

Indigenous Peoples and Diabetes

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Indigenous Peoples and Diabetes
Community Empowerment and Wellness
Mariana Leal Ferreira *and* Gretchen Chesley Lang



Indigenous Peoples and Diabetes

Community Empowerment and Wellness

Edited by

Mariana Leal Ferreira
San Francisco State University

and

Gretchen Chesley Lang
University of North Dakota

Carolina Academic Press
Durham, North Carolina

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Library of Congress Cataloging-in-Publication Data

Indigenous peoples and diabetes : community empowerment and wellness / by Mariana
Leal Ferreira and Gretchen Chesley Lang.

p. cm.

ISBN 0-89089-580-5

1. Diabetes--Social aspects. 2. Indians of North America--Diseases. I. Ferreira,
Mariana K. Leal (Mariana Kawall Leal). II. Lang, Gretchen Chesley.

RA645.D5I53 2005

362.196'462'008997--dc22

2005007639

Carolina Academic Press
700 Kent Street
Durham, NC 27701
Telephone (919) 489-7486
Fax (919) 493-5668
www.cap-press.com

Printed in the United States of America

To all our relations!

and

To the Seven Generations!

Contents

Foreword, <i>Nancy Scheper-Hughes</i>	xvii
Series Editors' Preface, <i>Pamela J. Stewart and Andrew Strathern</i>	xxiii
Acknowledgments	xxvii
Introduction Deconstructing Diabetes, <i>Mariana Leal Ferreira and Gretchen Chesley Lang</i>	3
Who are Indigenous Peoples and Where Do They Live ?	8
What is Type 2 Diabetes? Expanding the Biomedical Point of View	9
Indigenous, the United Nations' Definition	10
Who is Indigenous? Territory, Politics and Identity	10
A Worldwide Epidemic	11
Biomedical Diagnosis and Treatment of Diabetes Type 2	12
Racializing Diabetes, Disempowering the People	12
Century of the Gene Becomes Century of Genetic Determinism	13
The Politics of Indigenous Identity: Consequences of the Once-Popular 'Thrifty Gene' Hypothesis	14
The Gene as Culprit	15
Linking Diabetes, Social Inequality, and Trauma	16
Outline of the Book	17
Final Thoughts	25
The International Labor Organization (ILO)	27
References	27
Chapter 1 Emotion, Grief, and Power: Reconsiderations of Hawaiian Health, <i>Jo C. Scheder</i>	33
Part 1. Taro Tales: Land, Power and Hawaiian Health	34
Part 2. The Death of Health: Cosmology and Emotion in Colonial Depopulation	39

Why “Depopulation”?	40
In Theory: The Biology of Depopulation	41
New Pathogens, Stress, and Immunity	42
Novel Pathogens	42
Chronic Stress and Immunity	42
Changes in Status and Role Expectations	42
Caregiving and Bereavement	43
Historical Reports and Cultural Meaning in Hawai‘i	43
Meaning and Being	46
The Tenacity of an Incomplete Idea	47
Questions and What We Know	48
Acknowledgments	49
References	49
Chapter 2 ‘In Their Tellings’: Dakota Narratives about History and the Body, <i>Gretchen Chesley Lang</i>	53
Narratives	55
Theoretical Considerations	56
“Things aren’t being done right around here on this reservation, and we seem to have more and more of these problems like diabetes.” — Carl Webster	58
Community at Devil’s Lake	62
“Worry makes my sugar go up.” — Mary Peters	64
Ethnographic Contexts	66
Final Thoughts	67
Acknowledgments	68
References	68
Chapter 3 Slipping Through Sky Holes: Yurok Body Imagery in Northern California, <i>Mariana Leal Ferreira</i>	73
Introduction	74
Mapping Lines of Life: Early Studies	75
The New Genetics and Indigenous Peoples	77
The Sick, the Insane and the Criminal: Embodying Human Relations in Disease	80
How to Read the Genealogical Charts	82
Sarah Tsurai	83
Mary Wo’tek	88
Julia Stowen	93

Curiosity in Hybrids and Monsters or “The White’s Blood Obsession”	94
The Distribution of Land and “Indian Soul and Conduct”	96
Concluding Observations	98
Acknowledgments	99
References	100
Chapter 4 Diabetes in Réunion Island (Indian Ocean): From Sugar Plantations to Modern Society, <i>Muriel Roddier</i>	105
Historical Background: The Peopling of Réunion Island	106
From the Relation to Sugar in the Local Context to ‘Sugared Diabetes’	108
The History of Diabetes on La Réunion	110
Construction of Diabetes by Those Who Experience It	114
Conclusions	118
Acknowledgments	119
References	119
Chapter 5 Nêhinaw (Cree) Socioeconomic, Political and Historical Explanations about the Collective Diabetes Experience, <i>Jocelyn Bruyère</i>	123
Historical Background: The Disruption of Cree Traditional Life	123
Etiology: <i>Wāmistikosew</i> , <i>Me’chim</i> , and Ecological Destruction	128
Me’chim (Food), History, and Politics	132
Final Thoughts	135
Acknowledgments	135
References	135
Chapter 6 Mino-Mijjim’s ‘Good Food for the Future’: Beyond Culturally Appropriate Diabetes Programs, <i>Emily Omura</i>	139
Methods	141
Mino-Mijjim	141
Mino-Mijjim: Margaret’s Program	142
White Earth Land Recovery Project (WELRP)	143
White Earth Land Recovery Project: Addressing Structural Violence	145
Production of White Earth Traditional Food Packages	149
Traditional Food?	149
Food and Community Identity	150
History of Lifestyle Changes	153
Food Availability and Individual Choices	157
Narratives of Diabetes	160

Conclusion	162
Acknowledgments	163
References	163
Chapter 7 Diabetes and Identity: Changes in the Food Habits of the Innu — A Critical Look at Health Professionals’ Interventions Regarding Diet, <i>Bernard Roy</i>	167
A Fight to the End Against “Bad Food Habits”	168
Food Guide and “Culturization” of the Message	169
Mixed Results	170
Conscious and Knowledgeable Populations	172
Why the Repeated Failures?	173
The Complexity of Food Habits	174
The Act of Eating — A Political Act	175
Recognition and Differentiation through Eating	175
Sunday Meal	177
Eating as Differentiation	178
Assertion and Withdrawal	179
Eating as a Political Act	180
Acknowledgments	183
References	183
Chapter 8 Prenatal Mysteries and Symptomless Diabetes in the Gila River Indian Community, <i>Carolyn Smith-Morris</i>	187
Introduction	189
An Ethnography of Pregnancy	190
Gestational Diabetes	191
Healing Practices on the Reservation	192
Pima Women’s Understandings of GDM	193
Fluctuating Test Results	194
Symptomless Diabetes	195
Related Problems in Diabetes	198
Summary and Discussion	200
Acknowledgments	201
References	201
Chapter 9 Talking about a New Illness with the Dakota: Reflections on Diabetes, Foods, and Culture, <i>Gretchen Chesley Lang</i>	203
Introduction	205

Theoretical Considerations	207
Diabetes from a Biomedical Perspective	209
Background: Devil's Lake Sioux Community	211
Traditional Medicine and Religion	213
Foods, Eating and the "Diabetic Diet"	214
Etiological Explanations, Experience of Illness and Efficacy of Treatments	220
Discussion and Conclusion	224
Acknowledgments	226
References	226
Chapter 10 Burying the Umbilicus: Nutrition Trauma, Diabetes and Traditional Medicine in Rural West Mexico, <i>Leslie E. Korn and Rudolph C. Ryser</i>	231
Part 1. Center for Traditional Medicine—Philosophy and Practice	232
Drugless Medicine in the Tropical Forest	236
Meaning and Success	238
A. Traditional Medicine Practices in Western Mexico	239
B. "Defective Modernization"	242
C. Imposed Development and Chronic Disease	244
D. Community Trauma	245
E. Nutrition Trauma	249
F. Intergenerational Traumatic Stress	250
G. Stress and Diabetes	252
Part 2. Metabolizing Trauma: The Case of the <i>Comunidad</i> Indigena de Chacala	253
Part 3. History of Nutrition Trauma in Mexico	256
Pre-Colonial Diet	256
NAFTA-Cized Mexico: The Global Soybean, Defective Modernization and Diabetes	258
Part 4. The Pedagogy of the Nourished	259
Natural Medicine Health Promoter Training	262
A. Exotic Food Preparation Using Local Foods	262
B. Intergenerational Activities	263
C. Herbal Validation	263
Nutritional Protocols for the Treatment of Diabetes	266
A. Nutritional Supplementation	267
B. Essential Fatty Acids	267
C. Vitamin and Mineral Supplementation	269

Project Significance	269
Acknowledgments	270
References	270
Chapter 11 A Sickly-Sweet Harvest: Farmworker Diabetes and Social (In)Equality, <i>Jo C. Scheder</i>	279
Background: Social Conditions, Stress, and Diabetes	280
Psychological and Social Correlates of Diabetes	282
The Neurophysiological Link Between Stress and Glucose Intolerance	283
The Mexican-American Migrant Lifestyle, Stress, and Diabetes	283
Stressors Among Mexican-American Migrants	284
Mortality and Morbidity from Diabetes Mellitus Among Mexican-Americans	287
Research Design	288
Results	290
Discussion	297
Models of Social Conditions and Diabetes	302
Conclusion	303
Acknowledgments	305
References	305
Chapter 12 Diabetes as a Metaphor: Symbol, Symptom, or Both?, <i>Terry Raymer</i>	313
Introduction	314
Genetics and Lifestyle	315
Taking Food for “Granted?”	318
The Greedy Father, as told by Paula Allen (Yurok, Karuk, and Hoopa)	318
Gestational Factors	322
Complex and Obscure: Stress, Depression, and Cultural Trauma	324
Conclusion?	329
Acknowledgments	330
References	330
Chapter 13 The Spirit’s Cell: Reflections on Diabetes and Political Meaning, <i>Jo C. Scheder</i>	335
Prologue and Perspective	335
Paths to “Untangling”	339
The Spirit’s Cell: A Physiology of Oppression	342
Native Hawaiian Health	343

Compulsory <i>Aloha</i>	347
Acknowledgments	349
References	350
Chapter 14 Love in Colonial Light: History of Yurok Emotions in Northern California, <i>Mariana Leal Ferreira</i>	357
Introduction	358
Mollie Ruud: “Indian people have always been closely watched and controlled”	358
The Social and Political Context Where Diabetes Originates	362
Mollie Ruud: “I just can’t handle freedom”	364
Illness Narratives, Traumatic Experience, and Type 2 Diabetes	368
Ethnographic Research Methods: Correlating Qualitative and Quantitative Information	369
Emotional Experience and the Autonomic Nervous System	372
Recipe for Acorn Soup	373
Hitting the Jackpot: Love, Solidarity and Generosity	376
A Politically Meaningful History of Emotions	380
Acknowledgments	381
References	382
Chapter 15 Relaxation and Stress Reduction for People with Diabetes Mellitus, <i>Angele McGrady and Kim Grower-Dowling</i>	387
Introduction	387
Part 1. Types of Relaxation	389
Breathing Therapy	390
Autogenic Relaxation	390
Progressive or Neuromuscular Relaxation	391
Yoga	392
Transcendental Meditation	393
Mindfulness Meditation	394
Part 2. Enhancement of the Relaxation Response	394
Healing Words	395
Imagery	395
Biofeedback	396
Part 3. Autogenic Relaxation Process and Benefits	397
Part 4. Effects of Relaxation on Diabetes Mellitus	400
Summary	401
References	402

Chapter 16	Community Empowerment for the Primary Prevention of Type 2 Diabetes: Kanien'kehá:ka (Mohawk) Ways for the Kahnawake Schools Diabetes Prevention Project, Ann C. Macaulay, Margaret Cargo, Sherri Bisset, Treena Delormier, Lucie Lévesque, Louise Potvin and Alex M. McComber	407
	Introduction	408
	Primary Prevention of Type 2 Diabetes	410
	Origins of the Kahnawake Schools Diabetes Prevention Project	412
	A Participatory Approach to Community-based Research	415
	KSDPP Community Advisory Board	415
	The KSDPP Code of Research Ethics	417
	Kahnawake Schools Diabetes Prevention Project	419
	The KSDPP Model of Community-based Intervention	419
	Elementary Schools' Interventions to Educate Young Children	421
	Community Interventions to Promote Living in Balance	423
	Reflections on the KSDPP Model	425
	Challenges	426
	Reflecting on Community Governance	426
	Conclusion	427
	Acknowledgments	428
	References	429
Chapter 17	"I'm Too Young for This!": Diabetes and American Indian Children, Jennie R. Joe and Sophie Frishkopf	435
	Type 2 Diabetes	437
	Pediatric Type 2 Diabetes	437
	Risk Factors and Complications	438
	Social and Political Factors	439
	Childhood/Youth Culture and Diabetes	442
	Cultural Competency from Within and Without	444
	Intervention/Prevention Programs for Children/Youth	444
	The NARTC Summer Wellness Camp	447
	Issues of Cultural Sensitivity	449
	Physical Activities and Diabetes Education	450
	The Campers	451
	Personal and Psychosocial Consequences	452

Evaluating Outcomes	454
Campers' Opinions about the NARTC Summer Wellness Camp	454
Summary	455
Acknowledgments	455
References	456
Chapter 18 Touch the Heart of the People: Cultural Rebuilding at the Potawot Health Village in California, <i>Mariana Leal Ferreira, Twila Sanchez and Bea Nix</i>	459
Introduction: The Importance of Culture for a Healthy Community	460
Everyday Life and the Power of Ethnographic Fieldwork	461
Cultural Rebuilding at the Potawot Health Village	463
<i>Touch the Heart of the People: Suggested Activities for a Theory of Cultural Rebuilding</i>	473
1. Women Support Groups	474
2. Music Therapy: Sacred Songs and Chanted Prayers	477
Music Therapy Websites	479
3. Art Therapy: Basket Weaving, Beading, and Abalone Carving	480
4. History Telling	481
5. The Right to Food: Traditional Food Gathering and Preparation	482
The Right to Food. Indigenous Peoples International Consultations on the Right to Food	483
Final Thoughts	485
Acknowledgments	486
References	486
Chapter 19 Culture Blindness? Aboriginal Health, 'Patient Non-Compliance' and the Conceptualisation of Difference in Australia's Northern Territory, <i>Kim Humphery</i>	493
Australian Socio-Cultural Research on Indigenous Health: Some Background	495
The Uses of Culture	497
Researching 'Patient Non-Compliance'	498
Voicing Cultural Difference	501
The Place of 'the Cultural' in Aboriginal Health Services Provision	505
Conclusion	507
Acknowledgments	507
References	507

Chapter 20 Striving for Healthy Lifestyles: Contributions of Anthropologists to the Challenge of Diabetes in Indigenous Communities, <i>Dennis Wiedman</i>	511
Introduction	511
Cultural Sensitivity through Community and Clinical Collaborations	515
Profile: Rebecca Hagey	515
Cultural Models of Diabetes	516
Profile: Linda Garro	517
Patients and Providers	518
Profile: Linda Hunt	520
Biomedical Domination and the World System	521
Indigenous Medicine	521
Modernization and Technological Change	523
Profile: Joel Gittlesohn	524
Policy Development	526
Profile: Cheryl Ritenbaugh	527
Anthropologist and Indigenous Community Collaborations	528
Acknowledgments	529
References	530
Contributors	535
Index	543

Foreword

Diabetes and Genocide— Beyond the Thrifty Gene

Nancy Scheper-Hughes*

“To say I am Native American means I am or will be diabetic.”

“That’s what the doctor told me. We Indians have bad blood. See, that’s why I drank so much all my life. It’s in me, in my blood. So there’s not much I can do about it, either.”

Yurok individuals to Mariana Ferreira, this volume

“The tradition of the oppressed teaches us that the state of emergency in which we live is not the exception but the rule. We must attain to a conception of history that is in keeping with this insight. Then we shall clearly recognize that it is our task [as intellectuals] to bring about a real state of emergency, and this will improve our position in the struggle against Fascism. One reason why Fascism has a chance is that in the name of progress its opponents treat it as a historical norm.”

Walter Benjamin, “Theses on the Philosophy of History”

There are different ways of imagining, ‘reading,’ and interpreting history: bio-evolutionary history; social or collective history; individual/biographical/personal history. While all of these can offer essential insights toward understanding and responding to the particular vulnerabilities of Indigenous Peoples and communities world wide to adult onset (i.e., type 2) diabetes, this collection emphasizes the impact of social history—colonial histories and their sequelae, to be exact—on the etiology and epidemiology of diabetes today in Indigenous communities in North America, Latin America, the Arctic, Australia and the Indian Ocean.

Walter Benjamin,¹ writing on the eve of World War II, recognized an invisible feature of social and political life, which while appearing in a more exaggerated form under fascism, obtains in most societies and under various forms of governance and

* Nancy Scheper-Hughes, Ph.D., is a Professor of Medical Anthropology and Director of the Critical Studies in Medicine, Science, and the Body at the University of California at Berkeley.

1. Walter Benjamin. 1968 [1940]. *Illuminations: Essays and Reflections*, edited by Hannah Arendt. New York: Schocken.

governmentality: the tendency to ‘normalize’ suffering, disease, and premature death among certain excluded or marginalized classes and populations. This is what Michael Taussig² (reflecting on Benjamin) calls “terror as usual” and what I have called “everyday violence,”³ though we do not usually associate disease with violence and terror, except perhaps when diseases are linked to biological warfare and other forms of blatant bio-terrorism. But violence and disease are linked in more ordinary way in social and bureaucratic indifference toward the excess morbidity and mortality of certain populations under the assumption that alarming statistics are not to be seen as alarming at all but rather as ‘normal’ to the population and therefore ‘to be expected.’ Another, is in the rush to biologize and racialize gross differences with respect to vulnerability to disease. Thus, alcoholism, depression, and suicide, obesity and diabetes in Indigenous communities have been normalized and racialized, consciously or not, in etiological theories.

To date, the prevailing medical model of diabetes etiology focuses on the ‘faulty genes’ of Indigenous Peoples combined with their faulty diets and other unhealthy behaviors, victim-blaming hypotheses that only serve to trap the sick person inside a cage of disease that is seemingly of their own making. Thus, some of the chapters of this new collection hark back to Susan Sontag’s angry and visionary broadsheet, *Illness as Metaphor*, and refer to diabetes as symbol, as metaphor, even to diabetes as myth, in an effort to contest the view of diabetes as a plain thing, a natural fact, as disease itself.

This innovative book, a paradigm-breaking endeavor, is a creative assemblage of chapters by medical anthropologists, health professionals, nurses and doctors, Indigenous Peoples and community workers. It shifts the medical gaze from the diseased body to a diseased colonial and post-colonial history of genocide, the collective experience of trauma reproduced in the many ‘small wars and invisible genocides’ practiced against Indigenous Peoples to this day.

This volume is a bold attempt to reframe the meaning of diabetes as a socio-political pathology and to place the disease outside and beyond the body of the individual sufferer and to see it as the consequences of genocide and its aftermaths and in the signature that these collective losses have left on the bodies and even the physiologies and chemistries of Indigenous Peoples in the past and today. To say that diabetes is a socio-political pathology is not to deny the medical model of disease but rather to search for ultimate, rather than immediate causes and to recognize that what medical anthropologist Margaret Lock calls ‘local biologies’ (with reference to her comparative study of menopause among Japanese and North American women) emerge out of distinctive and collective experiences and histories of embodiment and risk producing local

2. See Michael Taussig. 1992. “Terror as Usual: Walter Benjamin’s Theory of the History as State of Siege.” In *The Nervous System*, esp. pp. 11–16, and 195–96. New York: Routledge.

3. See Nancy Scheper-Hughes. 1992, *Death without Weeping: The Violence of Everyday Life*. Everyday violence encompasses everything from the routinized, bureaucratized, and utterly banal violence of young children dying of hunger and maternal despair in Northeast Brazil to elderly African-Americans dying unnecessarily of heat stroke in suffocating apartments in inner city Chicago during the heat wave of 1995. See Eric Klinenberg, 1999, “Denaturalizing Disaster: A Social Autopsy of the Chicago Heat Wave,” *Theory and Society* 28: 239–92.

and even culture bound symptoms and experiences of supposedly universal illnesses and disease. These papers look at the social context of diabetes within Indigenous experiences of colonial expansions and occupation that disrupted Indigenous ways of being-in and living-in the world and of living in and experiencing their bodies.

Several chapters discuss how socio-inequality, traumatic experiences and psychosocial stress produce observable changes in the neuroendocrine system, affecting the production and circulation of hormones, including cortisol, glucagons, catecholamines and insulin itself. In the absence of protective factors, the leading symptom of diabetes mellitus, hyperglycemia or high blood sugars, sets in and its persistence brings terrifying problems for the body: blindness, poor circulation of hands and feet leading to gangrene and amputations, sexual impotence and other serious afflictions. Strong family ties, networks of social support, generosity, solidarity and love can produce what the authors here call emotional liberty. In their absence, the ability to grieve, to feel pain, and to suffer is impaired, generating intense emotional pain and suffering which pave the way for diabetes mellitus to set in.

Genocide, trauma, emotion, food, the loss of and return to hunting and gathering as cultural and biological survival are generative themes of this collection. Contributors contend that the prevailing research focusing on obesity, nutrition, and individual health behavior—although undeniably contributors to health outcomes—obscures social and historical issues that are even more fundamental to the etiology of the disease. The link between diet and diabetes is a robust one, of course, but these authors and clinicians argue from a political and human rights perspective that recognizes the devastating effects of colonization on Indigenous health and on access to abundant and nourishing food. Ferreira and her associates argue that “access to quality, nutritious food has become a human rights issue for Indigenous Peoples globally since everyone has the right to be free from hunger and undernutrition.” This new civil right—a ‘right to *good* food’—is enshrined in various international statutes including the Rome Declaration on World Food Security (1996), the International Covenant on Economic, Social and Cultural Rights (1966) and the Universal Declaration of Human Rights (1948). The authors note that there are profound contradictions between prevailing economic and clinical visions of what a “healthy diet” is, and the hunger and scarcity that prevails in Indigenous communities, as documented in Part 2 of this book (chapters 6 by Omura; 7 by Roy; 8 by Smith Morris; 9 by Lang; and 10 by Korn and Ryser). The healing power of traditional forms of food gathering and preparation, its highly ritualized and communal dimensions requires not only equitable and sustainable food systems, but rights to the security of Indigenous livelihoods, meaning rights to land, to labor, and to social and political security, all of which are presently lacking for most of the world’s Indigenous Peoples.

I recall a visit in 1995 to a dispossessed band of Kung San people originally of the Kahahari Desert, who had resettled, for a price, on the private estate of an Afrikaner entrepreneur in the Northern Cape of South Africa. In exchange for the right to live on the estate, which was turned into a nature reserve and living cultural museum for tourists, the resident Kagga Kama had to dress traditionally in animal skins and entertain wealthy tourists with their display of traditional tools and weapons, story-telling and boasts of their hunting prowess. Back stage, however, the Kagga Kama lived in

wretched pre-fabricated huts, a veritable slum in the wilderness. They were prohibited from hunting the plentiful springbok deer, rabbits and other small animals and from digging up and gathering the roots, berries, melons and eggs that had once been the mainstay of their diets. All their 'hunting and gathering' was now limited and contained to the estate-owned company store where dried corn meal, coffee, sugar, lard, flour and canned foods were the only food available to these 'faux' hunters who entertained the white tourist tribes with their displays of blow guns, darts, and digging sticks which they were prevented from using. A dietician supplied by a local university was conducting a study of the effects of 'poor dietary' habits on the Kaga Kama San who suffered inordinately from respiratory infections, tuberculosis, and, of course, diabetes. The Afrikaner student of nutritional science saw no irony in her empirical studies recording the daily caloric intake and nutritional analyses of the 'deficiencies' of Kagga Kama diets.

In this important and innovative collection the authors situate diabetes *inside* history rather than outside it, as in the shadowy, mythological and certainly myth-making anthropological and bio-evolutionary models of the prehistory of hunting and gathering peoples. James Neel, the controversial human geneticist of Yanomami fame, contributed a particularly dangerous view of Indigenous genetics around his hypothesized "thrift gene" theory of genetically-transmitted propensity to diabetes. Neel imagined Indigenous Peoples as camel-like beasts with an inherited ability to over-eat during times of plenty so as to produce a storage pouch of abdominal fat that could be drawn on during times of famine and food scarcity. Like many such hypothetical and imaginative theories ("just so stories") of bio-evolutionary and physiological adaptations, the inherited traits become liabilities and risks under new or rapidly changing circumstances. Thus, the 'thrifty gene' (a gene that has yet to materialize in the age of modern genomics) is seen as an evolutionary mechanism that back-fired once hunting and gathering peoples 'evolved' toward more 'civilized' and sedentary lives complete with cash stores and McDonalds and Kentucky Fry take-outs on or in easy reach of every reservation, not to mention every inner city neighborhood. Hunting and gathering amidst alternating periods of fast and famine disappeared, but (according to the 'thrifty gene hypothesis) the propensity to store fat lives on in Indigenous Peoples causing them to sicken from overweight and diabetes-prone sedentary habits.

The notion of the 'thrifty gene' (and the way it has been interpreted by health workers) suggests that "Indigenous blood" carries a taint—the threat of passing on an inherited risk of diabetes for which the only solution, paradoxically, is the dilution of Indigenous blood through racial intermarriage, another form of 'invisible genocide.' Thus, bad genetics combines with bad anthropology to produce a theory that put Indigenous People in their place—that is, on the margins as bio-evolutionary holdovers and deviants only capable of reproducing cycles of medical and social pathology. Despite this, the thrifty gene hypothesis has been adopted not only by doctors and other biomedical practitioners but by Indigenous Peoples themselves looking for an explanation for the ills that disproportionately beset their communities.

Like all reductionist theories, the 'thrifty gene' is nothing if not a 'thrifty'/nifty hypothesis, one that simplifies and excludes the complexities, the bio-social interactions,

and the intervening variables like social class, gender, and the impact of colonial and post-colonial experiences of dispossession, forced migrations, and resettlement, chronic malnutrition, segregation and social exclusion. As Ferreira notes, the thrifty gene hypothesis erodes self-knowledge and turns sufferers into their own worst enemies as they adopt the idea that they are the heirs of faulty genetics and faulty behaviors (junk-food eaters, alcoholics, etc.) This, too, is another dimension of invisible genocide.

This volume is, therefore, more than a conventional medical anthropological presentation of illness narratives to balance the medical model of disease. Rather, the authors are engaged in taking at face value what Indigenous Peoples say, and feel, and do about the diabetes 'epidemic.' The goal is to move away from the purely medical model of diabetes and toward Indigenous models and understandings, an effort that was spearheaded not by physicians and social scientists but also by Indigenous Peoples themselves who chose to invite collaborations with clinicians, social scientists and researchers, but on their own terms. New efforts, such as the Kahnawake Schools Diabetes Prevention Project described by Ann Macaulay et al., confront the ethics of research and present a model for new partnerships among scholars, activists and community members.

The invention of new therapies in some communities include successful projects of culture restoration and rebuilding, including music therapy and relaxation, language and oral history workshops, bike paths, walking trails, summer camps for young people, providing social support and the emergence of new social movements to build solidarity. Acknowledging the role of mind-body interactions in stress reduction therapies, the editors have included a provocative chapter discussing evidence of the positive effects of relaxation techniques on the production of insulin.

Indigenous Peoples and Diabetes makes an eloquent case for a new and enlarged model and understanding of a modern epidemic on behalf of those who are doubly stigmatized by a disease that is seen as hopelessly mired in faulty adaptations (biological and cultural) to modern life. The book is inspired by a strong commitment to a liberation medicine and to the belief that access to good food, respect for cultural traditions, and integrative therapies are basic human rights.

Series Editors' Preface

Pamela J. Stewart and Andrew Strathern

We are pleased to see the present set of essays included in the *Ethnographic Studies in Medical Anthropology* Series. This collection is a unique set of essays that address a serious and significant medical problem, i.e., type II (also referred to as Adult Onset) diabetes. This form of diabetes is becoming an increasing problem around the world, both among wealthy populations who can buy whatever sorts of foods they wish, including healthy foods, and also among populations who may not be able to purchase, do not wish to, or do not have available to them healthy food supplies.

The approaches to the management of the Type II diabetes that are discussed in the collection could profitably be applied to contexts in many geographic areas among peoples living in diverse economic situations. Diet, exercise, emotional well-being, and family support have proven to be significant factors in the proper management of chronic disease states, including diabetes. Education of the individual with diabetes and their family is vitally important. Doctor-patient / health-care worker-patient communication is an important part of treatment. Since the management of diabetes is complex, requiring continuous vigilance, it is important that health-care workers and patients have an easy means to exchange information and that they rely on each other in a relationship of communication and mutual understanding (see discussions in Strathern and Stewart 1999).

The essays in this volume each have their individual strengths and the book will certainly take its place in the literature on medical anthropology. We read and commented on the Introduction and Chapters 1–20 during 2004. The topics in the essays are such that the work could be used in many different contexts and set for a variety of courses, e.g. those on critical medical anthropology, cultural identities, patient-physician communication, epidemiology, and nursing awareness, also in community educational centers and in training programs for healthcare practitioners.

The ways that Indigenous Peoples deal with health, diet, and disease are of particular interest to many scholars as they are also to ourselves in our research. In two of our recent books, *Curing and Healing: Medical Anthropology in Global Perspective* (Strathern and Stewart 1999) and *Humors and Substances: Ideas of the Body in New Guinea* (Stewart and Strathern 2001), we set out to explore how the peoples we work with in Papua New Guinea see their physical bodies and the sicknesses that influence their bodily functions as a part of their larger world-view or emplacement of themselves within their indigenous cosmology.

It is also always interesting and important to learn about how people build up their bodies through food and how they think their bodies are constituted in healthy or unhealthy ways. Here we will take an example from the Mount Hagen people of Papua New Guinea, among whom we have worked for many years and published on widely (e.g., A.J. Strathern 1971; Strathern and Stewart 2000). Historically they have had definite ideas about food and the body. For them, the sweet potato (*Ipomoea batatas*) was their staple, the focal member of a class of food sources called *röng* in the local language. This also included taro, yams, green vegetables of many kinds, bananas, sugarcane, edible ferns, shoots, and inflorescences. All of these foods were appreciated and many were planted together in complex garden areas known as *pana*, a term which later came to signify “year” in colonial times after the 1930s.

Sweet potatoes, an introduced crop, nevertheless had become, in the several hundred years after its arrival in New Guinea, the staple crop for the peoples of the Highlands region, because of its ability to grow well in mountainous conditions. For Hageners, then, sweet potato was the quintessential “food”, which they even described in the 1960s, using a term from the lingua franca Tok Pisin, as their “merasin” (medicine), i.e., a food that could keep them feeling well. Taro, although a much more ancient crop, was not described in this way, but people did say of it *kun pei na petem*, “there is no hunger in it”, it was very satisfying to eat and staved off the pangs of hunger.

All categories of *röng* were contrasted, and paired, with the category of *kng/kung*, “pork”, which in colonial times was expanded to include beef and mutton, introduced forms of meat. The provision, for special occasions, of *kng röng rakl*, “pork and vegetables”, was seen as an important marker of hospitality; and what pork especially added to foods in general was *kopong*, “grease”. In turn “grease” was a general marker of vitality, prosperity, and fertility. To have *kopong* was therefore to be vital, alive, healthy, and even influential. A body lacking *kopong* was not seen as healthy.

Hageners’ ideas about bodily composition, therefore, led them to associate “fatness” with “health”, a supposition that can further lead to problems for them in contexts where their dietary intake has changed. Pork was rarely eaten in the past and consumed only at special ceremonies along with vegetables, which were daily staples; the availability of fatty meat and fried food in urban stores has changed this situation radically. This observation underlines the importance of studying diet as an integral part of a people’s whole set of historical and adaptive circumstances and their own ideas of ideal bodily and mental states. In Hagen a good *noman* or “mind” was also said to be reflected in a “healthy” body, i.e., one with *kopong* (grease/fat).

In thinking about the body in sickness one must also consider the body and its place within the social system at large. Many discussions on the body in anthropology have tended to oscillate between a stress on the body as a passive marker and the body as a locus of agency. Mary Douglas in her writing distinguished clearly between different social environments and their effects on perception and experience (Douglas 1966) and spoke of the “social body” as constraining the perceptions of the “individual body” (Douglas 1970: 68). Thomas Csordas, by contrast, has emphasized embodied experience as the foundation of culture (e.g. Csordas 1994).

But if one starts with a different set of propositions, i.e., looking at the emplacement of the individual body within a cosmological world-view, this opposition is itself mediated. To say that the body is a part of the cosmos implies already that it has its place in the cosmos and that the cosmos, in a sense, runs through it as well as vice-versa. To be a part of the cosmos, however, is also actively to experience life within it and to experience change and stress that evoke active and energetic responses. When disjunctions occur between a sense of “proper” cosmological emplacement it is more difficult for individuals to place their bodily well-being into a cycle of day-to-day health maintenance. This is true for those peoples classified as “indigenous” and those that are not classified in that way. Issues of this kind are explored in thoughtful, practical, and concerned ways by the contributors to this volume.

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Acknowledgments

Mariana and Gretchen would like to thank each of the authors in this anthology—it has been a pleasure to work with you! We greatly appreciate the collaborative spirit and strict work ethics in putting this exciting collection of original essays together. We especially want to thank Dr. Jo Scheder for her generous contribution to this volume, inspiring all of us to look deeply into a physiology of oppression as it relates to type 2 diabetes and the on-going process of colonization of Indigenous Peoples across the planet. The critical work of Nancy Scheper-Hughes has also stirred us toward a liberation medicine that believes access to good food, respect for cultural traditions, and integrative therapies are basic human rights. Indigenous professionals, elders and community members from different nations have provided us all with invaluable knowledges and conscientious practices for the empowerment and well-being of First Peoples worldwide. Thank you!

Our thanks to the Senior Editors of the Medical Anthropology Series, Carolina Academic Press, Pamela Stewart and Andrew Strathern, for all the encouragement and editorial advice.

Mariana Leal Ferreira would like to acknowledge all the trust and support received from United Indian Health Services in northern California, and the Yurok community in particular. Research grants were provided by the Brazilian agencies CNPQ (Conselho Nacional de Desenvolvimento Científico e Tecnológico) and FAPESP (Fundação de Amparo à Pesquisa do Estado de São Paulo), and from Graduate Programs in the United States at the University of California at Berkeley, University of Tennessee, and San Francisco State University. Gretchen Chesley Lang expresses her gratitude to the Spirit Lake Dakota community, as well as colleagues and mentors, Profs. Dorothy K. Billings, Eugene Ogan, H. Clyde Wilson and the late Bernard O'Kelly, Arts and Sciences Dean (University of North Dakota), for their encouragement of her work with Indigenous health issues over many years.

