. Another woman said jokingly that there is no point of eating it

because by the time you are finished chewing one it has taken so long that you are hungrier than when you started.

For some, especially children, the transition to a traditional diet was slightly difficult as they had grown up with rice as the main staple, but for others it was not a problem, and for some of the older members of the community it was even a welcomed change. However, when discussing the transition to a more traditional diet with women in the community they explained that they were looking forward to having rice again as the increased use of sweet potato, cassava and taro meant longer and harder working days for them, both in planting, weeding, harvesting and cooking.

This example shows that what happens in the world on a macro level, does affect Zabana people on a very basic level, however Zabana people are flexible and adaptive, and we can see this reflected in the use of medicines. As we saw, the lack of medicines in Kia encouraged the use of different techniques depending on the available resources which resulted in an increase of their use of *kastom* medicine, a phenomenon which was also observed to occur in PNG during the crisis.

The example of increased use of traditional medicines during the tension exemplifies the fact that in times of limited availability of biomedical drugs, equipment and personnel, Zabana people's use of *kastom* medicine increases. During interviews and conversations, several of my informants stated that the lack of a microscopist and medicines at the clinic affected their use of *kastom* medicine. They explained that they would rather use *kastom* treatment in cases of illness instead of going all the way to the clinic where it was unlikely that they could receive any help. Furusawa (2006:86) found similar results in his study in Roviana where the lack of presence of a nurse in the village increased the use of *kastom* medicine.

The use of kastom medicine in biomedical settings

In Kia, the lack of medicines at the clinic did not only affect the patients' use of *kastom* medicine, it also affected the nurses' use of *kastom* medicine. In periods when they did not have medicines available, the nurses would frequently suggest or recommend the use of *kastom* medicine to cure various ailments, however they only suggested treatments they were sure or fairly sure had a positive effect on that particular condition. This process has also been noted in Papua New Guinea where staff at medical aid posts have begun to treat patients with herbal or traditional medicines because of a severe shortage of drugs (RNZI 2002)

An example of the relation between infrastructure, availability of resources and the nurse's willingness to try *kastom* medicine occurred in Kia towards the end of my field work.

> On a Sunday morning a young girl of about 15 years came into the clinic with strong stomach pains. The young nurse examined her and palpated her stomach. After his examination he was sure of the diagnosis, it was appendicitis[38]. He tried treating the girl with what he called "hospital medicine", but without result, the girl's condition did not improve. He realized that the girl needed to go to a hospital and have her appendix removed so he attempted to get hold of a boat to transport the girl to the hospital in Buala. Unfortunately the boat belonging to the clinic had been taken out by another member of staff and the nurse could not find any other boat in order to transport the girl. He explained to me that he did not think *kastom* medicine could do anything in this case. According to what he had learned, appendicitis needed surgical treatment in which the appendix is removed, but having no other option he walked through the village, trying to find someone with a *kastom* treatment for appendicitis. He found a woman who had a plant treatment for this condition. She made the medicine and followed the nurse to the clinic and gave the girl *kastom* medicine to drink. The following evening the girl told the nurse that she felt much better and the next day she had no pain whatsoever and her previously swollen abdomen was fine. The nurse explained to me that he was very surprised because according to his education it was not possible to treat appendicitis with medicine, only with a surgical procedure.

I will however mention that the situation in Kia is not representative for all of Solomon Islands and I observed large differences between various healthcare facilities. Before travelling to Kia I spent some time in Buala, the provincial capital of Isabel located on the opposite side of the island. I interviewed patients, nurses and the doctor at Buala Hospital. During my stay in Buala I found that many biomedically trained healthcare workers had an ambivalent relationship to traditional medicine. Some readily accepted the use of traditional medicine whereas others entirely dismissed the use of them. When I questioned the doctor at Buala hospital about the use of *kastom* medicine, he explained to me that the use of *kastom* medicine in the hospital was illegal, and if they found anyone using it they would not accept it. The doctor explained that the problem with *kastom* medicine is that no one is sure about the effects or the potency. According to several employees at hospitals and clinics, *kastom* medicine was dangerous because it was not possible to calculate the correct dosage. At the hospital in Buala they are afraid that *kastom* medicines would have an effect on the medicine

[38] According to biomedicine appendicitis is an inflammation of the appendix. The treatment for appendicitis is appendectomy, a surgical removal of the inflamed appendix.

the patients were given at the hospital, putting the patient at risk[39]. However while interviewing some of the nurses in Buala Hospital they explained to me that although usually they would not allow the use of *kastom* medicine in the hospital, in certain cases it could be used. The case mentioned was if a birth was very difficult and the baby would not come out or if the woman suffered from severe blood loss, they accepted and in certain cases even encouraged the help and medicines from *kastom* midwifes as they believed that *kastom* medicines were effective in facilitating a quick birth and the arrest of heavy bleeding. However, I did get the impression that this was not something that was a product of an agreement with the doctor and the hospital but rather decisions made by the individual nurse in charge of the birth. When I asked if they believed that this was also done at the National Referral Hospital in Honiara none of the nurses believed it was so. They explained that in Honiara the doctors and the nurses were much more strict and that they would not allow *kastom* medicine of any kind in the hospital.

Based on this information it is clear that there is a big difference between the various hospitals and clinics attitude towards *kastom* medicine and it seems that the less resources they have available, the more open they are to the use of *kastom* medicine. Buala is a much larger healthcare centre than Kia and the availability of medicines there is much better. Although the hospital in Buala are facing problems with lack of equipment and at times lack of medicines, their supply and their range of treatment options is much larger than Kia. As my fieldwork was almost entirely based on the island of Isabel I did not have a chance to personally investigate the attitude towards *kastom* medicine in Honiara, but through conversations with informants I received the impression that in Honiara, the use of *kastom* medicine is even more frowned upon than in Buala. During an interview with a woman about the use of *kastom* medicine in clinics and hospitals she told me that in Honiara the nurses would get very angry if they found that somebody had given *kastom* medicine to a patient. She explained that the nurses would scream and yell and in some cases they would even throw the patient out of the hospital. The story was later confirmed by a nurse who previously had worked in Honiara.

[39] The effect feared by the hospital staff is described by Etkin (1999:177) who states that the interaction between certain plants and pharmaceuticals might have potentiating or antagonistic effects. Potentiating refers to the enhancing effect of something on the activity of a drug, antagonists are substances that impede the action of a drug.

Both the fact that the clinic in Kia was more open to the use of *kastom* medicine than both the provincial hospital in Buala and the National Referral Hospital in Honiara coincide with the statement made by the WHO (2009)

"In 1979, the Government (of SI) officially recognized and accepted the use of traditional medicine as a supplement to allopathic medicine in rural communities where **the availability of allopathic drugs is limited.** The policy states that traditional medical practice is not to be institutionalized but, rather, is to remain largely in the hands of individual practitioners."

(Emphasis added)

Both the hospital in Honiara and to a large extent the hospital in Buala have high availability of what is here called allopathic drugs[40]. Because of this the use of *kastom* medicine is deemed as unnecessary. In Kia the availability of biomedical drugs is limited and for long periods of time the clinic can be completely without medicines. This makes the clinic more dependent on other alternatives and *kastom* medicine becomes important. The government having allowed the use of *kastom* medicine as a supplement to biomedicine further increases openness towards the use of *kastom* medicine. The hospital in Honiara, being the main national hospital, is much better equipped both with staff, equipment and medicines than both the hospital in Buala and the clinic in Kia. And they would rarely, if ever have no other available options than *kastom* medicine and are thereby free to deny the use of *kastom* medicine at the Hospital in accordance with the 1979 legislation.

Conclusion

Grønhaug (1978) states that events in large scale fields, such as the national economy, affect local level processes. This has been shown concerning the decision making processes in regards to healthcare in Kia, in which the increased use of *kastom* medicines can be understood as a response to global or national, economic or political changes. In this chapter I have sought to establish the relation between the different fields following Singer's (1986), different levels. It was possible to examine how events on the macro level affect healthcare on the micro level which I argue is essential in the understanding of the healthcare of Zabana

[40] In this context allopathic drugs is the equivalent of what I have referred to as biomedical drugs.

people as it allows for a greater understanding of the changing availability of their healthcare options and how this affects their practises related to health.

Solomon Islands is a developing country which has, and still is experiencing great economic challenges as well as political instability in recent years. Due to these circumstances funds have been allocated in certain ways and according to some such as Friedlander (1987) the funds have been allocated in a way which only benefits the fortunate few while the majority of the population living in rural areas have become ignored. As a result of this, rural areas such as Kia are experiencing a lack of personnel, equipment and medicines.

As I have shown in this chapter, the challenges experienced by clinics and hospitals in rural areas affect the level of healthcare they are able to provide to people in their respective areas. The experienced lack of personnel and medicines in rural areas affects patients' attitudes towards the use of the biomedical options available to them. Furthermore, the lack of equipment and medicine leads to an increased use of *kastom* medicine by both biomedical staff and patients.

This chapter has placed the healthcare reality of Kia in the context of its political and economical surroundings and has exemplified the adaptive nature of Zabana people as they adjust to changes in their lives introduced by factors outside their control.

Afterword

The main focus of this thesis has been to explore the medical realities of life in a rural Solomon Islands village; a reality which I have argued is one of medical pluralism. How does the medically pluralistic system of Kia play out and which factors affect it and Zabana people's use of the healthcare available to them? This thesis argues that in order to understand the complex nature of Zabana people's knowledge and practice related to health and their current healthcare system, a holistic approach is required, which incorporates the cultural, historical and political-economical factors which influence life in Kia.

Before the arrival of whalers, traders and missionaries in Solomon Islands the local population already had a complex understanding of health, illness and the associated methods for prevention and treatment. *Kastom*, as a medical system, incorporates both the physical and the spiritual world as it seeks to explain, cure and prevent illness. In the meeting between a medical system which incorporates spiritual factors in its explanatory model, and biomedicine which essentially is reductionist and excludes spiritual factors from its paradigm, the notion of a dichotomy is common, often in the form of "traditional medicine" opposed to a "modern medical system" (Crandon 1986). Baer et al (2003) state that within many societies whom exhibit medical pluralism, the nature of pluralism tends to be plural rather than pluralistic, as one medical system gains dominance over another, commonly exemplified by biomedicine dominance over other medical systems. Throughout this thesis I have argued that the situation in Kia is essentially pluralistic, as the healthcare system is both flexible and dynamic where both *kastom* medicine and biomedicine have been incorporated into a single system.

In order to understand interactions between important categories of medical knowledge and practice in Kia, which I have described as *kastom* medicine, biomedicine and Christianity, I have chosen to focus on the history of Christianity and biomedicine in the region. Noting how Zabana people perceived and incorporated both Christianity and biomedicine into an existing body of knowledge and practice reveals the flexible and open

nature of Zabana people's world view and their pragmatic approach to life in general and health and healthcare in particular.

Within the current medical and religious paradigm, with which they have incorporated both *kastom* beliefs and medicine with Christianity and biomedicine, Zabana people are free to choose whatever treatment available which they perceive as best in a situation where illness has occurred. The use and practise of *kastom* medicine for the people in Kia, therefore, does not represent a conflict with their Christian identities. Thus, I have argued that a Zabana approach to illness is essentially pragmatic as their choice of treatment is dependent on the utility of the treatment in a given situation.

In this locally grounded analysis of healthcare in Kia I have considered important aspects of local understandings of health and illness, the local approach to illness and the local medical paradigm in general. However, in the exploration of Zabana people's approach to illness, certain statements underline the need for a theoretical approach which provides a wider scope, such as; "The clinic is too far away", "petrol is very expensive" and "we don't go to the clinic because it is always out of medicines".

Solomon Islands is recognized as one of the poorest countries in the world and with the least developed economy in the Pacific (Economic Affairs 2009). Within the last ten years the country has experienced a 4 year long period of tension from which the entire country's political and economical system experienced near total collapse. In 2006 the country experienced a new period of unrest resulting in the resignation of the country's prime minister. This political unrest in the country has gravely affected political and economical attention to health. By applying Grønhaug's (1978) field theory, whereby "specific fields should be studied in the context of their interrelations" (1978:104), I have found it possible to find links which connect actions of people on the local level with political-economical factors on both the national and on a further macro level (Singer 1986). After examining the tension in Solomon Islands I found that it was followed by a collapse of law and order, infrastructure and economy. Biomedical healthcare options became restricted nationwide and the provinces' interaction with and supplies from the capital were limited. In the absence of imported food, equipment and medicines, Zabana people turned to traditional food production and to *kastom* medicine. By employing an anthropological approach, which not only considers local dimension of healthcare, but which also considers political-economic forces which influence attitudes towards availability of healthcare options, one gains a more complete understanding of the rural healthcare system.

Solomon Islands is today facing many challenges related to health and healthcare. With limited funds the country is forced to deal with both the continuous high level of infectious disease in addition to the quickly increasing group of non-communicable diseases such as diabetes and heart disease (WHO 2006:319). My thesis is a contribution to medical anthropological research in the region, but I argue that more research of this kind is needed. In order to conclude this thesis I will propose some directions for future research and pose some questions which I believe will become increasingly important for the population of Solomon Islands in the years to come.

Solomon Islands health policies are developed on a general level and not adjusted to local circumstances. In this respect the approach which I have argued for throughout this thesis, which seeks to take into consideration both the local and the macro level, can be of critical value. An example of an area of research that I believe could benefit from the holistic approach which I have advocated throughout this thesis, is sexually transmitted diseases (STDs). Over the last 10 years Solomon Islands have experienced an increase in the prevalence of STDs (SINHSP 2006). The increase is especially significant in Honiara, but remote rural villages such as Kia have also noticed the spread. Why are STDs spreading more rapidly now than before? Who and what is contributing to their spread?

The national Solomon Island's government are now deeply concerned that the increase in cases of STD's is a indicator of an eminent epidemic of HIV/AIDS similar to the one seen in Papua New Guinea. In PNG the prevalence of HIV is now rated at 1.8% and in city areas it may be as high as 3.5%. (Bowtell 2007:3). This is an unwanted development as the human suffering is great, and economically Solomon Islands do not have the funds to deal with a similar epidemic. In many areas of the world, sexually transmitted diseases represent a sensitive cultural issue. Therefore a proper analysis of the experience of sexually transmitted diseases must necessarily transgress the physical boundaries of the disease itself and include the social and religious context in which it occurs. A holistic approach towards such illnesses therefore encourages an understanding that may have immense practical value in education aimed at the prevention of such diseases.

On a similar, but somewhat different note, in recent political developments in Solomon Islands, certain provinces of Solomon Islands are working towards becoming acknowledged as separate states. If Isabel Province follows in the footsteps of Western Province, who now seeks to achieve statehood as "State of the Western Solomons" (Government of the state of Western Solomons 2000) with less contact and infrastructure connecting Isabel to Honiara, what will happen to health and biomedical healthcare?

Economically Isabel will become entirely dependent on logging and mining activities. *Kastom* medicine today is already facing threats posed by increasing logging activities conducted everywhere in Solomon Islands. Recently, it has become increasingly clear that mass deforestation of certain areas of the world results in large environmental changes, which can have an effect on the variety and availability of various types of medicinal plants. Furthermore it will have an affect on diet of Solomon Islanders living of subsistence farming which according to WHO (2004:331) include 79% of the population. In the case of further increased logging in Solomon Islands, how will this affect diet, health and *kastom* medicine, and subsequently, rural healthcare?

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