Healthy houses – perspective on well-being in rural Cambodia

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In a remote area of north-east Cambodia, health is seen more as a matter of living in a spiritually favourable house than of preventing and controlling diseases in individuals. However, this way of seeing things is being influenced towards a more collective view on the one hand, and a more individualistic one on the other.

Culture, the way people think, influences health behaviour in profound ways. It defines the reality of illness and cure. In some cultures, such as the ones I discuss here, the significant “unit” of health is not the individual but the household. Health behaviour always has social implications, and here it reinforces the household as an institution, though current changes appear to undermine this system.

Many years ago, the king provided a hospital for his people, and in a statement that marked this effort he declared his hope that all subsequent kings, along with their wives, dignitaries, and friends, would come to a place where there was no more illness. The location he was referring to, the place of no illness, was Nirvana – not a place in the usual sense, but a state of being where people have left the cycle of rebirth. While this was in 12th century Cambodia, the king’s ambitions bear some resemblance to the objective of WHO, the “attainment by all peoples of the highest possible level of health”, and the difference between the two is what I am concerned with. Notions of health are entangled in assumptions that also underlie our world-view and social life, and what people do about health always has social implications.

Though my work as an anthropologist was with rather small minority groups in a remote area of Cambodia, their social life reveals an aspect of health that may be of general interest, which is that “health” is not a domain of action or experience that can be separated from other domains such as farming, religion, or politics. Cultural differences make a social and political difference; they are not a thin veneer that obscures how people and their health are everywhere the same. I will make my case with reference to the minorities in the Cambodian hinterlands. A fuller account of these people and their situation appears elsewhere (1).

Houses and health

The minority peoples, who grow rice, maize, tubers, and other crops in swidden fields (temporary agricultural plots), are quite concerned about health. How people try to attain health points to the larger issue of how health behaviour implies social relations. When the illness was not an eating disorder that could be changed with altered diet, people would assume that it was caused by spirits. A woman was frequently ill, and she and others said that the ghost of her dead husband made her ill, and would make her better once she fed him by making an offering of a pig. This was not an isolated incident, though most were not this drastic. People made offerings to ancestor spir-
its and village guardian spirits, and asked them to keep away illness and death.

Well-being depends on the transfer of soul-stuff between the spirit world and the human world, which requires occasional offerings of chickens, pigs or buffaloes, and people get rather drunk at the feast that follows. Also, illness afflicts not only individuals but houses and villages. The offerings and the feasting are not cultural factors that are separate from local notions of health and well-being, but are central to how these people live.

Spirits cling to structures such as houses, and it is only as householders that people have access to them. When people are not doing well, they may discern that the spirits are not taking good care of them, and then move to another house for another “contract”, and they may abandon a village for this reason. One couple I knew had moved a few times because the woman had not got pregnant. This is assuming that without blessing derived from spirits, the biology of pregnancy will not work. Newborn babies are considered rather soulless, and to derive their soul from their mother’s milk during their first year. No doubt, the frequency of infant deaths reinforces the view that babies are lacking soul-stuff.

A person of any age can lose the soul he or she has, which results in fatigue, depression, or other signs of what locals call a “lack of strength”. The soul needs to be called back, and it is called back to the house where the person is living. The house is a container for soul-stuff, and people will not live in a house they think does not keep them in good health.

The effect of health behaviour

Among these upland minorities, ideas of health assume households engaged in rice-farming, with some supply of domestic animals. What people do about health reinforces the household as an institution, and relations among households. To a varying extent, people conduct rituals at the village level, to guarantee good health in the coming year, and then they invite people from other villages to join in their feast. This health behaviour is quite different from, say, that of the 12th century king of Angkor, whose activities required the corvée labour of hundreds or thousands of subjects in his construction projects. It differs likewise from the way international health projects require monetary contributions from individuals, associations or governments, and the paid or voluntary labour of Western health workers on a sojourn in the Third World. In each case, what people do about health is entangled in assumptions about social life and has social and political consequences.

My views are to some extent the result of extended stays in some of the upland villages; the reality of villagers was my main source of information on health issues and their relation to other factors. Justice (2) has shown how people at different levels of international health projects have different views on what the issues are. Her analysis shows that changes in project priorities are more apparent in reports than in practices in the “field”. What gets done is to some extent determined by the need to show results over time. Thus, there is an emphasis on gathering statistics, and some projects have been chosen simply because they were more amenable to statistics than other health issues.

These statistics take certain kinds of illnesses for granted, and measure their prevalence by the number of individuals who fall within each category.

Such efforts reaffirm the notion that individuals are the units of illness, and propagate the notion of people as patients. The notion of “patients” is a cultural category, and what is at issue is not the “cultural construction of clinical reality” but the “clinical construction of cultural reality”, as Taussig (3) points out. Taussig is concerned with situations where there is an effort to overcome cultural difference in approaches to medicine. This is done by eliciting the cultural framework of the locals, which is viewed as an obstacle to the efficient provi-
sion of health care. The outcome is that one cultural framework is manipulated through another, and this places the control of the

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social situation unambiguously with those on the side of the medical system, who assume that their activities are beyond culture.

Reasonable effort

The lengths to which people are willing to go for health and well-being are not uniform. For the villagers I stayed with, a man would move into the house of his wife’s parents at marriage and stay there for about two years. His work for this household is in exchange for the prosperity granted by the ancestors of the wife’s parents, and during these two years the couple is expected to have their first child. Later they can establish their own household, and engage in exchange relations with villagers and spirits on their own. As we have seen, people also make offerings on the village level for their health and prosperity. Villagers then pool their resources to buy a buffalo.

Any health behaviour implies the mobilization of labour and resources, and different cultural frameworks define certain efforts as more plausible and desirable than others. I do not want to give the impression that culture in the hinterlands was static. There were various tensions over the kinds of efforts that should be made, and one headman organized all the villages in his commune for a collective offering. This had never been done before, but the increased pressure to integrate this former hinterland into national administrative structures, together with the presence of an international health project, made the case for such efforts seem stronger than before. Health behaviour appears to be increasingly pulling people in two directions, both away from the household. On the one hand, it is making them individuals, which is away from the household as a unit of health. On the other it channels their labour to commune-level efforts because health centres are at the commune and district level, and local health workers work at the commune level, making regular visits to villages, thus also away the household as the unit of work. The national government may resolve these tensions in a rather harsh way, as recent news reports indicate that they are likely to devote the whole province to plantations in an effort to end swidden cultivation.

Culture and health are not separate. These are intertwined domains of knowledge and action, that reinforce particular definitions of where illness resides, and imply particular social arrangements. Within a culture, there may be tensions over what to do about health issues, but this is significantly more complicated in multicultural settings. I have pointed out some of the issues of difference by presenting the logic of a particular system of health knowledge and some of the social dimensions that influence how it is acted out. I raise these points in the hope of provoking further discussion on health and health care in multicultural settings.

References

