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Education & Training | Apo Aporosa

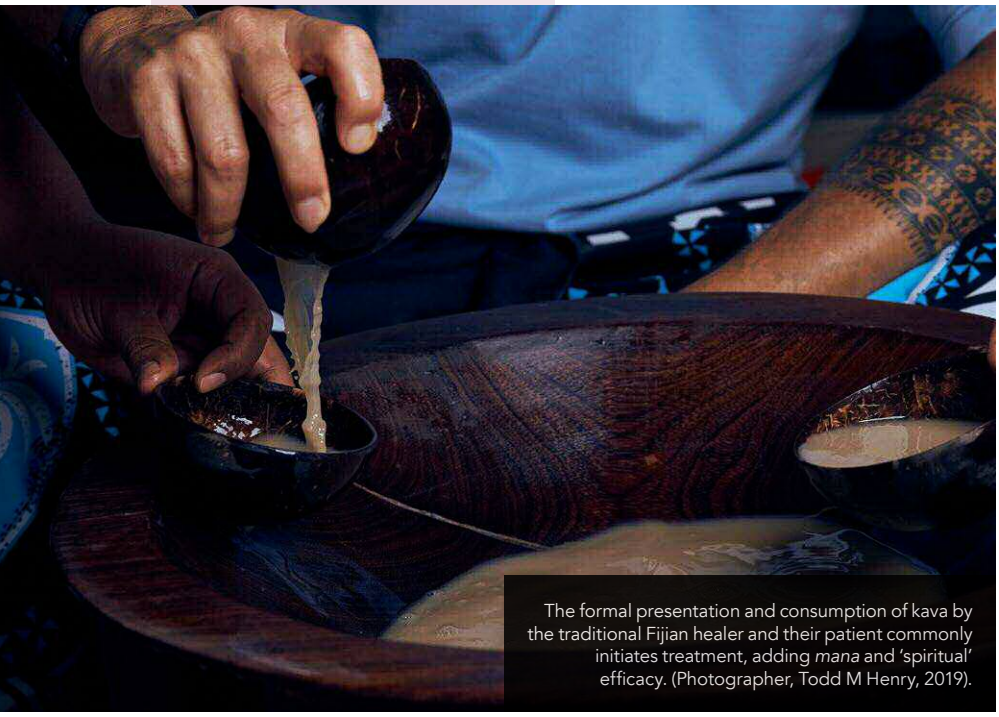
Supernatural curses in Pacific communities

A challenge for modern healthcare

While largely ignored by modern medical science, spirituality and supernatural phenomena continue to play a significant role in the belief systems of Indigenous peoples. In the Pacific and Pacific diaspora, 'curses' are commonly cited as the cause of death, poor health, and diminished wellbeing. At The University of Waikato, Dr Apo Aporosa teaches future healthcare workers the importance of acknowledging and respecting these beliefs, even if they go against personal belief structures. This encourages 'cultural safety' aimed at improving healthcare delivery and health equity in Pacific communities.

Since time immemorial, science and religion have navigated a tricky and often confrontational relationship. In 1633, Galileo Galilei was tried by the Inquisition and imprisoned for publishing his theory that the Earth revolves around the Sun. Conversely, medical science broadly sidestepped such conflict as supernatural powers and spirituality were believed to influence issues of health. In Ancient Egypt for instance, prayer together with herbal remedies and medical procedures were all tools of the healthcare worker; in Tudor England, hospitals were commonly run by monks from various religious orders in which prayer was a key element of healthcare delivery.

For the Global North (and those lands under colonial control), the situation changed with the advent of modern medicine. Led by 18th-century medical pioneers such as Dr John Hunter,[1] the Western 'secular scientific worldview' rapidly superseded belief in a paranormal or supernatural existence, with medical practice and healthcare systems now largely independent of religion. Nevertheless, there remain pockets around the world where communities still hold strong traditional beliefs linking medicine and healthcare with Indigenous spiritualism and demonic and 'malevolent influences'.[2] With that Western 'secular scientific worldview' dominating most healthcare learning and delivery systems, this has created challenges for healthcare professionals working in, and with, peoples from communities with strong ties to Indigenous spiritualism. This necessitates healthcare practitioners who seek to move past 'cultural competency' to 'working towards cultural safety and critical consciousness' (see Curtis et al[3]), and who acknowledge and accept the belief systems of their patients, regardless of their own belief structures. At the University of Waikato in Aotearoa New Zealand, Dr Apo Aporosa teaches undergraduate health and psychology students about the interconnection between supernatural causes, curses, and Pacific perspectives on health and wellbeing.[4] This is aimed at encouraging culturally safe reflective practice among their future healthcare workers.



The formal presentation and consumption of kava by the traditional Fijian healer and their patient commonly initiates treatment, adding *mana* and 'spiritual' efficacy. (Photographer, Todd M Henry, 2019).

In many Pacific communities, including the Pacific diaspora, belief in the supernatural is deeply ingrained in daily life, with some individuals navigating their relationships to mitigate the risk of being cursed.[5] Additionally, it is common for death, disease, and illness to be reasoned on curses, activated by

Following the presentation and consumption of kava, these traditional Fijian healers commence their treatment.

nefarious actors and/or linked to the violation of *tapu* (taboo).[6] This belief in curses therefore has implications for healthcare delivery and healthcare workers, particularly for those from strong secular backgrounds and trained within highly Eurocentric training environments that favour biological over spiritual explanations. Aporosa brings his teaching to life through case studies, revealing to his students the real-world healthcare implications for those working with Pacific peoples.

PACIFIC *WAIRUA* (SPIRITUALITY): A CASE STUDY FROM FIJI

One such case study comes from Aporosa's own community, where two small villages with close kinship ties sit less than a kilometre apart. Village 1 has no river, and only an intermittent supply of water; Village 2 has a large freshwater river with abundant fish resources. Village 1 has limited areas of fertile soil and only a small number of cattle, pigs, and goats; Village 2 has an abundance of fertile ground and large herds of animals. Village 2 is also home to two ex-military personnel who receive a regular Government pension, providing the village with a regular and reliable income. Objectively speaking, and according to development metrics used in modern academic discourse, Village 2 enjoys a richer resource base and should be comparatively 'better off' than Village 1. In reality, this is not the case. Village 2 has high rates of illness, particularly eye and skin conditions. Most children born are female; those that are born male – who are important to physically demanding work – tend to be sickly and develop slowly. The villagers suffer from poor wellbeing; they are often lethargic and struggle with feelings of powerlessness. Over the sharing of kava – a drink made from the crushed root of the kava plant and widely believed to be imbued with *mana*, or spiritual power[7] – Aporosa met with the people of Village 2, and learned that these misfortunes in the face of apparently bountiful natural resources result from '*matenivanua*', or a curse on the *vanua* – the land, the culture and the people.

The story of the 'curse', as detailed below, provides a fascinating insight into the historical, social, and cultural heritage of Fiji, and the interplay with health, wellbeing and community psychology linked to deeply held spiritual beliefs. Supporting the notion of the 'curse', and therefore adding to its efficacy, were ministers from the Methodist Church, who believed that it had resulted from 'the sins of the fathers falling on their children'. Tomlinson,[8] citing a similar situation, wrote that a curse is 'exceedingly vivid in the Fijians' imagination', literally manifesting as 'a voice to intimidate' from the underworld. Aporosa leaves it to his students to decide if the curse is 'real', although he encourages dialogue to aid cultural safety and critical consciousness. For instance, does the curse continue to exist simply because

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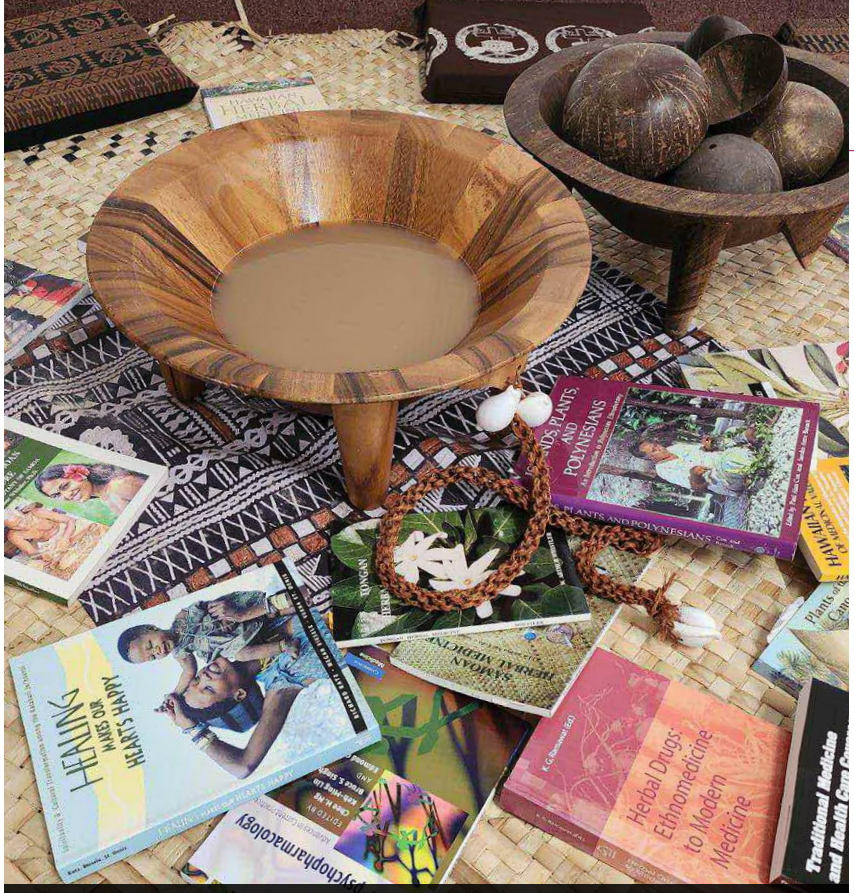

Aporosa aims to inspire future healthcare workers to cultivate professional relationships with patients that nurture their Indigenous and spiritual belief systems, thereby supporting their aspirations for health and wellbeing.

of the continued and widespread discussion of it in the community – that is, 'the more you talk about it, the more it becomes real'? Are the impacts of the curse in fact the natural result of actions taken by the villagers in response to their belief structures – that is, self-fulfilling fatalism, simply a result of cause and effect? Or, is the curse real? Other supernatural events have been reported around the world, some in authoritative peer-reviewed publications; were these also real, or are there logical, scientific explanations?

From the perspective of healthcare provision and Aporosa's teaching, the answers to these questions are aimed at stimulating critical thinking and cultural safety, encouraging his future 'health practitioners to examine themselves and the potential impact of their own culture on clinical interactions'.[3] This in turn contributes to the 'creation of culturally safe environments and therefore to the elimination of Indigenous and ethnic health inequities.' [3]

A TALE OF TWO VILLAGES

In the 1600s, war was raging between two opposing districts in Fiji. In Village 1, perched high on a hillside for defensive reasons, the village chief had twin sons. Following a brotherly rift, one of the twins took a band of followers and left the village, establishing Village 2 in the opposing territory. There, his followers married into the local community, creating new ties with their former enemy.

Safe and effective healthcare requires culturally informed 'critical consciousness' and healthcare professionals who acknowledge and accept the belief systems of their patients.

In the 1840s, when the war had ceased and defence was no longer a concern, Village 1 moved down the hillside to reap the benefits of direct sea access (fishing, transport, and trade). The new location was just 700 m from Village 2, now a vibrant, bustling, and healthy community in which missionaries had established a school (which still stands today as the community high school) on adjacent land belonging to Village 2.

In the 1920s, and now under British colonial rule, the government established the Native Lands Commission, who were tasked with that popular colonial go-to activity of creating district boundaries. These boundaries were to run along conveniently straight lines, regardless of traditional and/or more intuitive divisions (eg, river valleys and other natural topographical features). Meetings were held with the chiefs of adjoining districts, including between those of Villages 1 and 2, to determine where boundaries should fall. To resolve a disagreement, the chief of Village 2 was asked to settle the boundary based on ancestral connections, and to affirm his decision by kissing a Christian bible. Forgetting, or ignoring, the ancestral links between the two villages, he drew a line between them. On that kiss, the boundary between the villages was established in law, but so too was the curse, which has now blighted Village 2 for more than 100 years.

In recounting this ethnography, Aporosa stresses that it is not unique to these two particular villages. Similar stories and 'curses' are reported across Fiji and other islands of the Pacific, with similar impacts on health and wellbeing. Today, modern healthcare professionals must be aware of their own belief systems and how their biases potentially interfere with the delivery of healthcare to those who conceptualise supernatural influences in their experiences of illness. Moreover, dismissing nativist dogma in Western-practiced healthcare systems enacts colonised structures and ways of doing under the guise of helping, resulting in the systematic dismantling of healthcare equity and the sociocultural fabric for those who experience greater health disparities. Unless healthcare professionals rise to this challenge and work from a position of cultural safety, health workers should not practice in Pacific Island communities.

Behind the Research

Dr Apo Aporosa

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Research Objectives

Drawing from a case study in rural Fiji, Apo Aporosa aims to raise awareness and sensitivity to the belief systems of Indigenous peoples, which have implications for quality healthcare delivery. Through an increased understanding, healthcare workers can enhance health and wellbeing outcomes.

Detail

Bio

Dr 'Apo' Aporosa is maternally related to the village of Naduri in Macuata, Fiji. He has a doctorate in Development Studies from Massey University (Aotearoa New Zealand). Based at Te Huataki Waiora School of Health at The University of Waikato, Apo is the current holder of the *Duruvesi – Bula ni Pasivika* role as a Senior Lecturer in Pacific Health. He also teaches, is a senior leader in the Pacific Strategic Team, and investigates the cultural, health and psychopharmacological aspects of kava when used at traditional consumption volumes.

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Collaborators

- Dr Jordan Te Aramoana Waiti (Māori Measures and Outcomes, ACC, Aotearoa New Zealand)
- Dr Gloria Hinemoa Clarke (Te Huataki Waiora School of Health, The University of Waikato)
- Professor Dennis Itoga (School of Professional Psychology, Chaminade University of Honolulu)
- Professor Emeritus Richard Katz (First Nations University of Canada)

THE UNIVERSITY OF WAIKATO
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PACIFIC AT WAIKATO

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Personal Response

What practical steps can healthcare workers take when addressing the health problems in Village 2, while also remaining respectful of the local belief in the curse?

" Underpinning Pacific practice and embodiment is *vā*, known as *veiyaloni* in Fiji. This is the development and maintenance of relational connections associated with *talanoa* (meaning-making through conversational processes). For a healthcare worker to address the matters in Village 2, this would require a significant level of *vā/veiyaloni,* affording a depth of interpersonal influence and sociocultural approval allowing the practitioner to consult and collaborate with the Village 2 community and traditional healers and Pacific Christian Ministers, to enact a process to 'break' the curse. Consensus among the villagers that the curse has been 'broken' is very important. I would suggest the healthcare worker then utilises an integrative *Indigenous* / community psychology approach grounded upon partnering with stakeholders to examine *Indigenous Healing Psychology's*[9] *'way of living'*, and create a shared narrative that initiates a paradigm shift moving forward, with the intention of achieving community-informed long-term strategies. Given that the curse is several generations old, the initial paradigm shift requires strong investment by all participants to create agreed upon change objectives in the short-term, while aiming for regular *talanoa*, assessments, and re-evaluation of newly emerged perspectives as Village 2 moves towards long-term goals. "